Psychotherapy

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

www.societyforpsychotherapy.org

BULLETIN

In This Issue

Society for the Advancement of Psychotherapy

2023 VOLUME 58, NUMBER 2 & 3 (Combined Issue)

Society for the Advancement of Psychotherapy /APA Div 29 2023 Governance

ELECTED BOARD MEMBERS

OFFICERS

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

President-elect
Tony Rousmaniere, PsyD
Sentio Counseling Center
3756 W. Avenue 40, Suite K, #478
Los Angeles, CA 90065
Office: 206-384-8058
trousmaniere@sentiocc.org

Secretary
Stewart Cooper, PhD, 2021-2023
Valparaiso University Counseling Services
1602 LaPorte Avenue,
Valparaiso, IN 46383
Ofc: 219-464-5002
stewart.cooper@valpo.edu

Treasurer
Joshua Swift, PhD, 2022-2024
Department of Psychology
Idaho State University
921 S. 8th Ave, Stop 8112
Pocatello, ID 83201
Ofc: 208-282-3445
joshua.keith.swift@gmail.com

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

Domain Representatives

Public Interest and Social Justice
Rosemary Phelps, PhD, 2021-2023
University of Georgia
402 Aderhold Hall
Athens, GA
Ofc: 706-542-1812
rephelps@UGA.EDU

Psychotherapy Practice
Barbara Vivino, PhD, 2022-2024
921 The Alameda #109
Berkeley, CA 94707
Ofc: 510-303-6650
bvivino@aol.com

Education and Training
Cheri Marmarosh, PhD, 2022-2024
The George Washington University
Professional Psychology
Washington DC 90008
Office: 301-728-0410
marmaros@gwu.edu

Membership
Rebecca Ametrano, PhD, 2022-2024
Office of Patient Centered Care
VA Boston Healthcare System
1400 VFW Parkway
West Roxbury, MA 02132
rametrano@gmail.com

Early Career
Yujia Lei, PhD, 2023-2025
leiyujia1984@gmail.com

Science and Scholarship
Patricia Spangler, PhD, 2023-2025
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, 2023-2025
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 Representative
Elizabeth Nutt Williams, PhD, 2023-2025
enwilliams@smcm.edu

Jeffrey Younggren, PhD 2023-2025
jyounggren@salud.unm.edu

Student Representative
Krizia Wearing 2023-2025
Chestnut Hill College
Dept. of Professional Psychology
9601 Germantown Avenue
Philadelphia, PA 19118
Ofc: 215-248-7000
wearingk@chc.edu

2023 STANDING COMMITTEES

Continuing Education
Chair: Ken Critchfield, Ph.D.
kenneth.critchfield@yu.edu

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

Early Career Psychologists
Chair: Michelle Joaquin
michjoaquin@gmail.com

Education & Training
Chair: Melissa Jones
melissa_jones@byu.edu

Fellows
Chair: Robert L. Hatcher, PhD
rhatcher@gc.cuny.edu

Finance
Chair: Nili Solomonov, PhD
Nis2051@med.cornell.edu

International Affairs
Co-chair: Lauren Behrman, PhD
laurenbehrman@gmail.com

Co-chair: Maria Del Pilar Grazioso, PhD
mpgrazioso@PROYECTOAIGLE.ORG.GT

Membership
Chair: Nick Morrison
nicholas.r.morrison@GMAIL.

Nominations and Elections
Chair: Tony Rousmaniere
trousmaniere@gmail.com

Professional Awards
Chair: Gerry Koocher, PhD
koocher@gmail.com

Program
Chair: Jamie Bedics, PhD
jbedics@callutheran.edu

Psychotherapy Practice
Chair: Genee Jackson, PhD
gendeja@gmail.com

Science & Scholarship
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
Jeffrey E. Barnett, Psy.D. ABPP

Psychotherapy Practice
Barbara Vivino, PhD and
Genee Jackson, PhD

Psychotherapy Research, Science and Scholarship
Patricia Spangler, PhD and
Harold Chui, PhD

Public Interest and Social Justice
Rosemary Phelps, PhD and
Linda Campbell, PhD

Washington Scene
Patrick DeLeon, PhD

Early Career
Yujia Lei, PhD and
Michelle Joaquin, PhD

Student feature
Krizia Wearing

Editorial Assistants
Kate Axford, MS and
Sree Sinha

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

Website
www.societyforpsychotherapy.org

PSYCHOTHERAPY BULLETIN

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

Society for the Advancement of Psychotherapy

2023 Volume 58, Number 2 & 3 (Combined Issue)

TABLE OF CONTENTS

PRESIDENT'S COLUMN

Jean M. Birbilis, PhD, LP, BCB
University of St. Thomas

There has been a tremendous amount of productivity in our Society thus far in 2023. The Task Force that I appointed for my initiative (to improve communication, continuity, and consistency in the governance of SAP and to initiate an archive) has continued to meet almost every week since the February Board Meeting, building on the 2022 work of the Task Force under the leadership of Jennifer Callahan. Recommendations on May 19 of the Task Force were enthusiastically received by the Board at a virtual Board Meeting, and the Board encouraged the Task Force to continue working on them. Consequently, the Task Force has resumed meeting and is addressing: increased contact among members of governance; role clarifications for Domain Representatives (voting Board Members) and Chairs of Standing Committees; increasing content in the Bulletin; and pursuit of an ongoing archive that documents the activities and achievements of SAP. The composition of the 2023 Task Force is Jean Carter (co-chair), Linda Campbell (co-chair), Stewart Cooper, Melissa Jones, Barbara Thompson, Tracey Martin, and me. If you would like to offer input to the Task Force, we encourage it!

Other activities of note since the last issue of the Bulletin include but aren't limited to the following. The Board approved renaming the Student Diversity Paper Award the Lillian Comas-Diaz Student Diversity Paper Award. The Practice Domain has submitted material to our website regarding climate change and psychotherapy. The International Domain has continued to strengthen our relationship with Oriental Insight in China in multiple ways. The Education and Training Committee chair, Melissa Jones, designed a new, 3 step process f or submitting proposals for webinars (whether for continuing education credits or not); the link to a description of the process and associated forms is on our website. (The link can also be used to suggest topics for future webinars.) This process will facilitate advertising through all of SAP's communication channels, avoid scheduling conflicts associated with our Zoom link, and prevent inadvertent redundancy of content. We also hope that it will serve as a mechanism for creating a path leading to collaboration across Domains and contribute to one of my initiative goals: increasing contact and subsequent communication among members of SAP governance.

We have also been pursuing collaborative relationships with both the Society for the Exploration of Psychotherapy Integration (SEPI) and the Society for Psychotherapy Research (SPR). For example, I traveled to the SEPI Conference in May to award our Jeremy Safran Memorial Poster Award to Eduvigis Cruz-Arrieta. The SPR Conference included pre-conference workshops by Clara Hill and John Norcross, and we were a major sponsor of the Conference. We also had a very successful APA convention in August in Washington, D.C. The programming has been posted on the SAP website for you to see, and while you're there, check out other new content. We hope to see you at other events coming down the pike!

EDITOR'S COLUMN

Joanna M. Drinane, PhD
University of Utah

"…We must speak of us and our problems because our life, our existence, will always be riveted to death, love to loss, freedom to fear, and growth to separation. We are, all of us, in this together."

— Irvin D. Yalom

Dear SAP Membership,

I write to express my apologies for the delayed release of this combined super issue of the *Psychotherapy Bulletin*. In collaboration with the Division's leadership, over the last year, the Editorial and Website teams have been working to develop a system for submission and publication that honors the demands placed upon Domain Representatives; however, we are still ironing out the kinks. This has involved reducing the number of yearly columns expected from each Domain. That said, we did not anticipate the variability that would emerge regarding the timing of when each representative might choose to submit. Accordingly, we did not have a full, substantive issue to release in June and we are strategizing as a group to prevent such a problem from happening again. We thank those who did contribute and want to acknowledge the value of your time and writing.

The Division's Domain Representatives and broader base of authors rallied for the September issue as you will see in this combined super 55-2/3 document. Unfortunately, the increase of submissions corresponded with the death of my mom and subsequent challenges on my part to balance my grief with my editorial responsibilities. I take the timely release of the *Psychotherapy Bulletin* very seriously and appreciate the kindness and support shown to me by colleagues in Division 29 as I took some space to celebrate my mom's life and miss her presence. As Irvin Yalom speaks to in the introductory quote above, "We are, all of us, in this together." While the loss of my mom certainly triggered my fears of isolation, I have since been reminded of the connection I feel in this community, which I know many of us experience as we read the work submitted by our diverse members.

The Editorial Team wants to express that our intention for the remainder of this year is to produce a substantive and on-time December issue and to cultivate a strong identity as a publication under the leadership of new Publication Board Chair, Dr. Amy Ellis. We continue to seek contemporary perspectives on issues faced by practitioners, researchers, instructors, and activists. Submissions from the Division's Domain Representatives are extremely valuable, and we have also worked to round out our content by soliciting pieces from different authors across the country and beyond. You will notice that in addition to our anticipated contributions from Dr. Jeffrey Barnett on Ethics, the International Domain, the Science and Scholarship Domain, and the Membership Domain, we also had four Features, which are pieces that we often correspond with outside authors about. We continue to consider ways to extend our reach as a Division and representing different voices and perspectives is one such way to do so.

continued on page 4

As you consider your final submission for the year, please know that we welcome columns of variable lengths and whose focus generally aligns with the following: "The Therapist of 2023: Reengaging with our Purpose and our Process." Thank you in advance for your insightful approaches to writing about this theme and for the time and effort you invest into bridging the gaps between practice, research, and education through the *Psychotherapy Bulletin*.

I personally extend my gratitude to each of you, especially the authors, for your patience and compassion as I grappled with my own humanity this summer and fall. I look forward to a productive and engaging final issue of 2023 and hope to see your work coming through our Wufoo submission portal soon (http://societyforpsychotherapy.org/bulletin-about/)! The final deadline for the year is listed as October 15, but for this issue, we will prioritize anything turned in by November 8th. Please reach out with questions to joanna.drinane@utah.edu. We look forward to learning from and with you through your work!

Warmly,
Joanna

Society for the Advancement of Psychotherapy

FEATURE

Call for Systemic Changes to Alleviate International Students' Practicum Barriers in APA Accredited Psychology Programs

JiSoo Park, M.A.
University of Utah

Yeeun Kim, M.A.
Arizona State University

In counseling psychology programs, students face unique challenges related to the scientist-practitioner model of training.[1] Unlike many people in graduate school who only have research responsibilities, counseling psychology students are expected to have dual duties: engaging in research and practicing mental health.

Practicum experiences shape students' future careers as mental health professionals. During their doctoral work, students' direct intervention hours occur in different sites (e.g., Veterans Affairs Hospitals, community mental health clinics, university counseling centers, etc.) and contribute to success in the Association of Psychology Internship Centers (APPIC) match, which is a requirement for students to graduate from American Psychological Association (APA) accredited psychology programs. To apply for APPIC internship programs, students must reach clinical minimums, including at least 300-500 hours of direct therapy or assessment intervention hours. Thus, students in APA-accredited programs must decide whether to apply to field practicums[2] inside or outside the university that may change yearly to meet clinical requirements for competitive APPIC internship application.

The stress of choosing placements and building a clinical resume intensifies in the case of international students who study under student visas.[3] International students, especially those from nations that do not use English as their first language, likely face barriers to language and acculturation. On top of these stressors, international students may encounter additional challenges with restrictions from their legal status that limit their opportunities for practicums outside their universities. Full-time students with F-1 Visas are allowed to work on U.S. soil, yet only at their academic institutions, with some exceptions of working

continued on page 6

[1] In this article, we have focused on issues of international students in APA-accredited Ph.D. programs. Masters' level students may have similar but slightly different experiences than Ph.D. students.

[2] The term "field practicum" will be used to indicate externships outside program-sponsored practicum sites (on-site clinics) that need a separate application process.

[3] Most international students hold F-1 student visas, but some other visa holders are eligible to study in the U.S. For example, many dependents of nonimmigrant visa holders are allowed to study in the U.S. (USICE, n.d.).

outside the host institution during (i.e., Curricular Practical Training; CPT[4]) or after graduating (i.e., Optional Practical Training; OPT) from the program (USCIS, n.d.). Moreover, it is important to note that certain federal or state facilities, such as Veterans Affairs (VA) or correctional facilities, have restrictions limiting applications to American citizens only (Clay, 2009), which varies depending on their locations.

What does this mean for international students? Their legal status in the U.S. can lead to complications in gaining experience that may influence their future practice. For some international students who want to work outside academia, practicing only in university settings may limit their opportunities to specialize in such areas and exposure to the target population they want to work with in the future. For example, international students who want to gain expertise in trauma may benefit from training in VAs, which are known for treating post-traumatic stress disorders. However, if local VAs will not accept international applicants, it can be difficult for students to gain experience treating trauma from one of the best practices in the field. Above all, there may be other barriers when searching for field practicum: whether working in that specific practicum can harm students' legal nonimmigrant status to stay, study, work, and thrive in the U.S. For instance, if the students' practicum site match was made outside the university without the consultation of International Students and Scholars Services (ISSS), it might jeopardize their legal status, exposing them to the risk of deportation.

A gradual advocacy effort from the field of counseling psychology has aimed to raise awareness of these challenges of international students through scholarly publications. Last year, *The Counseling Psychologist* (TCP) dedicated a special issue centered on international students, presenting articles focusing on the career hurdles confronted by international students and the collective experiences shared by international faculty members (Consoli et al., 2022; Domínguez et al., 2022). Despite efforts to draw attention to these issues, translating the discovery into action has a long way to go. In fact, international students are still undergoing issues that Lee (2013) and Clay (2009) stated 10-plus years ago, without substantial guidance from experts who know about the field of psychology.

Psychology has traditionally attempted to advocate for minorities and to amplify their voices to make meaningful changes in society. We believe that international students deserve the spotlight because of these persistent, predictable systemic challenges. Therefore, this article provides practical recommendations that may help international students successfully maintain their legal status and flourish in their psychology programs during field practicum and internships, with some examples of issues that students are likely to encounter.

continued on page 7

[4] Both CPT and OPT are programs for international students to gain training opportunities that supplement the knowledge students learn in academia (Department of Homeland Security, n.d.). They require separate documentation processes with the designated school official, who is the staff responsible for advising visa holders at the ISSS. The main difference between the two programs is when students apply; CPT can be filed when students are within the program, while OPT is mostly filed after students' completion of the program. When students use up "one year or more of full-time CPT," they may be disqualified for post-completion OPT.

Need for Systematic Approach to International Students' Practicum Issue

As international students in counseling psychology PhD programs in the U.S., the authors have observed confusion within each department concerning practicum-related matters of international students. Despite the dedicated efforts of the Directors of Clinical Training (DCT) and advisors, there are significant gaps of knowledge among various entities, including the program, department, graduate school, ISSS, and internship sites, in effectively addressing the career concerns of international students within psychology programs.

Even though field practicum issues can have detrimental consequences for international students' ability to remain and study in the United States, it often falls on international students to solve these issues. Typically, international students ask and confirm with the ISSS about their eligibility for field practicum applications. However, due to the unique requirements of APA-accredited programs regarding field practicum hours and internships, international students may have to go back and forth to their program, department, and ISSS, and they may not find answers.

For this reason, at times, international students rely on peers in their programs who have gone through similar processes, as they can be reliable sources to obtain specific tips. However, this might not work if there is only one student visa in a department. Some may be lucky to find nationwide networks of students and psychologists of the same ethnic background who are trying to navigate this issue collectively (e.g., Korean Psychologist Network, Taiwan Psychologists Network). Nonetheless, students in universities that traditionally do not have many international students or who are not members of a larger ethnocultural professional group may wind up with the feeling isolated and without information. It is a complicated task for international students lacking resources to remedy these issues as there may be legal implications, especially if the student wants to migrate to the U.S. in the future.

Therefore, we believe there should be a more systemic approach that includes the different entities at the macro and micro levels to address the complex issues that international students are expected to encounter.

Macro Level: Guidelines made by APPIC and APA

International students confront incidents like those minority students face in multicultural counseling classes. Minority students are often asked to elaborate on their experiences of discrimination to students of privileged groups. This happens to international students as well and they are also asked to explain their situation in programs, departments, ISSS, field practicum sites, and even full-time internship sites.

The problem with this approach is that international students are not experts in the legal execution of these issues. International students may have more interest and knowledge in immigration laws and processes than laypersons, but their recommendations cannot guarantee the best outcome for international students' legal status. Further, these struggles regarding their legal status can add emotional and financial burdens (that can range from a few hundred dollars to more than $10,000, depending on the institution) for international students that might impact their schoolwork and psychological well-being. Most of all, independently tackling the system does not lead to a dismantling of systemic issues that international students face.

continued on page 8

To dismantle the systematic problems, we believe APA and APPIC are key to solving the issue related to international students' training site restrictions. APA and APPIC are the accrediting bodies of psychology programs and internship sites. They define and uphold requirements for quality psychology education, these organizations may be most effective in establishing systematic change. Further, these two entities are better resourced than individual students, and can provide more accurate information that DCTs, internship sites, and international students can reference.

Therefore, we suggest APA and APPIC provide structured, verified information about international students' hurdles in practicum and internships in the form of guidelines, manuals, or Frequently Asked Questions (FAQ) for students, faculty, institutions, and ISSS. In recent years, there have been efforts to educate internship sites and programs to deal with international students' issues from APPIC (Hwang & Hurley, 2018). However, these efforts have not been successfully spread to each program and internship site to assist the needs of international students. Thus, like the hiring process of international employees in private companies and universities, where the Human Resources department of each company provides pre-established sets of documents to their new employees, APA and APPIC can compile a list of expected challenges and solutions that international students might encounter and distribute them to each program, field practicum, and the internship site to navigate the issues effectively. It may include a legally compliant contract format that fulfills the necessary requirements while accommodating the students' needs.

Micro Level: Increased Connectivity of the Program, Department, and ISSS

Consider the following statement from a 2nd year student in a counseling psychology doctoral program, "I have been between the advisors, training directors, program, department, and ISSS multiple times, wanting verified information by those departments. At the end of the day, I asked my international friend in another program for a guideline."

Even if there are guidelines from APA and APPIC that provide broad, structural information for international students, specific regional information may be only available through programs and universities. However, as presented in the quote above, international students can experience a lack of resolution regarding student visa issues in their departments. When something related to immigrant policies emerges (e.g., some financial aid is only for citizens and permanent residents), students are advised to solve the issues with ISSS, a department specialized in dealing with international students' problems.

However, sending students to ISSS for practicum applications or internship issues is not as effective for psychology students, as practicum is embedded in the training ideals of the program and students' career paths. Rather, increased collaborative efforts should be made between programs, departments, and ISSS to reduce confusion over practicum and internship issues.

One of the challenges international students face during the internship year due to the lack of collaboration between school entities circles around preserving the F-1 visa status and managing the associated tuition fees. It has been individual international students' responsibility to navigate the number of credits

continued on page 9

that they should enroll in to ensure visa compliance, as F-1 visa holders are required to be full-time students to maintain their status, as well as find ways to finance the credits that are not covered by tuition benefits from the program during the internship year. This issue is complicated by varying university policies. For example, in many cases, the decision to approve a reduced course load has been left to the discretion of the ISSS, while the provision of reduced tuition to maintain a full course load is determined by the individual program and graduate school. As a result, these discrepancies in policies within the school entities put international students in challenging positions. Stress around legal status can become a significant financial burden, as international students may be obligated to cover the international student tuition fees for the entire course load during their predoctoral internship year when the university often does not financially support them.

To address these issues, we again recommend fostering collaborations among the psychology program, department, graduate school, and ISSS. Each program may clarify the issues that international students face and verify the requirements and related policies from the ISSS (e.g., whether the program's reduced/minimum credits on internship affect students' full-time student status, location (as international students are only allowed to work on campus without CPT or OPT), whether practicum hours are less than 20 hours a week).

Further, we suggest that each program create internal guidelines for current and future international students. There is another underlying issue with the lack of resources for international students within the program or department: not preserving what is learned. To prevent losing valuable information, we recommend documenting important information related to working with international students. For instance, the program may include an international student section in the student handbook. Moreover, programs might create a list of practicum sites where international students have successfully completed their practicums and routinely check international students' application eligibility within each practicum site with ISSS. It is also important to acknowledge international students' lived experiences and hardships, use the opportunity to advocate for themselves and other remaining students, and compensate international students for their efforts.

Increased Communication and Networking: A National-Level International Psychology Students Association

For international students who cannot find useful resources in their own program or university, an alternative and supplemental nationwide network of international students in APA-accredited programs might provide a forum to ask others who may know about the issue. To that end, we recommend creating an interactive, year-round networking community of international students. Currently, there is a Facebook page run by the international psychology sector in Division 17, yet they are mostly active around the annual APA convention and less active at other times. Annual communication is helpful for international students, but it would be more useful to have a timely and responsive forum as issues arise. Thus, we suggest mediums that enable an interactive international student community, such as a mailing list, group chat, or an internet bulletin where individuals can communicate freely and interactively, asking questions and getting responses more promptly.

continued on page 10

Conclusion

International students have encountered practicum and internship challenges for decades, and these serve as systemic barriers to becoming psychologists. To resolve these prolonged issues of international students, we suggest alternative ways to enhance the situation at the macro (APA and APPIC guidelines) and micro levels (more connectedness among sectors at the university level, documentation of international students' issues within the program). We also call for a more interactional international student community to exchange information and support.

Finally, the matter of international student issues should not merely be regarded as isolated concerns related to international students. Rather, it necessitates open discussion within the program, fostering an environment where the community can engage in dialogue and gain insights into the common challenges encountered by international students. By empowering and facilitating the exchange of valuable information brought forth by international students, not only will the international students themselves benefit, but also so will other students and faculty members. This discourse can foster an inclusive and welcoming culture for international students, while also preparing other students and faculty to provide effective support and guidance to international students and clients in the future.

Author Note

We would like to thank Joonwoo Lee, MEd, faculty, and all international students for their thoughtful feedback on our article.

References

Clay, R. A. (2009, November). *Welcome to America Coming to the United States for your studies? Check out these practical tips*. American Psychological Association. https://www.apa.org/gradpsych/2009/11/welcome

Consoli, A. J., Çiftçi, A., Poyrazlı, Ş., Iwasaki, M., Canetto, S. S., Ovrebo, E., Wang, C. D. C., & Forrest, L. (2022). International students who became U.S. counseling psychology faculty members: A collaborative autoethnography. [Special issue]. *The Counseling Psychologist*, *50*(6), 874–910. https://doi.org/10.1177/00110000221098377

Department of Homeland Security. (n.d.). *Training opportunities in the United States*. Retrieved June 29, 2023, from https://studyinthestates.dhs.gov/students/training-opportunities-in-the-united-states

Domínguez, D. G., Cheng, H.-L., & De La Rue, L. (2022). Career barriers and coping with international students in counseling psychology programs. [Special issue]. *The Counseling Psychologist*, *50*(6), 780–812. https://doi.org/10.1177/00110000221097358

Hwang, B., & Hurley, D. (2018). *Successfully matching, training, and graduating international psychology interns and postdocs.* APPIC. https:// www.appic.org/Portals/0/2018%20Conference/2018_APPIC_Presentation_Hwang_Hurley.pdf

Lee, K. C. (2013). Training and educating international students in professional psychology: What graduate programs should know. *Training and Education in Professional Psychology*, *7*(1), 61–69. https://doi.org/10.1037/a0031186

USCIS. (n.d.). *Students and Employment*. USCIS. Retrieved May 2, 2023, from https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/students-and-employment

USICE. (n.d.). *Nonimmigrants: Who Can Study?* US Immigration and Customs Enforcement. Retrieved July 6, 2023, from https://www.ice.gov/doclib/sevis/pdf/Nonimmigrant%20Class%20Who%20Can%20Study.pdf

FEATURE

Ageism: The Hidden "Ism"

Cordaris Butler, MSBS, Doctoral Student
University of Kansas

Ageism and Identity—The Hidden-Ism

The population in the United States is greying at a high rate. According to the World Health Organization (WHO), the world population over 60 will almost double from 12% to 22% from the year 2015 to 2050 (WHO, 2022). While this is great news, there are challenges that lie ahead. With increased aging adults in society, there have been increased rates of reported negative attitudes toward aging adults (Kang & Kim, 2022). Allen, Solway, Kirch., Singer, Kullgren, Moïse, and Malani (2022) state in a in a cross-sectional study of 2035 older adults that 93.4% of aging adults experience ageism daily. Additionally, aging adults report negative attitudes not only from society but also from their own self-perceptions (Levy, 2018; Kang and Kim, 2022).

Ageism is defined as the prejudice and or discrimination of an individual's age (Kang and Kim, 2022). Several instances of ageism exist in our cultural spaces. "Old Farts" "Dead-beats" and "Greedy Geezers" are among the many examples of comments that have been directed toward aging adults (Barney, Chrisler, and Palatino, 2016). Barney et al (2016) states how ageist remarks negatively impact the well-being of older individuals, particularly women. Not only are women greatly impacted by negative attitudes toward aging but also underrepresented aging adults in non-White, heterosexual communities (Detwiler, 2016; Hoy-Ellis & Fredriksen-Goldsen, 2016; Hoy-Ellis & Fredriksen-Goldsen, 2017). Aging adults existing in the communities encounter significant challenges regarding racism, sexism, homophobia, and other barriers which further impact their identity and well-being in relation to intersectionality and age. The purpose of this write-up is to provide awareness of growing sentiment toward ageism, identity challenges toward aging, as well as potential strategies to mitigate the impact of ageism.

Identity Challenges in Aging

While ageism is a continually growing concern worldwide, there are many challenges with relation to aging and identity. One major concern is loss of identity and or role confusion. Many older adults report a lost sense of self as one ages. Generally, their children are adults, likely with their own children and life responsibilities. Women, according to traditional gender roles, are seen as caregivers, which may impact one's view of their identity. Older men experience a greater sense of loss in relation to vocational identity (Harris et al., 2016).

Aging adults are likely to have experienced a significant shift in their financial and social relationships. For example, many aging adults have experienced the loss of work identity, financial changes, friends, family members, or even spouses (Harris et al., 2016). These life events can have a profound impact on their identity and well-being. In some situations, aging adults may experience internalized ageist beliefs which further impact their identity. Chrisler et al (2016) and Hoy-Ellis and Fredriksen-Goldsen (2016) reference distancing

continued on page 12

behaviors as an internalized ageist behavior evidenced by statements reflective of physical appearance and life events. Life events that aging adults experience can have negative impacts on their identity and well-being.

Another major concern in reference to ageism and identity revolve around societal expectations of aging adults. As previously stated, negative stereotypes reinforce harmful impacts onto aging adults. One example of this is associated systems in work. Aging adults are likely to experience extended wait times for longer unemployment while simultaneously accepting lower paid jobs (Harris, Krygsman, Waschenko, and Rudmon, 2018). Additionally, aging adults experience higher bouts of discrimination due to employer beliefs, attitudes, and actions. Many organizations view aging adults as cognitively unable to learn compared to their younger counterparts, be productive, and demonstrate flexibility in the workplace (Harris et al., 2018). Even subtle jokes regarding aging workers such as "old-timer's" or "senior moments," have negative connotations, insinuating that aging adults have cognitive limitations (Barney et al., 2016). Consequently, societal and organizational structures impact aging adults on an internal level, which fuels harmful thoughts for aging individuals (Barney et al., 2016). Aging adults may experience a lack of self-confidence and self-worth.

As adults age, another layer of identity challenges are their views of life meaning. It is not uncommon for aging adults to reflect upon their life with varying degrees of thoughts and emotions. Moreover, aging adults view their current selves as whether they have meaning or value in society. According to Barney, Chrisler, and Palatino (2016), society views aging adults as a burden to our healthcare system as well as other resources. Much of these negative societal views can further fuel negative attitudes such as aging adults constantly having health problems. Negative sentiments as such can have harmful effects on aging adults' identity.

How Can Psychology Mitigate Ageism?

Strength-Based Approach

Psychology holds a variety of mechanisms that may be used to positively impact society's view regarding the aging process. Furthermore, there are actions that can be taken to influence thoughts about aging. One notion is the emphasis on strength-based language. The GSA's Reframing Aging Initiative (GSA, 2020) discusses the impact of aging being process that leads to new self-discoveries, wisdom, and acquired knowledge. It can be helpful to utilize language that highlights an aging adult's strengths. For example, it could prove beneficial for communities to focus on the wealth of knowledge an aging adult provides to society. Moreover, it is important to acknowledge how much society benefits from hearing their lived experiences.

Empathy and Compassion

Empathy toward aging adults can be a powerful buffer toward negative attitudes in aging. Despite the variety of different definitions constituting empathy in the literature, it appears that the consensus is that empathy is defined as the ability to feel what a person is feeling, see things from their point of view, and perspective taking (Goetz, Keltner, and Simon-Thomas, 2010). While empathy and compassion are central to helping professions and human connection, it is important to be mindful in the way empathy is used. For example, it could be seen as invalidating to fully perceive the pain that an individual is experiencing, particularly in situations with under-

continued on page 13

represented groups. Compassion can be another opportunity to mitigate ageism. According to the literature, compassion is defined as a person encountering another individual's suffering, therefore, being motivated to act (Goetz, Keltner, and Simon-Thomas, 2010). In the current landscape of the literature, compassion is a powerful, yet, underutilized method toward mitigating ageism. Mazzarelli and Trzeciak (2019) proclaim that compassion matters in that it can improve psychological well-being. Furthermore, compassionate positive interactions with aging adults reduce negative attitudes toward aging (Levy, 2016). Simply put, compassion is empathy in action.

Age-Inclusive Language

Age-inclusive language is a major factor in promoting positive sentiments toward aging. Inclusive aging language mitigates negative stigma regarding how aging adults view their identity as well as how society views the aging process (Harvey Friedman Center for Aging, 2022). Furthermore, age-inclusive language can empower aging adults by reframing the aging process. When we utilize language regarding aging adults, we must consider respect and humility. The language that we use can break stereotypes and mitigate harm.

The Gerontological Society of America (GSA), particularly the Reframing Aging Initiative, recommends a variety of tips to include inclusive language within our society. One recommendation is the use of unifying language. This can be accomplished through avoiding use of terminology that implies helplessness by putting the person first when describing a condition. "Othering" language can be harmful for aging adults. For example, referring to aging adults as elderly, aged-dependent, and et cetera implies a sense of separation from social communities (GSA, 2021). Instead, focus on advancing language such as "we" and "our" statements. It is also important to consider contextual and cultural factors associated with the language used within communities. For some communities, referring to an aging adult as an "elder' could be seen as a sign of respect while others view it as harmful rhetoric (Hirito & Yarry, 2018).

Creating New Narratives

One avenue that can be worth exploring is the notion of current narratives for aging adults. Kang and Kim (2022) found that whether aging adults had experienced or perceived ageism, it held more negative impacts for their psychological well-being. Another article referenced the vulnerability narrative of aging adults. Swift and Chasteen (2021) report that the vulnerability narrative that affects aging adults holds self-limiting views in how society as well as the aging adult views ageism. It is not uncommon for society as well as aging adults to view the aging process as negative. Despite the views on ageism and identity, it is vital to consider the concept of developing new narratives for ourselves and society moving forward. It is also important to refer to aging as a natural human experience framed with positive narratives. Talking affirmatively about the aging process can reframe viewpoints upon aging (GSA, 2021). Moreover, society and communities should express collectivist responsibility regarding aging matters. Detweiler et al (2023) state the importance of social connection for aging adults, which can have mitigating effects on ageism. It is important to acknowledge that everyone is interconnected and that cultural and systemic factors play vital roles in individuals' lived experiences.

Concluding Thoughts

While this paper could not address all the nuances and challenges of ageism

continued on page 14

and identity, my hope is to bring attention to a seemingly neglected area of psychology and mental health. Moreover, the aim of this paper is that the strategies outlined may inform how we can continue mitigating the societal and psychological challenges of aging. One thing that we all have in common is growing older. A key component I would like to add for this bulletin piece is how aging can be a beautiful process, however, we must ensure that we collectively as a society can help improve the aging process.

References

Allen, J. O., Solway, E., Kirch, M., Singer, D., Kullgren, J. T., Moïse, V., & Malani, P. N. (2022). Experiences of Everyday Ageism and the Health of Older US Adults. *JAMA network open*, *5*(6), e2217240. https://doi.org/10.1001/jamane-workopen.2022.17240

Chrisler, J. C., Barney, A., & Palatino, B. (2016). Ageism can be hazardous to women's health: Ageism, sexism, and stereotypes of older women in the healthcare system. *Journal of Social Issues, 72*(1), 86-104. doi:https://doi.org/10.1111/josi.12157

Caskie, G. Detwiler, B. & Johnson, N. (2016). *Minority stress in the sexual minority older adult population: Exploring the relationships among discrimination, mental health, and quality of life*

Goetz, J. L., Keltner, D., & Simon-Thomas, E. (2010). Compassion: An evolutionary analysis and empirical review. *Psychological Bulletin, 136*(3), 351–374. https://doi.org/10.1037/a0018807

Harris, K., Krygsman, S., Waschenko, J., Laliberte Rudman, D., & Pruchno, R. (2018). Ageism and the older worker: A scoping review. *The Gerontologist, 58*(2), e1-e14. Retrieved from https://www2.lib.ku.edu/login?url=https://www.proquest.com/scholarly-journals/ageism-older-worker-scoping-review/docview/2174059840/se-2

Hiroto, K. E., & Yarry, S. J. (2018). Cultural differences in aging experiences of ethnic and sexual minority older adults. In B. P. Yochim, & E. L. Woodhead (Eds.), *Psychology of aging: A biopsychosocial perspective; psychology of aging: A biopsychosocial perspective* (pp. 299-321, 357 Pages). New York, NY: Springer Publishing Company. Retrieved from https://www2.lib.ku.edu/login?url=https://www.proquest.com/books/cultural-differences-aging-experiences-ethnic/docview/2085978998/se-2

Hoy-Ellis, C., & Fredriksen-Goldsen, K. (2016). Lesbian, gay, & bisexual older adults: Linking internal minority stressors, chronic health conditions, and depression. *Aging & Mental Health, 20*(11), 1119-1130. doi:https://doi.org/10.1080/13607763.2016.1168362

Hoy-Ellis, C. P., & Fredriksen-Goldsen, K. I. (2017). Depression among transgender older adults: General and minority stress. *American Journal of Community Psychology, 59*(3-4), 295-305. doi:https://doi.org/10.1002/ajcp.12138

Society for the Advancement of Psychotherapy

FEATURE

Religion, Spirituality, and Suicide: The Role of Psychologists in Encouraging Life-Promoting Beliefs

Samuel Knapp, Ed.D., ABPP

When evaluating suicidal patients, it is often indicated to ask them about their religious beliefs about suicide because many patients believe that their spiritual or religious beliefs[1] are closely linked to their mental health (Yamada et al., 2020). For example, some patients in significant emotional distress say they would not kill themselves because their religion strongly condemns it. For them, religion includes a *life-protecting belief* that prohibits them from attempting suicide.

Nonetheless, the relationship between religion, spirituality, and suicide goes deeper than just prohibitions against suicide. Instead, religious and spiritual beliefs influence how people care for themselves, interact with others, think about themselves, and interpret their life histories. For example, some people have religious or spiritual beliefs that command them to live their lives productively, express their talents and abilities, and show love for others while experiencing joy. For them, religion includes *life-promoting beliefs* that encourage them to flourish and thrive.

The goals for treating suicidal patients are to keep them alive and to help them create lives worth living. While life-protecting beliefs may help keep many patients alive (at least temporarily), life-promoting beliefs help keep patients alive and also help them to create lives worth living. This article suggests ways psychologists can encourage life-promoting beliefs when working with suicidal patients.

Religious and Spiritual Beliefs

When treating suicidal patients, it may be clinically indicated to ask them about their religious or spiritual beliefs and the relationship of those beliefs to their suicidal thoughts. Of course, some patients may not see religion or spirituality as relevant to their problems, and others may not wish to discuss their beliefs. Nonetheless, many patients see a relationship between their beliefs and their suicidal behavior (Lusk et al., 2018) and want to talk about them.

If patients are interested and if religious or spiritual beliefs appear related to the clinical issues being discussed, then psychologists can ask their patients about the nature of their religious or spiritual beliefs, their religious affiliation and their involvement with religious activities, the role that religion or spirituality plays in their lives, including their day-to-day thoughts and interpretations of events, any changes in their religious activities or beliefs over time, and what, if any, circumstances led to those changes, how religion has helped or harmed them during periods of stress (Alonzo & Gearing, 2021), what link, if any, between religious or spiritual beliefs and their emotional wellbeing, including their moods, their beliefs about suicide, and their beliefs about religion and their personal well-being. During these conversations, psychologists should remember that beliefs are not a lump. Instead, religious and spiritual beliefs can be fluid, nuanced, unique, and multidetermined.

continued on page 16

Beliefs May Be Fluid

The salience of religious and spiritual beliefs can wax and wane depending on the circumstances. Similarly, the desire to kill oneself may wax and wane as well. Patients may say they would not try to kill themselves because doing so would violate a sincerely held religious belief. However, under stress, the influence of that belief may wane, and suicidal urges may become more salient. Although religious and spiritual beliefs often deter many patients from attempting suicide, they do not necessarily veto the option of suicide for all patients, at all times, or under all circumstances.

Beliefs May Be Nuanced

Although religions may have certain beliefs that they consider orthodox, few are ideological monoliths, and most have some wiggle room in their belief systems. For example, evangelical Christianity may look like a conservative monolith to outsiders. Although evangelical or "born again" Christians tend to be more conservative, many have adopted moderate or liberal positions on social justice issues, political affiliations, or relationships with non-Christians (Lancaster et al., 2021).

As it applies to suicidal thoughts, some patients have religious beliefs that condemn suicidal behavior but find passive suicidal thoughts more acceptable (e.g., "I wish the Lord would just take me away"). That is, they do not plan to attempt suicide but nonetheless would prefer to die. Nonetheless, passive suicidal thoughts are a risk factor for developing active suicidal thoughts, and over time people with passive suicidal thoughts have high rates of suicide attempts. This points to the importance of distinguishing between life-protecting and life-promoting beliefs. Life-promoting beliefs not only discourage suicide, but they can also urge patients to promote their well-being and address the life conditions or psychological vulnerabilities that lead them to wish to die.

Beliefs May Be Individually Unique and Multidetermined

Psychologists should attend closely to what their patients say about their religion or spiritual beliefs and should not be overly influenced by denominational labels or general descriptors. Life circumstances and experiences influence people's thoughts about religion and spirituality beyond denominational doctrine. For example, no two Christians are alike in all ways. Psychologists should not assume that they and their patients share the same beliefs only because they belong to the same religion. Brief descriptors of one's religious affiliation or spiritual inclinations may mask essential differences in the impact of these beliefs on one's life.

For example, many people are influenced by more than one faith tradition. These influences may be concurrent or consecutive. For example, some Latinx patients may identify with the Christian tradition but nonetheless be influenced by *Santeria* or *Espiritismo* (Baez & Hernandez, 2001). Although they do not usually practice the rituals associated with those traditions, they may visit a Santeria or a Spiritualist when under extreme stress. Other people may have consecutive religious traditions wherein their previous religious tradition still influences their current beliefs and behavior.

Addressing Beliefs in Psychotherapy

Religious affiliation and participation are usually correlated with lower rates of suicidal behavior, at least in Western countries with religious homogeneity (Wu et al., 2015). However, even in Western cultures, these beliefs or affiliations are not life-protecting for everyone

continued on page 17

under all circumstances. At times, psychologists may be able to activate the life-promoting dimensions of religion or spirituality to reduce the risk of suicide and help their patients create lives worth living. At other times, psychologists may need to help patients to address harmful religious or spiritual beliefs that reinforce psychopathology, self-hatred, and thoughts of suicide.

When Religion Is Life-Promoting

Although psychologists can welcome their patients' life-protecting beliefs, they are insufficient to help patients create lives worth living. Some of the psychological vulnerabilities associated with suicidal thoughts are perfectionism, shame or excessive guilt, impulsivity, loneliness, *perceived burdensomeness* (a sense that one is a burden to others), or a feeling of *entrapment* (a belief that one's pain is unbearable and that there is no end to it). These can be addressed through religious or spiritual beliefs that promote self-compassion, self-forgiveness, connections with others, hope, and a conviction that every person in God's creation has value. Although some psychologists may not believe in God or may believe in a God who is distant and uninvolved in human lives, their role is to work through their patients' belief systems, not their own.

If patients are interested, psychologists can reference religious scriptures or doctrines to reinforce life-promoting beliefs. When patients are distressed, psychologists may encourage them to engage in the religious or spiritual activities of their choice, such as praying, singing, engaging in religious meditations, attending religious services, or spending time with nature (Yamada et al., 2020). When patients encounter crises, they can engage in positive religious coping in which they see God as an ally who loves them and will assist them in dealing with life's difficulties (Pargament, 2007). Finally, they can rely on fellow church members for assistance during times of stress.

When Religion is Toxic

Psychologists should keep an open mind about how religion has impacted their patients. Religion could harm patients if they believe that God has abandoned them or is deliberately punishing them for some misdeed or indiscretion in their past. They may also feel cut off from a supportive spiritual community. The lack of self-forgiveness is often associated with suicidal thoughts (Hall et al., 2020). This negative religious coping may lead to a sense of entrapment or perceived burdensomeness.

Psychologists may challenge harmful religious beliefs when it is necessary to ensure the health or safety of their patients. Even then, it is best done with curious and supportive questions and gentle probes as part of *a respectful confrontation* (Johnson, 2016). Discussions will be more profitable if psychologists remember that religious or spiritual beliefs are nuanced, fluid, and multidetermined. Psychologists can ask their patients about their religious or spiritual lives and listen carefully to their stories and interpretations and try to understand how their beliefs and life circumstances led them to consider suicide as an option. While acknowledging positive elements in their patients' beliefs whenever possible, psychologists can also help them look for harmful idiosyncrasies in their beliefs or scriptural interpretations and help patients identify a linkage between their beliefs and their psychological distress.

Finally, psychologists may encounter patients who have experienced religion-related traumas or have been rejected by their religious communities because of

continued on page 18

interpersonal clashes, differences in their beliefs, or their sexual orientation. Although religious and spiritual beliefs can be crucial in promoting well-being and warding off suicidal thoughts, it is possible that the sense of social support from a religious community may be as important, or even more important, than the content of the beliefs themselves. Therefore, psychologists must take rejection from a religious community very seriously, as it may represent a significant trauma or disruption in a patient's social network. They may need to help their patients process these experiences and find new sources of social support.

Other Considerations When Addressing Religion and Spirituality

Religion is an aspect of culture. Psychologists need to show cultural humility and accept the role of learners who are striving to understand the influence that religion has on the lives of their patients. They should have examined the potential for their own biases or blind spots to ensure that they do not act as either implicit evangelists or implicit cynics. Effective psychotherapists always prioritize the patient's treatment goals and narrowly focus their discussion of religious or spiritual issues on those goals. While psychologists can encourage these religious activities, they need to ensure that they keep their appropriate roles. They are not there to answer religious questions, be a spiritual guide, or strengthen a person's adherence to a religion. Instead, they may make referrals to appropriate spiritual or religious leaders when necessary (Vieten & Lukoff, 2022).

Summary

Religious or spiritual beliefs can be related to suicide insofar as they prohibit suicide or encourage patients to create lives worth living. Therefore, when discussing religious or spiritual beliefs with suicidal patients, psychologists should remember that:

- Religious or spiritual beliefs often, but not always, protect patients from suicide. and
- The content or salience of their religious or spiritual beliefs may be fluid, nuanced, unique, and multidetermined.

Psychologists can reinforce healthy beliefs among most patients but may need to gently challenge harmful beliefs among some other patients. The most effective psychologists:

- Are self-aware and take appropriate accommodations to control their biases.
- Recognize religion as an area of culture that requires cultural competence. and
- Understand and keep within their psychotherapeutic role.

References

Alonzo, D., & Gearing, R. E. (2021). Suicide across Buddhism, American Indian-Alaskan Native and African traditional religions, atheism and agnosticism: An updated systematic review. *Journal of Religion and Health, 60*(4), 2527-2546. http://doi.org.10.1007/s10943-021-01202-z

Baez, A., & Hernandez, D. (2001). Complementary spiritual beliefs in the Latino community: The interface with psychotherapy. *American Journal of Orthopsychiatry, 71*(4), 408-415. http://doi.org/10.1037/0002-9432.71.4.408

Hall, B. B., Hirsch, J. K., & Webb, J. R. (2020). Spirituality and suicidal behavior: The mediating role of s elf-forgiveness and psychache. *Psychology of Religion and Spirituality, 12*(1), 36-44. http://doi.org/10.1037/rel000082

continued on page 19

Hill, P., & Pargament, K. (2003). Advances in the conceptualization and measurement of religion and spirituality. *American Psychologist, 58*(1), 64-74. http://doi.org/10.1037/ 0003-66x.58.1.64

Johnson, W. B. (2016). Challenging clinically salient religion: The art of respectful confrontation. *Spirituality in Clinical Practice, 3*(1), 10–13. http://doi.org/10.1037/scp0000099

Lancaster, S. J., Larson, M., Frederickson, J. (2021). The many faces of evangelicalism: Identifying subgroups using latent class analysis. *Journal of Religion and Spirituality, 13*(4), 493-502. http://doi.org/10.1037/rel0000288

Lipka, M., & Gecewicz, C. (2017). More Americans now say they're spiritual but not religious. https://www.pewresearch.org/fact-tank/2017/09/06/more-americans-now-say-theyre-spiritual-but-not-religious/#:~:text=About%20a%20quarter%20of%20U.S.%20adults%20%2827%25%29%20now,April%2025%20and%20June%204%20of%20this%20year.

Lusk, J., Dobscha, S. K., Kopacz, M., Ritchie, M. F., & Ono, A. (2018). Spirituality, religion, and suicidality among veterans: A qualitative study. *Archives of Suicide Research, 22*(2), 311-326. http://doi.org/10.1080/13811118.2017.1340856

Pargament, K. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred.* Guilford.

Vieten, C., & Lukoff, D. (2022). Spiritual and religious competencies in psychology. *American Psychologist, 77*(1), 26-38. http://doi.org:10.1037/amp0000821

Wu, A., Wang, J.-Y., & Jia, C.-X. (2015). Religion and completed suicides: A meta-analysis. *PLoS ONE, 10*(6). http://doi.org/10.1371/journal.pone.0131715

Yamada, A-M., Lukoff, D., Lim, C. S. F., & Mancuso, L. L. (2020). Integrating spirituality and mental health: Perspectives of adults receiving mental health services in California. *Psychology of Religion and Spirituality, 12*(3), 276-287. http://doi.org:10.1037/rel0000260

[1] Religion and spirituality are related but distinct concepts. Although scholars may differ on the exact differentiation, typically they define religion as the practices, creeds, and rituals of a group of people, while spirituality refers to a connection with a transcendent reality. Hill and Pargament (2003) cautioned against dichotomizing religion and spirituality too sharply, because many people incorporate their spirituality within their religious practices or rituals. More than one-quarter of Americans consider themselves to be spiritual but not religious (Lipka & Gecewicz, 2017).

Society for the Advancement of Psychotherapy

FEATURE

Psychoanalysis as Evolution: Beyond the Cobwebs of Unthought Known

Vineet Gairola, Doctoral Candidate
Indian Institute of Technology, Hyderabad

In this time of crisis where people feel isolated in an interconnected world, the mind is brushing from an "electrified tightrope" to take Eigen's word (Eigen, 2004). Mind in the line of fire reflects the breaking of links. In "attacks on linking" lies the pathology of limiting relationships between two objects (Bion, 1959, p. 308). Adding to Bion's emphasis on truth (Bion, 1992), love and care would ease the mind in discomfort. Joseph Campbell, a comparative mythologist, simplified Immanuel Kant's understanding of the "dual." He writes, "*a* is to *b* as *c* is to *x*" (Campbell, 2002, p. 29, author's emphasis). It is not about an imperfect resemblance of two things but "a perfect resemblance of two *relationships* between quite dissimilar things" (Campbell, 2002, p. 29, author's emphasis). In other words, psychoanalysis (*a*) and evolution (*b*) are related to one another in the way Bion's experience (*c*) resulted in him formulating the concept of O (*x*). "*x*" is not only "unknown," but "absolutely unknowable" (Campbell, 2002). This is something Bion also attributed to O (Bion, 1992).

Darwin's *On the Origin of Species by Means of Natural Selection* was first published in 1859 (Darwin, 1859), three years after the birth of Freud. Freud grew up in the aegis of Darwinism. Freud worked in the research laboratory of Ernst Wilhelm von Brücke in Germany (Scharbert, 2009), a passionate Darwinist from the Helmholtz School of Physiological Psychology. Freud was trained in comparative anatomy and physiology in Johannes Müller's tradition (Scharbert, 2009). From Darwin, Freud absorbed the idea of development through discrete evolutionary stages. This is radically distinguished from social Darwinism stemming from the reactionary ethnocentric social theorists who took Darwin's idea of natural selection and survival of the fittest to create an ideology whereby certain people were considered primitive, and western white civilization was seen as the pinnacle of the evolutionary process. It likewise assisted in exploiting Darwin's idea of the survival of the fittest to provide a spurious justification for competitive capitalism and rugged individualism.

For Freud, the focus is not on the survival of the fittest but on the idea of biological development, in Darwin's case, through discrete stages—much as we can trace the stages and phases of the development of the fetus as it moves from full-term and birth. Freud developed this idea of epigenetic development on the psychological rather than the biological plane. Freud gave us the oral, anal, phallic, latency, and genital stages of psychosexual development (Lear, 2005). It is somewhat analogous to the stages of biological evolution: unicellular organisms, multicellular, invertebrates, vertebrates, mammals, primates, and homo sapiens. In *The Life Cycle Completed*, Erik Erikson expanded Freud's theory following an epigenetic principle. He extended it to old age, stating that humans go through certain stages to develop (Erikson, 1982) fully. Three

continued on page 21

years after Erikson's death, his wife, Joan M. Erikson, published an extended version of the book where a ninth stage was added (Erikson & Erikson, 1997). The eight stages in his theory were about evolution, and the ninth stage was about devolution.

We learn to walk, control our urination, learn bowel movements, and acquire a capacity for intimacy with others. In the final stage, one becomes less capable of achieving intimacy because those with whom one was intimate may often die in old age. One is increasingly alone, especially in western civilization. As we continue to devolve, we become less autonomous and less able to look after ourselves; one might end up in a wheelchair or unable to walk and may end up in diapers on the way to death. Erikson adds the idea of devolution in extreme old age (Erikson & Erikson, 1997). Sociologically, Talcott Parsons began to speak about stages of social evolution (Parson, 1977) which was later extended by the psychoanalytic vigor of Eli Sagan: from hunter-gatherer societies and tribal societies organized through kinship to what he calls complex society (kingdoms, as in Tahiti, Buganda, Hawaii), to ancient civilizations (Sumeria, Babylonia, and Egypt) to classical civilizations (such as Athens) to early-modern monarchies to finally the societies that are increasingly democratic (Carveth, 2011). Just as the Eriksons recognized devolution and evolution, social devolution seems to be happening worldwide as authoritarian regimes increasingly threaten democracies. Psychoanalysis itself, therefore, is a type of evolutionary theory. Freud, Erikson, and Wilfred Bion conceived of the evolutionary process in psychology as an evolution toward truth (Freud, 1915; Erikson, 1982; Bion, 1992).

Freud was interested in developing the reality principle, ego growth. The function of the ego is reality testing—the growing ability to differentiate between facts and fantasies, to differentiate between wishful illusions and accurate perception of what is real, and the surrender of wishful illusions. Freud saw science as the reality principle in operation, trying to distinguish truth from error, reality from fiction, illusion, and outright delusion. Freud sees the mind as a development toward truth. In all emphasis on truth, we see Bion's commitment to rationalism, which he shared with Freud. Bion said the human mind needs truth, like a plant needs water (Bion, 1962). An adequately developing mind is increasingly acquiring the capacity to move closer to an ultimate incompletely knowable truth which he symbolizes as O. Bion is far from being an intellectual nihilist saying that O is incompletely knowable. He does not mean to deny that progress can be made. It requires the ability of the mind to link and separate to achieve greater integration and more complex ways of understanding and to draw closer to what is an ultimately only incompletely knowable O.

An unhealthy mind seeks prematurely to devolve away from the truth because sometimes the truth is unbearable. People differ in their capacity to bear the truth. A healthy mind can bear more truth. The unhealthy mind cannot bear it. Instead of evolving towards it, the mind devolves away from it. It withdraws, it regresses, and it avoids. Bion's symbol for knowledge is K. The mind can move towards K, but it can also opt for -K—a retreat from the truth to illusion, delusion, or various kinds of distraction from the march toward truths that are found unbearable (Bion, 1962). In this manner, psychoanalysis is an evolutionary theory conceptualizing a dynamic evolution toward truth. What, then, is a psychoanalyst? Someone who

continued on page 22

seeks to assist the patient in resuming their development towards truth. The patient may have become fixated at a particular phase of their evolution and unable to move on, or they may have moved on and then regressed—fallen back. They seek an analyst; the analyst tries to help them get the evolutionary process going again.

Just as an individual may become fixated or regressed, I think society, to move back to the social evolutionary theory thinking, may become fixated or regressed. I would say we are in a significant worldwide phase of regression. Societies that had managed until some point in the 1950s-60s had managed to evolve in the direction of greater and greater democracy and equality. Things were moving progressively until Lyndon Baines Johnson's war on poverty and his celebration of the good society ended in the face of imperialist adventures conducted by the military-industrial complex in the U.S. Then came Ronald Reagan with his ideology of free-market economics, free-market fundamentalism—essentially a religion. In the distant past, people thought God's invisible hand occasionally affected human affairs. However, in free-market economic ideology, the invisible hand is that of the free market. It did not work. We have this rise of authoritarianism, and we have a society that, instead of evolving toward truth, is evolving away from it—the so-called post-truth society in which there are always alternative facts. What constitutes truth on this side of the mountain is not considered truth on the other side, and there is no way of discriminating which of these versions of truth is correct. This is the slide into extreme social constructivism, an extreme cultural relativism. All of this is a regression on the social level. Hence, we need psychosocial therapists to help reverse this regressive trend in society, get societies to pull out of this regression, and return to a healthy evolution towards truth.

William Golding's *Lord of the Flies* gives us a deeper insight. In the novel published in 1954 (Golding, 1954), Golding writes about Ralph and Piggy as rationalist leaders who are trying to save boys by keeping the signal fires burning, knowing how to make fire, knowing not to eat certain fruits—all of this is a celebration of reason. However, there is a third leader that Golding recognizes, i.e., Simon, who stands for the humane values of caring and *Caritas* (love). He cares for the dying captain and the creatures of the forest. He is essentially a Jesus figure. He was coming to tell the people the good news to ease their paranoia that no monster exists. Jack had spread the myth of the monster. There was no monster, it was simply the dying captain's parachute blowing in the wind. Before he could tell them the good news, he, of course, is killed, crucified as it were, by Jack's crazed horde. In addition to the rational leader, Golding recognizes a social and emotional leader (Simon) who brings the values of the heart in addition to those of the head.

Regression is a regression not just from the truth towards lies, from reason towards unreason; it is a regression from *Caritas* (love), caring, and kindness towards either indifference to the needs of others or outright rejection of their needs. The regression we are currently undergoing is not just a regression of reason; it is a regression away from caring, essentially from love towards indifference, narcissism, and hate. To evolve, then, to use Bion's O is not to develop a capacity to love but to be l(O)ving. What cures, then? Is it insight or relationship? Perhaps both. We need to reflect on the capacity for listening from the therapist's end. The

continued on page 23

work is in confrontations, hiatuses, and awkward moments of the therapeutic relationship. We need not only good enough mothers (Winnicott, 1971) but also good enough therapists to evolve towards being l(O)ving.

References

Bion, W. R. (1959). Attacks on linking. *The International Journal of Psychoanalysis*, *40*, 30-315.

Bion W. R. (1962). *Learning from experience*. Karnac.

Bion, W.R. (1992). *Cogitations*. Karnac.

Campbell, J. (2002). *The inner reaches of outer space: Metaphor as myth and as religion*. New World Library.

Carveth, D. L. (2011). On the psychoanalytic sociology of Eli Sagan. *Clio's Psyche*, *18*(3), 357-361.

Darwin C. (1859). *On the origin of species by means of natural selection*. Murray.

Eigen, M. (2004). *The electrified tightrope*. Karnac.

Erikson, E. H. (1982). *The life cycle completed*. Norton.

Erikson, E. H., & Erikson, J. M. (1997). *The life cycle completed: Extended version*. W. W. Norton & Company.

Freud, S. (1915). Observations on transference-love (Further recommendations on the technique of psycho-analysis III). *Standard Edition*, *12*, 157-171. Hogarth Press, 1958.

Golding, W. (1954). *Lord of the flies*. Faber and Faber.

Lear, J. (2005). *Freud*. Routledge.

Parsons, T. (1977). *The evolution of societies*. Prentice Hall.

Scharbert, G. (2009). Freud and evolution. *History and Philosophy of the Life Sciences*, *31*(2), 295-311. https://www.jstor.org/stable/23334448

Winnicott, D. W. (1971). *Playing and reality*. Routledge.

ETHICS

Ethical Decision-Making for Psychologists

Jeffrey E. Barnett, PsyD, ABPP
Loyola University Maryland

As licensed professionals, psychologists are obligated to serve in their professional roles and to carry out their professional duties and responsibilities in an ethical manner. We have a fiduciary duty to our clients that requires that all decisions made, and all actions taken, are motivated by and in keeping with our clients' best interests (Jorgenson et al., 1997). The Ethical Principles of Psychologists and Code of Conduct (Ethics Code, APA, 2017) provides aspirational general principles and enforceable ethical standards to provide both "guidance for psychologists and standards of professional conduct" (p. 2). Yet, the Ethics Code cannot provide clear and unambiguous answers for what to do in every challenging situation a psychologist may face in the course of their career.

Ethical Dilemmas and the APA Ethics Code

Psychologists may regularly be confronted by ethical dilemmas; situations where no one correct answer is immediately evident or where multiple possible courses of action exist, each of which may have potential risks and benefits associated with them. Psychologists may also face situations where ethics and law conflict (see Ethical Standard 1.02), where ethics and organizational demands conflict (see Ethical Standard 1.03), where the ethics code does not address the challenge being experienced, and when the psychologist is confronted by conflicts between the general principles. Additionally, the ethics code may at times seem vague in the guidance it provides when using modifiers such as "*reasonably, appropriate, potentially*" (p. 2). The use of these terms acknowledges that "a set of rigid rules" could "be quickly outdated" (p. 2) as the profession evolves and previously unexperienced and unanticipated dilemmas arise for which psychologists must use their professional judgment to determine the most appropriate course of action.

When faced with an ethical dilemma it would be nice to be able to look up the one correct answer for how to proceed, but the Ethics Code can only provide this specific guidance for addressing ethical problems, which can be defined as situations with clear acceptable and unacceptable courses of action. These standards set what Knapp et al. (2017) describe as the ethical floor, defined as the minimal standard that must be met and "prohibited acts" (p. 13) that must be avoided. Conduct that falls below this ethics floor violates the ethics code and constitutes unethical behavior. Examples from the Ethics Code (APA, 2017) include "Psychologists do not engage in sexual harassment" (Ethical Standard 3.02, p. 5), "Psychologists do not engage in sexual intimacies with current therapy clients/patients" (Ethical Standard 10.05, p. 14), "Psychologists do not misrepresent their fees" (Standard 6.04c, p. 9), and "Psychologists do not present portions of another's work or data as their own…" (Standard 8.11, p. 11).

Yet, many standards are more broad and general, requiring the application of one's

continued on page 25

professional judgement and thoughtful decision-making. Examples from the Ethics Code (APA, 2014) include:

"Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service" (Standard 10.10a, p. 14). How does one determine when this is reasonably clear, at what point in time should this decision be made, might this vary based on each client's individual needs and circumstances, and where does one find guidance to help in making these decisions?

"A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists" (Standard 3.05a, p. 6). Are impaired objectivity, competence, and effectiveness all-or-nothing phenomena? If not, what is the threshold for making this determination? Can psychologists accurately make such determinations independently or do they need input and guidance from colleagues? Would it make a difference if the client is in crisis? Would living and working in a small and isolated community with limited resources for referrals impact one's decision about what is reasonable? Does *reasonable* vary by setting and circumstances? How does one decide?

The Need for an Ethical Decision-Making Process

It is evident that the guidance of *just follow the Ethics Code* will be found to be lacking in these and so many other situations. Additionally, responding impulsively and trusting one's instincts or gut has been shown to be a poor substitute for a logical decision-making process. The use of a decision-making process can help psychologists to avoid fast, instinctive, intuitive, and emotional decision-making that is flawed by personal biases and blind spots, and instead to engage in slower, more deliberate active reasoning, and more logical thinking and decision-making that involves "focused cognitive effort to actively evaluate problems, weigh evidence, and make rational decisions" (McManus, 2021, p. 155), what Kahneman (2011) have described as Type 1 and Type 2 thinking, respectively.

When faced with an ethical dilemma an important first step is to consider the foundational general principles on which each of the enforceable ethical standards are based. These underlying values of the profession of psychology may be utilized to help clarify one's obligations when faced with an ethical dilemma. These principles as articulated by Beauchamp and Childress (2012) are: beneficence, non-maleficence, fidelity, autonomy, and justice.

Ethical Decision-Making Models

M. K. Johnson et al. (2022) provide a comprehensive review of available decision-making models. Further, the Markkula Center for Applied Ethics at Santa Clara University is an excellent resource about ethical decision-making. Its website may be accessed at: https://www.scu.edu/ethics/. Some very specific decision-making models are available such as Gottlieb's (1993) and Younggren and Gottlieb's (2004) decision-making models for deciding about post-treatment multiple relationships, Barnett and Johnson's (2011) decision-making model to assist clinicians to make decisions about integrating religion and spirituality into psychother-

continued on page 26

apy, and Kellen et al.'s (2015) ethical decision-making assists clinicians to make decisions regarding participating in social media in our professional roles.

One representative general ethical decision-making model, articulated by Barnett and Johnson (2008) involves the following steps:

Stage 1: Define the Situation Clearly

- Articulate the exact nature of the situation.
- Gather as many relevant facts and details as possible.
- Pinpoint the primary quandary or conflict(s).
- Begin to consider the potential ethical issues and your obligations

.

Stage 2: Determine Who Will be Impacted

- Identify the primary clients as well as any secondary clients.
- Consider the full range of persons who might be impacted by your decision.
- Articulate your professional obligations to and the rights of each person and group involved.
- Be especially sensitive to the potential for harm to any person involved.
- Reflect on your obligation to promote the best interests of those involved.
- Begin to consider the potential impact of various decisions on those involved.

Stage 3: Refer to both Universal Ethical Principles and the Standards of Your Profession's Code of Ethics

- Ask yourself the following principle-based questions:
- How can I contribute to my client's welfare (beneficence)?
- How can I avoid harming my client and others (nonmaleficence)?
- How can I promote my client's independence (autonomy)?
- How can I remain loyal to my client (fidelity)?
- How can I ensure equitable treatment of clients (fairness)?
- How can I protect my client's disclosures (privacy)?
- Review Your Profession's Code of Ethics.
- Identify the standards and universal principles most germane to your situation.
- When specific standards are ambiguous regarding your question, consider the more fundamental obligations conveyed in the universal ethical principles.
- Consider consulting one or more current ethics texts or articles on ethics in professional journals for additional guidance or case examples.

Stage 4: Refer to Relevant Laws/ Regulations and Professional Guidelines

- Review legal statutes and regulations bearing on counseling in your jurisdiction.
- Consider agency and institutional policies
- Identify and review any relevant counseling guidelines bearing on the situation, client type, problem, and type of service.
- Consult with a lawyer to determine your legal obligations and the legal consequences of various courses of action.
- Consult with colleagues or ethics organizations concerning potential conflicts between ethical and legal obligations.

Stage 5: Reflect Honestly on Personal Feelings, and Competence

- Take time to reflect honestly about the thoughts and feelings aroused by the situation.

continued on page 27

- Consider whether feelings aroused about yourself (e.g., shame, diminished esteem) or others (e.g., anger, anxiety, sexual attraction) involved may negatively impact your decision-making.
- Honestly consider whether you have the requisite competence—defined by education, training, and supervised experience—to effectively handle the situation.

Stage 6: Consult with Trusted Colleagues
- Carefully select one or more colleagues whom you know to have experience, good judgment, solid familiarity with ethical and legal issues, and preferably, experience in the area of concern.
- Seek consultant referrals, if needed, from local or national counseling organizations.
- Select consultants who are honest, forthright, and respectful of confidentiality.
- Prepare carefully for the consultation by summarizing key facts, apparent ethical issues, personal concerns, and possible courses of action.

Stage 7: Formulate Alternative Courses of Action
- Take time to think about the full range of possible responses to the situation.
- Consider all of the ways you might proceed in light of the facts at hand (e.g., full array of interventions, research designs, methods of confronting a student or colleague).
- Consider the feasibility and ethical/legal implications of each approach.

Stage 8: Consider Possible Outcomes for All Parties Involved
- Evaluate the probable impact—for each client and stakeholder—of each course of action considered.
- Enumerate possible outcomes for those involved paying particular attention to potential risks and benefits.
- Assess the implications of each approach in light of your ethical and legal obligations.
- Document this reasoning process.

Stage 9: Make a Decision and Monitor the Outcome
- Based on the first 8 stages and all relevant information available to you at this time, select the best option and implement it.
- When possible, discuss your decision and your rationale with stakeholders.
- Always take full responsibility for the decision.
- Clearly document each stage of your ethical decision-making process.

Stage 10: Engage in an Ongoing Assessment and Modification
- Carefully monitor—to the extent possible—the effects of your course of action on those involved. Modify your plan as needed and continue this process until the best possible outcomes are achieved.
- Engage in ongoing monitoring and feedback.
- Adjust actions as needed.

(pp. 177-180)

Key Points and Recommendations

While psychologists are faced with numerous ethical dilemmas throughout their careers, it is not always possible to engage in a comprehensive decision-making process. A client may ask their psychotherapist a question that requires disclosing personal information, they may ask their psychotherapist for a hug at the end of a session, or they may give their psychotherapist a gift as an expression of thanks. At times, psychotherapists must make quick decisions and use their

continued on page 28

best judgment in the moment. But, even in these situations if the clinician has thought about such issues in advance and has a context for evaluating possible courses of action, they will be better prepared for responding to these situations in a thoughtful and appropriate manner.

There will be common dilemmas that psychotherapists may anticipate and thus be better prepared for when they arise. Having written procedures to follow when requests for treatment records are received and having a clear policy in place to address the use of social media and how to respond to client requests for online interactions are possible examples.

Finally, there will be occasions when psychotherapists can take the time to go through the steps of a decision-making process to determine the most appropriate course of action that is consistent with the general principles of the Ethics Code, that is consistent with the client's treatment needs, and that feels comfortable for the clinician. Examples include being invited to a client's special occasion such as a graduation ceremony, deciding if it would be appropriate to evaluate or treat a family member or someone known to a current client, and deciding when one possesses sufficient competence to treat a certain client whose treatment needs fall outside one's usual areas of practice.

Perhaps most importantly, it is essential to be able to recognize when one is faced with an ethical dilemma and is prepared to consider options in a thoughtful manner that is consistent with our obligations to our clients. It is also of paramount importance that we each realize that consultation with expert colleagues and the thoughtful use of their input will invariably assist us to make better decisions in the face of ethical dilemmas.

References

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, amended effective June 1, 2010, and January 1, 2017). http://www.apa.org/ethics/code/index.aspx.

Barnett, J. E., & Johnson, W. B. (2008). Making an ethical decision: A process model. In J. E. Barnett & W. B. Johnson *Ethics desk reference for psychologists* (pp. 177-180). American Psychological Association.

Barnett, J. E., & Johnson, W. B. (2011). Integrating spirituality and religion into psychotherapy: Persistent dilemmas, ethical issues, and a proposed decision-making process. *Ethics & Behavior, 21*(2), 147-164.

Beauchamp, T. L., & Childress, J. F. (2012). *Principles of biomedical ethics* (7th ed.). Oxford University Press.

Gottlieb, M. C. (1993). Avoiding exploitative dual relationships: A decision making model. *Psychotherapy, 30*, 41-48.

Johnson, M. K., Weeks, S. N., Gimpel Peacock, G., & Domenech Rodriguez, M. M. (2022). Ethical decision-making models: A taxonomy of models and review of issues. *Ethics & Behavior, 32*(3), 195-209.

Jorgenson, L. M., Hirsch, A. B., & Wahl, K. M. (1997). Fiduciary duty and boundaries: Acting in the client's best interest. *Behavioral Sciences and the Law, 15*, 49-62.

Kahneman, D. (2011). *Thinking, fast and slow*. Farrar, Straus and Giroux.

Kellen, K., Schoenherr, A. M., Turns, B., Madhusudan, M., & Hecker, L. (2015). Ethical decision-making while using social networking sites: Potential ethical and clinical implications for marriage and family therapists. *American Journal of Family Therapy, 43*(1), 67–83. https://doi.org/10.1080/01926187.2014.942203

continued on page 29

McManus, J. (2021). Emotions and ethical decision making at work: Organizational norms, emotional dogs, and the rational tales they tell themselves and others. *Journal of Business Ethics, 169*, 153-168.

Younggren, J. N., & Gottlieb, M. C. (2004). Managing risk when contemplating multiple relationships. *Professional Psychology: Research and Practice, 35*(3), 255-260.

ETHICS

Risk Management and Clinical Excellence for Psychotherapists

Jeffrey E. Barnett, PsyD, ABPP
Julie Grammatico, M.S.
Loyola University Maryland

No psychotherapist wants a licensing board complaint or malpractice suit filed against them. While the overall risk of such events happening during the course of one's career can be fairly low, their consequences may be quite significant for the psychotherapist. Even just the threat of such actions being taken can be stressful and may be a significant source of distress experienced by psychotherapists (Knapp et al., 2013; Packman et al., 2009). Being sued for malpractice and having a licensing board complaint filed against oneself have long been found to be very stressful and even traumatizing events for health and mental health professionals (e.g., Adames et al., 2023; Charles et al., 1984; Montgomery et al., 1999). Such actions can have debilitating emotional consequences for the clinician, impacting both their professional and personal lives; these may be time consuming and costly processes, at times seemingly taking over one's life and often taking years to resolve; and they may negatively impact one's professional reputation, insurability, employment opportunities, and earnings (Kennedy et al., 2003).

Risk Management and Defensive Practice

It is therefore quite reasonable to expect that all psychotherapists will want to do all they reasonably can to avoid such events from occurring. While there is no known way of guaranteeing that a complaint or lawsuit will never be filed, there are steps one can take to help minimize the chances of this occurring, and if one is filed, to greatly reduce the chances of a negative outcome occurring. Collectively, the actions psychotherapists may take, both proactively and in response to challenges and difficulties that may arise in clinical practice, are known as risk management (Knapp et al., 2012). Risk management strategies, when applied appropriately and effectively, minimize risk to the clinician while simultaneously serving the client's best interests.

Risk management is described as prudent practice and is contrasted with defensive practice which is described as "risk management in the extreme" (Younggren et al., 2016, p. 403), something that is typically motivated by the clinician's desire to reduce the risk of complaints against them and that not only may be inconsistent with clients' best interests, but that may actually be harmful to clients (Kleespies, 2014). In defensive practice, clinicians frequently over- or under-respond to client risk such as by rushing to hospitalize clients immediately upon any mention of suicidal thoughts, conducting extra tests or assessments that may not be relevant to providing effective treatment, and refusing to work with certain clients such as those perceived to be at risk for harm to self or others and those who may be perceived as being potentially litigious

continued on page 31

(Kleespies, 2014; Montgomery et al., 1999; Wilbert & Fulero, 1988).

Effective Risk Management

When appropriately applied, risk management strategies are consistent with the aspirational General Principles of the Ethical Principles of Psychologists and Code of Conduct and its enforceable Ethics Standards (APA, 2017). When guided by these ethics principles and standards, the probability of a positive outcome for client and clinician alike is greatly increased (Knapp et al., 2012). Put most succinctly, Knapp and VandeCreek (1995) boil effective risk management down to "Conduct Good Psychotherapy" (p. 67). While one cannot effectively argue with this advice, these authors and others cited above each describe essential strategies and practices essential to effective risk management.

There are multiple actions one can take based on common sources of complaints against mental health clinicians. These include avoiding sexual intimacies and other inappropriate boundary violations and exploitative and harmful multiple relationships with clients and those associated with them, not releasing confidential information without appropriate authorization, limiting your practice to areas where you possess sufficient clinical competence based on prevailing professional practice standards, not engaging in financial exploitation or fraudulent billing practices, conducting appropriate risk assessments when indicated based on timely and appropriate assessments of clients' treatment needs, never abandoning clients, and ensuring that subordinates are appropriately supervised (DeMers & Schaffer, 2012). Additionally, psychotherapists should utilize a decision-making process when confronted with ethical dilemmas, should engage in ongoing self-care to help ensure that ongoing stressors and challenges do not negatively impact one's professional functioning, and should work to establish and maintain effective relationships with their clients (Younggren et al., 2016).

In essence, each psychotherapist should practice ethically and not allow one's professional conduct to fall below accepted practice standards. While each of the above-mentioned goals are important, should a complaint ever be filed, how will one demonstrate their reasonable, good faith efforts to meet or exceed prevailing professional practice standards? Risk management experts (e.g., Knapp et al., 2013) describe three essential risk management strategies, informed consent, documentation, and consultation, that must be thoughtfully and effectively applied consistently in the course of each clinician's professional activities to achieve this goal. Applying these strategies in a cursory or minimal manner to 'check the box' will not prove helpful in preventing and responding to complaints. *How* each of these is applied on an ongoing basis will form the basis of effective risk management for clinician and client alike

Informed Consent

Informed consent focuses on the sharing of information with prospective and current clients sufficient for them to be able to make a reasoned decision about participation. Informed consent should be a collaborative process that engages the client in decision-making through open discussion of the professional services being offered, reasonably available options, and the relative risks and benefits of each. Informed consent goes far beyond a written document the client is given to read and then sign. While this may be an important component of the informed consent process, by itself it is insufficient (Snyder & Barnett, 2006).

continued on page 32

For the informed consent process to be considered valid four criteria must be met (Knapp et al., 2017):

1) The consent must be given voluntarily (there can be no coercion).
2) The individual must be competent to give consent. This includes having the legal authority to consent on their own behalf (e.g., minors of certain ages are not afforded this right, parents who do not have any legal custody of their minor child do not have this right). Additionally, the individual must have the cognitive or intellectual capacity to consent. Individuals with significant dementia, psychosis, or impairment from substances may lack this ability.
3) The clinician must actively ensure the client's understanding of what they are agreeing to. Merely asking if they have any questions is insufficient. Some clients may think they understand the parameters of the consent agreement when they do not, and others may not understand but are not comfortable acknowledging this to their psychotherapist. Discussing the details of the informed consent agreement and having the client explain these details and their implications for them in their own words will help ensure clients actually understand what they are agreeing to.
4) The informed consent process must be both written and verbal. The client receives the informed consent document, it is reviewed and discussed verbally to ensure the client's understanding and acceptance of this, and then the details of this process are documented in the treatment record.

It also should be understood that informed consent is an ongoing process, not a one-time event. Anytime a substantive change to the agreement is being considered (e.g., suggesting a client in individual psychotherapy also enter group treatment) the informed consent agreement should be updated. Additionally, the informed consent agreement should be reviewed with the client periodically to ensure their ongoing understanding of it and its implications (e.g., the need to report certain behaviors if they are disclosed by the client).

There are numerous key issues that should be included in every informed consent agreement. One goal of the informed consent process is for the client to have realistic expectations regarding each of these at the outset of the professional relationship. These include:

- **Confidentiality and its limits** – What information will stay private, what information might need to be shared with others and under what circumstances, the involvement of any third parties, and what steps the psychotherapist will take to respect and protect the client's privacy.
- **Fees and financial arrangements** – What the fees are for each service the psychotherapists provides, to include treatment sessions, assessments, report writing, telephone calls, e-mails, etc.; any fees charged for late cancellations or missed appointments; any participation in insurance or managed care and the role of pre-authorizations, deductibles, and co-pays, when payment for each service is due, and the mechanism by which payment is made.
- **Record keeping processes** – The fact that all communications with and about the client are documented and maintained in the treatment record, where and how are the records are stored, the client's right to access their treatment records.

continued on page 33

- **Nature and anticipated course of treatment** – It is essential that psychotherapists share sufficient information to demystify the psychotherapy process and help the client to have realistic expectations and a realistic understanding of their and the psychotherapist's roles and responsibilities in treatment. Clients should understand reasons for ending the professional relationship (both client and clinician motivated) and the process or mechanisms for doing so.
- **Communications between treatment sessions** – Clients should have realistic expectations regarding psychotherapist availability and typical response time to communications by the client to the psychotherapist between appointments.
- **Emergency procedures** – After-hour availability, how and when to contact the clinician between sessions if a crisis is experienced, and when to call 911 or go to one's local emergency room.
- **Recording** – Clients must give permission to be recorded such as is often done with trainee clinicians who are receiving supervision of all professional services they provide.
- **Clinician credentials and experience/expertise** – Clients have the right to know of the psychotherapist's licensing status, level of training, amount of experience, and any additional credentials, certifications, or areas of specialization.

Other issues that may be relevant to the reasons the treatment is being provided and they type of services being provided should also be addressed as part of this process. To serve the client's best interests, the informed consent process should maximize the client's involvement in their own treatment planning (Knapp et al., 2013) and should be engaged in flexibly, taking into consideration each clients' individual needs and differences (e.g., age, ability status, educational level, culture, language). Engaging in this process through collaborative discussion and decision-making to help the client to have realistic expectations of treatment, for their psychotherapist, and for themselves does not simply reduce risk for the psychotherapist, but also communicates respect for the clients' autonomy, and increases the trust between the client and clinician, and increases the likelihood of a positive treatment outcome (Fisher & Oransky, 2008).

Documentation

Timely, accurate, and comprehensive documentation not only protects the clinician from complaints, but it also honors and respects the clients' privacy and helps to foster effective, high-quality treatment (Reamer, 2005). Solid documentation creates a record that can be sent to other providers (Knapp et al., 2013) which assists with the continuity and coordination of services. It can help clinicians refresh their memory between sessions which leads to higher quality of care. Good documentation also serves as a tool for assessment and planning, a way to evaluate and monitor the progress that a client is making, and a form of accountability. But deciding exactly what to document can be a challenge. Good documentation would satisfy a lawyer when used as a defense against a complaint and would satisfy the client when used as a record of treatment progress. In other words, it should serve and protect all parties (Reamer, 2005).

Should a complaint be filed against a psychotherapist it is the treatment record that will be seen as the tangible record of the clinician's efforts to meet

continued on page 34

or exceed prevailing professional practice standards. Thus, it is essential that psychotherapists create each treatment record not just for their own purposes but also to convey to others what transpired in the professional relationship and treatment process. It is hoped that readers of the treatment record will see clear evidence of the high quality of the treatment services provided. It should be clear to the reader what services were provided and to whom; what the client's level of participation, cooperation, and follow-through with recommendations were; what options were considered, what decisions were made, and the rationale behind them; what the client's presenting problems were and changes in them over time; and what risk assessments were conducted, their results, and actions taken as a result. Further, all consultations and referrals made should be documented, all communications with the client outside of treatment sessions and with others regarding the client should be documented, and all recommendations made to clients should clearly be documented.

Consultation

Consultation refers to the process of seeking input from expert colleagues to gain more information and/or new perspectives to assist the psychotherapist to provide the highest possible quality of professional services. No psychotherapist can be expected to know everything or to know how to best respond to every clinical situation they are confronted with over the course of a career. What psychotherapists are expected to do is to know the limits of their expertise and to know when support, input, and assistance from colleagues would be consistent with the profession's aspirational ethics ideals as articulated in the General Principles of the APA Ethics Code (APA, 2017). Thus, clinicians should seek consultations when faced with an especially challenging or high-risk clinical situation, when an ethical dilemma is present, or when it is unclear if the clinician possesses the necessary competence to meet the client's treatment needs.

Knapp et al. (2013), list three specific benefits to consultation. First, the clinician receives new information. By speaking with an additional clinician, one can receive new ideas, notice new things, and increase their understanding of their own client. Second, the clinician you choose to consult may be think about the case with less emotionality and/or more clarity; they may be able to point out blind spots in the way you are conceptualizing the case. Third, you may receive feedback on the way you are thinking about the case. During consultation, it can be helpful to follow a few simple tips that can maximize these benefits: enter the consultation space with openness to new perspectives and non-defensiveness, write down what questions you have ahead of time, and do not seek confirmation only for an already determined course of treatment. Rather, be willing an open to other ideas about how to proceed with treatment (Knapp et al., 2013). On-going peer consultation may be an excellent way for even seasoned psychotherapists to continue to provide the best possible care for their clients.

Seeing consultation should not be seen as a sign of incompetence, inadequacy, or weakness. Such thinking would likely result in avoiding consultation, something that would increase risk for client and clinician alike. From a risk management perspective consultation demonstrates:

- an understanding of the complexity of a client's treatment needs and clinical situation,
- an understanding and acceptance of the limits of one's expertise,

continued on page 35

- a desire to provide the client with the best treatment possible, and
- a commitment to the highest ethics ideals of the profession.

Recommendations

It is hoped that all readers will see risk management, when done correctly and effectively, as a positive and helpful process that is consistent with psychotherapists' ethical obligations. Each risk management strategy discussed should be embraced and integrated into psychotherapists' ongoing clinical practice to provide client with the highest possible quality of care while simultaneously significantly reducing risk to the psychotherapist.

References

Adames, H. Y., Chavez-Dueñas, N. Y., Vasquez, M. J. T. & Pope, K. S. (2023). What to do (and not do) when facing an ethics, licensing board, or malpractice complaint (Chapter 35, pp. 231-234). In *Succeeding as a therapist: How to create a thriving practice in a changing world*. American Psychological Association.

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, amended effective June 1, 2010, and January 1, 2017). http://www.apa.org/ethics/code/index.html

Charles, S., Wilbert, J., & Kennedy, E. (1984). Physicians' self-reports of reactions to malpractice litigation. *American Journal of Psychiatry, 141*(4), 563-565. http://dx.doi.org.proxy-ln.researchport.umd.edu/10.1176/ajp.141.4.563

DeMers, S. T., & Schaffer, J. B. (2012). The regulation of professional psychology. In S. Knapp, M. C. Gottlieb, M. M. Handelsman, & L. VandeCreek, (Eds.). *APA handbook on ethics in psychology* (Vol 1., pp. 453–482). American Psychological Association.

Fisher, C. B., & Oransky, M. (2008). Informed consent to psychotherapy: Protecting the dignity and respecting the autonomy of patients. *Journal of Clinical Psychology, 64*(5), 576–588. https://doi.org/10.1002/jclp.20472

Kennedy, P. F., Vandehey, M., Norman, W. B., & Diekhoff, G. M. (2003). Recommendations for risk-management practices. *Professional Psychology: Research and Practice, 34*(3), 309-311. 10.1037/0735-7028.34.3.309

Kleespies, P. M. (2014). *Decision making in behavioral emergencies: Acquiring skill in evaluating and managing high-risk patients*. American Psychological Association.

Knapp, S. J., Bennett, B. E., & VandeCreek, L. D (2012). Risk management for psychologists. In S. J. Knapp, M. C. Gottlieb, M. M. Handelsman, & L. D. VandeCreek (Eds.) *APA handbook of ethics in psychology, Vol 1: Moral foundations and common themes* (pp. 483-518). American Psychological Association.

Knapp, S. J., Younggren, J. N., VandeCreek, M. C., Harris, E., & Martin, J. N. (2013). *Assessing and managing risk in psychological practice: An individualized approach* (2nd ed.). The Trust.

Knapp, S. J., & VandeCreek, L. D. (1997). *Treating patients with memories of abuse: Legal risk management*. American Psychological Association.

Knapp, S. J., VandeCreek, L. D., & Fingerhut, R. (2017). *Practical ethics for psychologists: A positive approach* (3rd ed.). American Psychological Association.

Montgomery, L. M., Cupit, B. E., & Wimberley, T. K. (1999). Complaints, malpractice, and risk management: Professional issues and personal experiences. *Professional Psychology: Research and Practice, 30*(4), 402-410. 0735-7028/99/S3.00

Packman, W., Andalibian, H., Eudy, K., Howard, B., & Bongar, B. (2009).

continued on page 36

Legal and ethical risk management with behavioral emergencies. In P. M. Kleespies (Ed.) *Behavioral emergencies: An evidence-based resource for evaluating and managing risk of suicide, violence, and victimization* (pp. 205-430). American Psychological Association.

Reamer, F. G. (2005). Documentation in social work: Evolving ethical and risk-management standards. *Social Work, 50*(4), 325-334.

Snyder, T. A., & Barnett, J. E. (2006). Informed consent and the psychotherapy process. *Psychotherapy Bulletin, 41*, 37-42.

Wilbert, J. R., & Fulero, S. M. (1988). Impact of malpractice litigation on professional psychology: Survey of practitioners. *Professional Psychology: Research and Practice, 19*(4), 379-382. 0735-7028/88/100.75

Younggren, J. N., Harris, E. A., & Martin, J. N. (2016). Malpractice and risk management. In J. C. Norcross, G. R. VandenBos, D. K. Freedheim, and L. F. Campbell (Eds.) *APA handbook of clinical psychology: Education and profession* (Vol. 5, pp. 395-407). American Psychological Association.

INTERNATIONAL COLUMN

Strengthening International Collaboration for Advancement of Psychotherapy: A Report from the International Domain/Committee

Changming Duan, Ph.D., International Domain Representative
Lauren Behrman, Ph.D., International Committee Co-Chair – Domestic
Maria del Pilar Grazioso, Ph.D., International Committee Co-Chair – International

Since its inception in 2015, the SAP (Div. 29) International Domain/Committee has actively pursued international engagement and collaboration for the purpose of advancing psychotherapy as a science, as a profession, and as a service promoting mental health for citizens and communities in the global village as well as in the United States (U.S.). Guided by the mission of the Domain (https://societyforpsychotherapy.org/domains/international/), we have diligently and actively pursued our division's interest in learning from and sharing with our international colleagues, psychotherapy scholars, and practitioners from different countries in the past eight years. In the pages to follow, we will submit to you, our division colleagues, and those who are interested in advancing psychotherapy for the diverse communities of the world, a brief report/summary of our activities. We will focus on the ongoing projects that are open for your input and/or participation. As a Division 29 Domain/Committee, we strive to represent your professional interests and to assist you on our shared journey of advancing psychotherapy. While it is impossible to include all the efforts our committee members have made in their roles, we want you to know that all our members are to be deeply appreciated for their commitment, devotion, and effort to the mission we are pursuing together. Due to time zone differences, some of our members stay up until midnight or get up as early as 5am to attend our regular committee meetings. Collectively we have made our team a supportive, friendly, and productive community.

Goal Oriented Efforts and Projects

Our committee has made specific efforts consistent with our Domain mission through collaborative programs and projects in the following areas. We will let you know how you can get involved if you wish to at the end of each area description.

1) Building a team of scholars, practitioners, and graduate students who are committed to the mission of the SAP International Domain and interested to serve and offer leadership toward our goals.

We have been successful in attracting leaders within and outside the United States. Currently, our international committee consists of 16 individuals from 11 countries/regions: Argentina, Guatemala, Hong Kong China, India, Israel, Mainland China, Mexico, South Africa, South Korea, Spain, U.S.

Lauren Behrman (U.S.)
laurenbehrman@gmail.com

Maria del Pilar Grazioso (Guatemala)
mpgrazioso@proyectoaigle.org.gt

Alfredo Padilla-Lopez (Mexico)
alfredopadilla@uabc.edu.mx

Rod Goodyear (U.S.)
rodk.goodyear@gmail.com

continued on page 38

Keeyeon Bang (Korea)
keeyeonb@gmail.com

Sean Waters (South Africa)
sean@stresslessclinic.co.za

Changming Duan (U.S.)
duanc@ku.edu

Sigal Zilcha-Mano (Israel) -on leave
sigalzil@gmail.com

Jeff Zimmerman (U.S.)
drz@jzphd.com

Patrick WL Leung (Hong Kong, China)
pleung@cuhk.edu.hk

Pragya Sharma (India)
pragya.cp@gmail.com

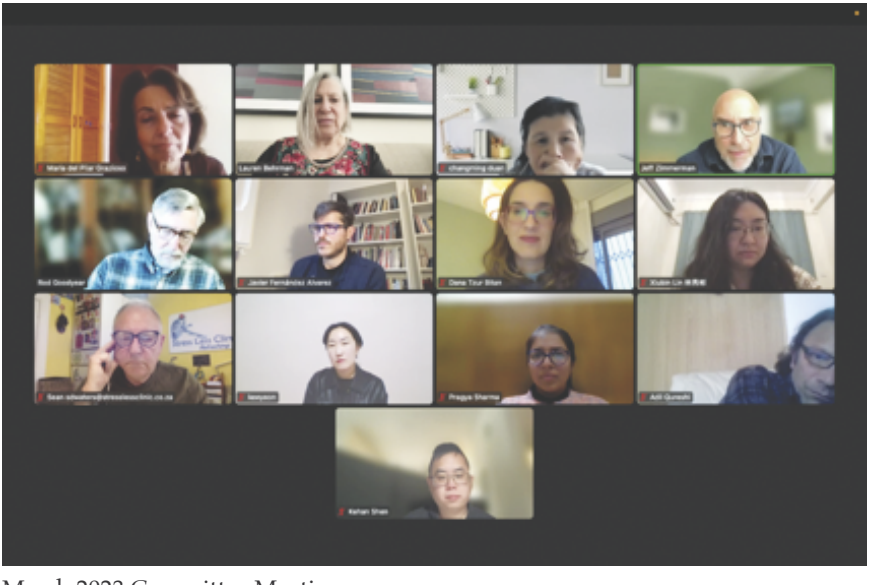
Xiubin Lin (Mainland China)
linxiubin@dfmjxl.cn

Adil Qureshi (Spain)
asfqureshi@gmail.com

Dana Tzur Bitan (Israel)
danatz@ariel.ac.il

Javier Fernandez Alvarez
(Argentina/Spain)
javferalvarez@gmail.com

Kehan Shen (international student – U.S.)
shen@ku.edu



March 2023 Committee Meeting

The committee meets regularly to plan, implement, and evaluate the various international projects. ***As a committee, we are open to new members from other international communities.***

2) Enlarging SAP membership outside of the United States.

We have made efforts to achieve this goal at both individual and organizational levels. We intentionally invite non-U.S. scholars and practitioners to join our committee, and as a result, they become SAP members and serve as messengers/recruiters for SAP in their country/region. Moreover, we have facilitated organizational levels of collaboration between SAP and professional organizations in other countries. We have achieved one successful such collaboration, the SAP-OI (Oriental Insight—in

continued on page 39

China) Collaboration Agreement, which has led to a sizable SAP membership (over 260 presently) in China. Moreover, we have designed and implemented an active member-engagement agenda with this group (see 2022-2023 report below) aiming at all three goals identified by our Division Mission Statement. ***We hope to be able to advance/replicate this membership development in other parts of the world and we welcome your suggestions and participation.***

3) Creating opportunities for SAP members in the U.S. to collaborate with colleagues from non-U.S. countries.

We have done so by connecting individual SAP members with international colleagues and organizing international conference trips yearly (although not during COVID). One of the several successful programs based on individual SAP members' collaboration with international colleagues/organizations is the long-term, systematic, and outside university clinical supervision training program, organized by the Chinese Clinical and Counseling Psychology Registration System and instructed by SAP members, Drs. Rodney Goodyear and Carol Falender. The training program has graduated over 600 first generation of clinical supervisors for China. Using international conferences as grounds for growing international collaborations, we have organized significant SAP presence at the **World Congress of Psychotherapy conference in Paris, France** (2017), the **International Congress of Applied Psychology (ICAP) in Montreal, Canada** (2018), and the **Interamerican Congress of Psychology in Havana, Cuba** (2019). After the break due to the COVID-19 pandemic, this year we attended the **Society for Psychotherapy Research conference in Dublin, Ireland** (2023). ***See below for detailed information of our SPR presentations.***

4) Helping SAP members learn internationally diverse cultural perspectives in psychotherapy practice and advancement by bringing scholarship, voice, and expertise from psychotherapists and colleagues from other countries.

There are several projects on going in this area. First, we have engaged in ongoing interviews with international scholars and have written up the interviews for SAP's Bulletin and website. Currently, we are finishing the creation of a home-study for CE course presenting the interviews with the two 2022 winners of Distinguished Award for the International Advancement of Psychotherapy from China (Dr. Guangrong Jiang) and Argentina (Dr. Hector Fernandez Alvarez) regarding psychotherapy in cultural contexts. Each interview was conducted in the home language of the awardee, with English interpretation/caption provided. Secondly, we have initiated and established a collaborative relationship with APA Div. 42 journal, *Practice Innovations*, which has agreed to publish a special issue on Psychotherapy Around the World. Two of our committee members are guest editors, Drs. Dana Tzur-Bitan and Rodney Goodyear. ***If you are interested in contributing to this special issue, please feel free to contact the co-editors.*** Thirdly, we are working with Division web management team to build **an International Hub** on SAP Website, where we will have information on psychotherapy practice and advancement as well as SAP-connected international professional activities presented in different languages. ***We welcome your suggestions and contribution to make this program successful.***

5) Enhancing culturally localized research on common topics related to psychotherapy advancement by engaging researchers from different cultures and countries.

Advancing psychological science requires the involvement of diverse cultural perspectives. We have been

continued on page 40

working toward developing true international research by engaging researchers and participants from diverse countries. Currently, we are in the middle of a coordinated research project on understanding professionals and non-professionals' attributions of mental health and illness in relation to cultural values and societal economic equality/inequality. At present, we have seven countries involved with at least one researcher from the country leading the project implementation. ***We look forward to having more countries/regions involved. If you are interested in joining this effort, please let us know.***

SAP Participation in 2023 SPR Conference in Dublin

As the first in-person international engagement post the COVID-19 pandemic, the International Domain/Committee decided to attend the annual convention of Society for Psychotherapy Research in Dublin, Ireland. We organized and submitted 6 conference programs, and each was accepted. The six programs, listed below, involved 43 presenters from 17 countries (Argentina, Chile, China, Germany, Guatemala, India, Ireland, Israel, Italy, Netherlands, Portugal, Romania, South Korea, Spain, Switzerland, United Kingdom, United States).

Panel Presentation 1:
Clinical supervision around the world

Program Chair: Keeyeon Bang

Discussant: Rod Goodyear

Presenter/Topic:
Adelya Urmanche/Power dynamics in supervision, Aisling McMahon/ Supervising the supervisors: An observational, participatory action research study of meta-supervision, Sarah Luk/Peer relationship: A neglected factor in training and supervision research, Xiubin Lin/ Will master's-level training improve facilitative interpersonal skills (FIS)? A longitudinal study in China

Panel Presentation 2:
Perspectives on mental health or illness in diverse cultural contexts

Program Chairs: Lauren Behrman & Pragya Sharma

Discussant: Pragya Sharma

Presenter/Topic:
Alemka Tomicic/Qualitative research on the experiences of mood disorders in undergraduate students of psychology in Chile, Vânia Silva/Quality of relational processes in video conference and in-person psychotherapy during COVID-19, Keeyeon Bang/Effects of CBT group psychotherapy for anxiety reduction of South Koreans: A meta-analysis

Panel Presentation 3:
Focusing on the strengths: The activation of patient's resources as a mechanism of change

Program Chairs: Javier Fernández Alvarez

Discussant: Christopher Flückiger

Presenters: Jan Schürmann-Vengels, Ioana Podina, Ulrike Willutzki, Javier Fernández Alvarez

Panel Presentation 4:
Cultural differences in psychotherapy expectations

Program Chairs: Dana Tzur-Bitan & Javier Fernández Alvarez

Discussant: Michael Constantino

Presenter/Topic:
Pragya Sharma/Process expectations in India and Argentina, Dana Elberg/ Process expectations in Israel, Agostino Brugnera/ The predictive effect of psychotherapy expectations on therapeutic outcomes

Structured Discussion 1:
Transdiagnostic and personalized psychotherapy: Complementary or opposite approaches?

continued on page 41

Program Chairs: Javier Fernández Alvarez & Anna Babl

Presenters: Zach Cohen, Shimrit Fisher, Jaime Delgadilo, Brian Schwartz, Kim de Jong, Shannon Sauer, Martin grosse Holtforth

Structured Discussion 2:
Paradigm shift in psychotherapy: Is it necessary?

Program Chairs: Jeff Zimmerman & Changming Duan

Presenters: Changming Duan, Harold Chui, Zac Imel, Lauren Behrman

2022-2023 Summary of Member Engagement/Recruitment Activities in China

In order to help our Chinese SAP members feel engaged and connected with the division, our committee worked closely with OI and developed and implemented an active member-engagement agenda, including the following organized activities:

Asking an Expert (问问专家)

Two rounds of "Asking an Expert" programs were completed in China 2022-2023. To decide on the topic, SAP members were first surveyed for clinical questions they encountered and hoped to learn more about. The most frequently raised questions were selected as the basis for this program. As the result, the first topic/theme selected was "Understanding and prevention of premature dropouts" and the second "Understanding psychotherapy integration and becoming an integrated psychotherapist." Then identified experts (Drs. Jeffery Zimmerman, Debra Gregory, Joshua Swift, and Barbara Vivino for the first, and Drs. Beatriz Gomez and Jeffrey Magnavita for the second) provided written responses to a series of specific questions on the topic, before offering an online presentation and member interaction.

The experts' written responses were translated and published over professional social media to SAP members first, and after two months, the publication became available for non-members. Over 8,700 professionals in China had accessed the published material, and many of them provided comments on how helpful it was to read experts' answers to those common practical questions they often encountered. The pictures below provide a visual image of how the information was disseminated through the *WeChat* social media platform.

Online Forum (线上论坛)

We organize online forums on specific topics related to psychotherapy or mental health promotion regularly. All the experts who have provided written answers to SAP members' questions were invited to attend an online forum in which they can deepen the discussion

continued on page 42

on the topic and engage members in discussions. Additionally, an online forum was held to address the need of mental health promotion on China's College Student Mental Health Day.

in learning more about SAP. Eventually among the 40 who applied to join SAP after the events, we approved 6 who met the membership requirements.

(2022年9月1日线上论坛截图)

The five online forums offered by seven experts, SAP members from the United States, were all broadcast live and received enthusiastic responses. Over 8,300 individuals listened in, and a cumulative 682 messages/comments were received. During the live streaming, many interactive comments were shared, questions raised, and sentimental reactions expressed. Many openly expressed gratitude for having such a learning opportunity and felt they positively benefited. When the session ended, some felt "having not had enough" (**意犹未尽**), and inqured about how to access video playback.

One tangible impact of these programs is the enhanced visibility of SAP in the Chinese professional community. During the live streaming of the online forum, 122 individuals added the *WeChat* number of the SAP China Member Operation Assistant, showing they were interested

***Psychotherapy* Article Abstract Translation (*心理治疗*文章摘要翻译)**

OI has provided the Chinese translation of all *Psychotherapy* articles' abstracts for Chinese SAP members. There have been over 80 translated abstracts available at the present time.

Member Salon (会员沙龙)

After reading the Chinese translation of *Psychotherapy* articles' abstracts, SAP members voted to select one article from each issue of the journal that they want to know more about. Then OI identifies one qualified individual who has good English comprehension to lead a sharing and discussion session on the article. Usually, the lead person would do a presentation of the major points of the article and then facilitate the member discussions. This activity has received extremely positive feedback from the

continued on page 43

SAP members and promoted the idea of science-practice integration among them.

This member salon has been held four times online in 2022-2023 (Topics: Therapist perceived meaning in life; Challenges for psychodynamic therapists; Collaborative crisis assessment and management, and Therapists compassion, corresponding to 4 *Psychotherapy* articles). The salon was streamed live, and over 2,500 people watched them. A total of 207 written comments were received.

Dissemination of *Psychotherapy Bulletin* Articles (文章传播)

OI has provided SAP members with Chinese translation of selected articles from *Psychotherapy Bulletin*. Selected articles are mostly those with practical implications, such as those related to supervision, crisis intervention, and self-care. In the past few months, eight articles have been widely distributed. This activity received positive feedback from many professionals, including clinical supervisors and mental health teachers, and some of them even shared the articles with their supervisees or students.

Positive Impact of the Programs (活动的积极影响)

The activities described above have aroused interest in SAP among Chinese mental health professionals. Some have started following SAP and hope to join it. OI has built SAP Event Community (via *WeChat*) and over 700 people have joined this community. Besides our SAP members, this group of people will have priority in receiving information about our future events. We hope that those who qualify for SAP membership among this group will eventually join SAP.

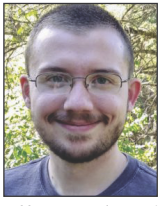
Summary

Our society, Div. 29, is one of the few APA divisions that have built an administrative structure, such as our International Domain/Committee, to promote international engagement. In the past eight years, under the leadership of SAP governance board and with the strong support from many colleagues among SAP members, our international committee members' diligent efforts in developing and pursuing an active international engagement agenda has yielded encouraging positive results. However, we know it is only the beginning and there is a lot more that we need to continue doing to further enhance our Domain's mission. In doing so, we welcome your perspectives and contributions. Together we can make international advancement of science, practice, and teaching of psychotherapy possible.

Society for the Advancement of Psychotherapy

Using Microprocess Methods to Study Client and Therapist Perceptions of Working Alliance Ruptures and Repairs

Wilson T. Trusty, M.S.
Idaho State University



Decades of research show that the working alliance, or the degree of agreement between a client and therapist on the goals and tasks of therapy and the quality of their affective bond (Bordin, 1979), is positively associated with clinical outcomes (Fluckiger et al., 2018). However, there are sometimes ruptures in the working alliance, or instances when a client and therapist disagree on therapy goals or tasks or experience a relational strain. Past studies indicate that alliance ruptures are relatively common and highlight the importance of repairing ruptures (Safran et al., 2011). In a meta-analysis, Eubanks et al. (2018) found that clients who experienced alliance ruptures that were then repaired had better outcomes than those with unresolved ruptures (i.e., lower rates of premature termination, greater symptom reduction). Additionally, clients with repaired ruptures had more positive outcomes than those who did not experience any ruptures. Thus, the process of repairing alliance ruptures may provide an opportunity for client growth.

There has been extensive writing and empirical work describing researcher perceptions of events that characterize alliance ruptures and repairs, such as confrontation, withdrawal, and renegotiating goals and tasks (Eubanks, Lubitz et al., 2019; Eubanks, Muran et al., 2019; Safran et al., 2011). Studies have also examined clients' and therapists' qualitative narratives of the working alliance (Schattner et al., 2017). However, less is known about client and therapist perceptions of moment-to-moment fluctuations in the alliance within single sessions and the degree of convergence in their perceptions of ruptures and repairs.

One way to examine these perceptions is to use a microprocess approach, in which an observer watches a recording of a therapy session while rating aspects of the therapy process (Altenstein et al., 2017; Clemence et al., 2012; Falkenström & Larsson, 2017). For example, Swift et al. (2017) asked clients and therapists to watch their most recent therapy session while using a dial to give moment-to-moment ratings of the helpfulness of session activities. Participants then wrote descriptions of what was occurring during their three highest- and lowest-rated segments and why those segments were especially helpful or hindering. Helpfulness ratings varied significantly throughout sessions, and client-therapist dyads differed considerably in their perceptions of helpful and hindering events (Penix et al., 2021).

At Idaho State University, we are conducting an ongoing microprocess study of client and therapist perceptions of working alliance ruptures and repairs using a similar method to Swift et al. (2017). This study examines agreement in client and therapist perspectives of these events, which may build on current understandings of the rupture-repair

continued on page 45

process. The following case example illustrates our method and highlights potential directions for future micro-process research on this topic.

Case Example

The client in this dyad was an Asian-American, cisgender, heterosexual man in his early 20s with an upper-middle class background. He presented to a psychology training clinic at a mid-sized university in the western U.S. for individual psychotherapy for anxiety and adjustment difficulties. He had been working with his current therapist for four sessions at the time of data collection. The therapist identified as a non-Hispanic White woman in her early 20s and was in the second year of her clinical psychology Ph.D. program. She indicated that her theoretical orientation was interpersonal but that she was taking an integrative approach with this client.

Procedure

The client and therapist came to the lab separately for data collection. After completing a demographic survey, they were presented with Bordin's (1979) definition of the working alliance and informed that they would be asked to provide ratings of the working alliance while watching a video recording of their most recent session. They both watched the same session and reported their own perceptions of the alliance (i.e., the therapist was not predicting her client's ratings or vice versa). While watching the recording, they used a dial to rate the working alliance continuously (DialSmith's Perception Analyzer); one rating was collected each second. The middle position of the dial (0) was labeled as 'Neutral,' and the extremes of the dial (-50 and +50) were labeled as 'Weakest Possible' and 'Strongest Possible,' respectively.

After the client or therapist finished providing moment-to-moment alliance ratings for their entire session, a researcher graphed the ratings and visually identified the three lowest-rated segments, which constituted the alliance ruptures. Alliance repairs were also visually identified. Repairs were defined as segments in which the alliance began to be rated more positively after a rupture. Afterward, the participants were shown a 2-minute segment of the beginning of each rupture followed by a 2-minute segment of the subsequent repair. After watching each rupture clip, they typed their responses to the following questions in an online survey: (1) "What was happening during this segment?" and (2) "Why was the working alliance weak during this segment?" After watching each repair clip, participants also typed their responses to (1) "What was happening during this segment?" and (2) "Just prior to this segment, you rated the working alliance more negatively. What led to this improvement?" This was repeated for all three identified rupture-repair sequences. Participants answered these questions for ruptures and repairs based on their ratings only (i.e.., the therapist did not respond to client-rated ruptures or vice versa).

Data Analysis

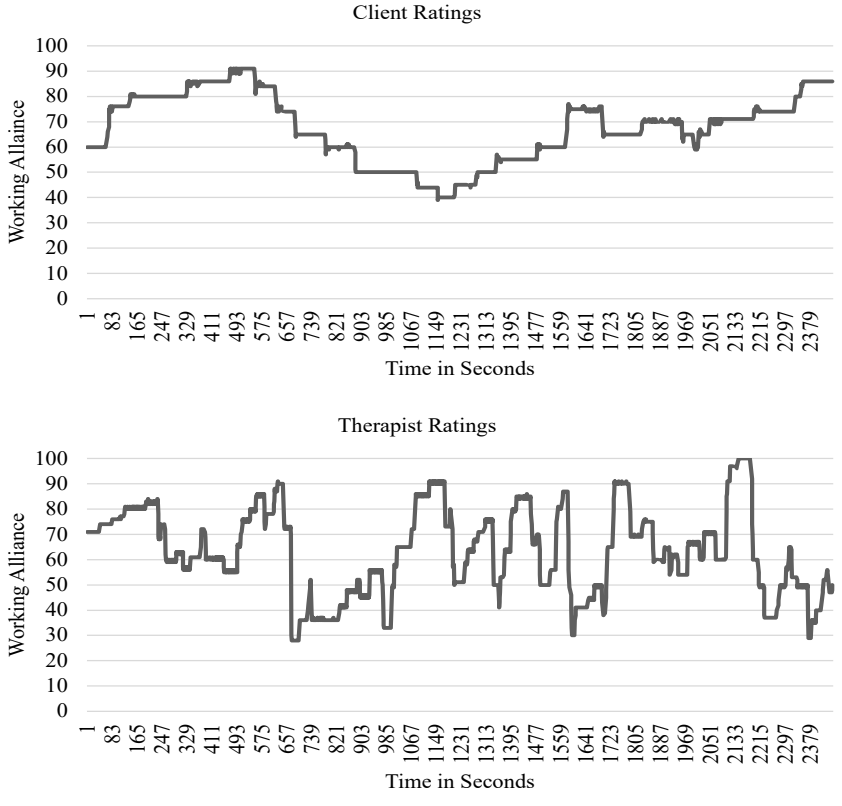
Two measures of client-therapist agreement in quantitative alliance ratings were computed (Penix et al., 2021). First, temporal congruence was calculated by conducting a bivariate correlation between client and therapist moment-to-moment ratings. Higher correlations indicate greater agreement on variations in the alliance throughout the session. Second, directional discrepancy was calculated by finding the difference between the client's and therapist's alliance ratings during each second of the session and then calculating the mean of these differences. Smaller absolute values indicate greater agreement in perceptions of the strength of the alliance at any given

continued on page 46

moment. While qualitative descriptions of ruptures and repairs would be typically analyzed with thematic analysis with group data, representative client and therapist descriptions of each rupture and repair are presented and discussed more informally in this case example.

Quantitative Results

Figure 1
Moment-to-moment client (top panel) and therapist (bottom panel) working alliance ratings



Client and therapist moment-to-moment working alliance ratings are shown in Figure 1. In terms of temporal congruence, the correlation between the two sets of ratings was trivial (r = -.05, p = .007). This indicates that client and therapist perceptions of the alliance did not fluctuate together over the session. Regarding directional discrepancy, the therapist rated the working alliance an average of 18.61 (SD = 13.17) units lower out of 100 than the client. This suggests that the therapist tended to under-estimate working alliance strength relative to the client. Overall, these results indicate substantial client-therapist differences in perceptions of the alliance at a moment-to-moment level.

continued on page 47

Qualitative Results

What was happening during ruptures?

The client indicated that ruptures were often characterized by his therapist asking him to do something in a way that was confusing or ambiguous. For example, he shared, "My therapist asked me to demonstrate something I was unsure of how to do, so it took me a while just sitting in silence, then I did it wrong." For a later rupture, he reported, "My therapist was asking me specifically how I could do something, and I was struggling to put the words together."

The therapist typically reported that she was introducing new concepts or activities to the client during ruptures: "We were doing a mindfulness exercise where he was instructed to let himself ruminate about distress and think about where he felt that in his mind and body." She later shared, "We were going to build new skills surrounding willingness, and I was introducing the concept of willingness and acceptance to the client."

Why was the alliance weak during those segments?

The client generally said that ruptures were due to disagreement or lack of clarity in the goals and tasks dimensions of the alliance rather than problems with the bond:

> "I think this is because our thoughts on how to meet my goals weren't aligned at that time, although it wasn't weaker because our bond was still strong because I knew that she was trying to explain it as best as she could, I just wasn't getting it."

Similarly, he later expressed that "the exercise my therapist gave me confused me and I didn't feel like our goals were aligned."

The therapist shared that ruptures based on her ratings were due to her being too directive, being distracted by note-taking, or failing to address the client's confusion about the rationale for certain activities or concepts:

> This segment didn't seem as collaborative to me, as I was more telling him concepts than also having him tell me why these might be important/what that might look like for him. I was also using notes which inhibited eye contact, so I couldn't gauge as much if he was resonating with these skills and concepts or if these were aligned with his treatment goals.

She also referenced a lack of directly addressing a potential rupture:

> We didn't conceptualize the activity similarly, and the client was confused multiple times in this segment. Subsequently, I didn't process this confusion or dissect in, but instead moved on to different forms of application. In this context, our bond and goals seemed to be inconsistent. I feel like I missed an opportunity to explain the utility of the activity in relation to treatment goals.

What was happening during repairs?

The client reported greater clarity on what his therapist wanted him to do during alliance repairs. For instance, he stated, "My therapist helped me understand what she wanted me to practice, and I did it right. The therapist then asked me how it felt, and I was able to answer confidently after being prompted to elaborate." He also alluded to greater collaboration on goals and tasks: "I was finishing telling my therapist about something that happened that frustrated me, and she related it to my values, which have been a main topic that we have been discussing."

The therapist shared that during repairs, they discussed how the client believed certain concepts applied to him personally: "We continued to talk about willingness and how that applied to the

continued on page 48

client's perception of his presenting concerns." She also described focusing more on the client's emotions: "We tied cognitive diffusion concepts to emotions and feelings, and how acknowledging thoughts impacted his emotions."

What lead to improvements in the alliance during those segments?

The client indicated that a greater mutual understanding and sense of productivity were responsible for alliance repairs. He shared, "I was finally able to answer the difficult question and I felt as though my therapist finally understood what I was trying to say." For another repair, he stated, "The improvement came when my therapist related what we were talking about to my goals that we have been discussing, so I felt like it was more than me just complaining, and it was more productive."

The therapist reported that increased collaboration and empathy and processing the personal meaning of concepts she introduced led to improvements in her perceptions of the alliance. She reported:

> We became more collaborative, and the client offered his insight as to whether these concepts would help and in which ways they might work. We also began to process what acceptance of his primary concerns means to him and what that would look like, so the focus was brought back to his goals and tasks he could do, of which we were on the same page about.

In addition, she later shared:

> The client realized that these thoughts influence his emotions and actions… and the client indicated increased confidence in understanding and applying these skills. In addition, I empathized with him more than I had in previous parts of the session, and it seemed like he responded well to that and expressed more motivation in applying these skills.

Future Directions

There are a variety of ways that microprocess paradigms could be used to study working alliance ruptures and repairs in the future. For example, research could test convergence of client and therapist ratings of ruptures and repairs with observer rating systems, such as the Rupture Resolution Rating System (Eubanks, Lubitz et al., 2019). Quantitative studies might also examine whether session outcomes differ between clients with resolved and unresolved within-session ruptures. Additionally, future research could test whether client- or therapist-rated within-session ruptures and repairs are most predictive of outcomes.

Qualitative client and therapist accounts of events that facilitate within-session rupture repairs could also highlight effective ways to resolve various types of ruptures, such as those stemming from therapist microaggressions, disagreement on goals or tasks (such as those in the case example above), or clients' interpersonal difficulties. Additionally, integrating qualitative perceptions with quantitative ratings could clarify whether different types of ruptures and repairs have different impacts on process and outcome. For instance, do within-session ruptures resulting from therapist microaggressions have a different impact on the alliance than ruptures based on disagreement on goals or tasks, and are the client's or therapist's alliance ratings impacted most?

Finally, microprocess methods could have training and clinical applications. For example, clinical supervisors could assist trainees in using free or low-cost moment-to-moment rating systems to reflect on processes such as the working alliance, collaboration, or empathy in their session recordings (e.g., Software for

continued on page 49

Continuous Affect Rating and Media Annotation [CARMA]; Girard, 2014). Clinicians could also have more informal discussions with clients at the end of sessions about moments when clients felt the working alliance was particularly strong or weak. This may assist in identifying potential ruptures and capitalizing on interventions that clients believe are particularly helpful.

References

Altenstein, D., Krieger, T., & Grosse Holtforth, M. (2013). Interpersonal microprocesses predict cognitive-emotional processing and the therapeutic alliance in psychotherapy fordepression. *Journal of Counseling Psychology, 60*(3), 445-452. https://doi.org/10.1037/a0032800

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

Clemence, A. J., Fowler, J. C., Gottdiener, W. H., Krikorian, S., Charles, M., Damsky, L., & Johnson, B. (2012). Microprocess examination of therapeutic immediacy during a dynamic research interview. *Psychotherapy, 49*(3), 317-329. https://doi.org/ 10.1037/a0026090

Eubanks, C. F., Lubitz, J., Muran, J. C., & Safran, J. D. (2019). Rupture resolution rating system (3RS): Development and validation. *Psychotherapy Research, 29*(3), 306-319.https://doi.org/10.1080/10503307.2018.1552034

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2018). Alliance rupture repair: A meta-analysis. *Psychotherapy, 55*(4), 508-519. https://doi.org/10.1037/pst0000185

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2019). Repairing alliance ruptures. In J. C. Norcross & M. J. Lambert (Eds.), *Psychotherapy relationships that work: Evidence-based therapist contributions* (pp. 549–579). Oxford University Press. https://doi.org/10.1093/medpsych/9780190843953.003.0016

Falkenström, F., & Larsson, M. H. (2017). The working alliance: From global outcome prediction to micro-analyses of within-session fluctuations. *Psychoanalytic Inquiry, 37*(3), 167-178. https://doi.org/10.1080/07351690.2017.1285186

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316. https://doi.org/10.1037/pst0000172

Girard, J. M. (2014). CARMA: Software for continuous affect rating and media annotation. *Journal of Open Research Software*. *2*(1), e5. http://doi.org/10.5334/jors.ar

Penix, E. A., Swift, J. K., & Trusty, W. T. (2020). Integrating clients' moment-to-moment ratings into psychotherapy research: A novel approach. *Counselling and Psychotherapy Research, 20*(3), 456-462. https://doi.org/10.1002/capr.12296

Penix, E. A., Swift, J. K., Russell, K. A., & Trusty, W. T. (2021). Client and therapist agreement in moment-to-moment helpfulness ratings in psychotherapy: A microprocess approach. *Journal of Clinical Psychology, 77*(1), 36-48. https://doi.org/10.1002/ jclp.23030

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48*(1), 80–87. https://doi.org/10.1037/a0022140

Schattner, E., Tishby, O., & Wiseman, H. (2017). Relational patterns and the development of the alliance: A systematic comparison of two cases. *Clinical Psychology & Psychotherapy, 24*(2), 555-568. https://doi.org/10.1002/cpp.2019

Swift, J. K., Tompkins, K. A., & Parkin, S. R. (2017). Understanding the client's perspective of helpful and hindering events in psychotherapy sessions: A micro-process approach. *Journal of Clinical Psychology, 73*(11), 1543-1555. https://doi.org/10.1002/jclp.22531

When is Quantitative Evidence Actually Useful for Day-to-Day Psychotherapy Practice? Why Unsystematic Qualitative Evidence Reigns Supreme

David J. Disabato, Ph.D.
Baldwin Wallace University

In this article, I will argue that quantitative evidence is not very useful to the practicing psychotherapist and instead most day-to-day clinical decisions are based on unsystematic qualitative evidence. I imagine this argument will be obvious to some in clinical practice and considered blasphemy against clinical science for others. It is a realization I have come to after practicing psychotherapy part-time for 9 years while also receiving doctoral and post-doctoral training in clinical science. I spent much time and energy trying to marry the two, psychotherapy and clinical science, and have concluded they simply aren't that compatible.

A pivotal moment during my development as a psychotherapist occurred while on my pre-doctoral internship. I told my supervisor in a rather whiny tone, "But I want to practice psychotherapy based on quantitative evidence!" Imagine the girl from Willy Wonka and the chocolate factory ("But I want an Oompa-Loompa now!"), but more professional. He empathetically responded, "I know you do, David, I know." I was realizing practicing psychotherapy primarily on quantitative evidence was a fantasy rather than a reality. I used to think the infamous "research-practice" gap in psychotherapy (Teachman et al., 2012) was due to psychotherapists not practicing based on quantitative research (Lilienfeld et al., 2013). Now I think the infamous "research-practice" gap exists because quantitative research is simply not that useful to the practicing psychotherapist. Day-to-day practice requires too many granular decisions for which quantitative evidence is too coarse to be applicable. I will argue a few forms of quantitative evidence directly relate to day-to-day practice; however, those are a minority of the clinical decisions a psychotherapist makes. Although this is not a new argument (Beutler, 2009; Levant, 2004), I believe it is worth re-stating in our current age of "evidence-based psychotherapies."

What do I mean by day-to-day psychotherapy practice?

By day-to-day psychotherapy practice, I mean the moment-to-moment decisions a psychotherapist makes during a session: the comments, questions, and listening (i.e., intentionally not saying anything and letting the client talk) a psychotherapist decides at each minute of a psychotherapy session.

As I progressed as a psychotherapist, thinking in terms of psychotherapy "types" or "modalities" was less and less useful. Even the level of "techniques" or "skills" is often too coarse. I remember one early supervisor told me, "Do cognitive restructuring"—as if that was clear enough instruction for a psychotherapist. There are hundreds of ways to "do cognitive restructuring" with a client. For example, you may not want to literally read verbatim from a CBT manual (Owen & Hilsenroth, 2014).

continued on page 51

Instead, you need to figure out what comments/questions you are going to say to your client, in what order, and how to respond to your clients' replies to "do cognitive restructuring." The level of "techniques" or "skills" is not granular enough for the practicing psychotherapist. A psychotherapist is not really deciding what broad "intervention" to do, but instead continually deciding what comment, question, or listening they are going to do in the next minute with their client. After several years of training, I would argue this is the level of granularity that a psychotherapist wants to be thinking and practicing at.

What forms of quantitative evidence will I be talking about?

By quantitative evidence, I mean empirical data involving numbers systematically collected within the field of psychological science (broadly construed). This usually involves research studies on psychotherapy done by clinical scientists (McFall, Treat, & Simons, 2015). I will be limiting my discussion to two forms of quantitative evidence: 1) basic clinical science, and 2) psychotherapy outcome research. I acknowledge there are other forms of quantitative evidence potentially more relevant to day-to-day psychotherapy practice (e.g., psychotherapy process research, routine outcomes monitoring, psychotherapy training research, etc.). However, these are beyond the breadth of this article.

1) Basic clinical science: Why being in the ballpark is just not good enough

People craft elaborate narratives loosely connecting quantitative evidence to some intervention they plan to do with a client. If there is *any* quantitative evidence in the ballpark of their claim/intervention, people will call it up like a divine spirit. For example, while attending a psychotherapy conference, I heard a panelist state we needed to focus on improving clients' grit. He cited Angela Duckworth's research showing grit is associated with not only elite performance (Duckworth et al., 2007) but also psychological well-being (Duckworth, 2016). He suggested doing grit interventions with clients. The problem is that there are no grit interventions with quantitative evidence, and none are explicitly framed within the context of psychotherapy (e.g., what comments/questions/listening would a psychotherapist do to increase their client's grit). The scientific evidence on grit being applied was too far removed from day-to-day psychotherapy practice to be clinically useful and yet the panelist claimed this was a new innovative way to do "evidence-based practice."

Quantitative evidence is most useful to practicing psychotherapists when it comes from one of the following: 1) human subjects research, 2) within-person studies, or 3) intervention testing. Psychotherapy usually involves higher-order cognitive processes such as language and meta-cognition unique to human beings. Research on animals, including primates, is not an appropriate analog for understanding psychotherapy. Psychotherapy is innately a within-person process involving change over time. Within-person studies seek to understand why a person has different levels of a construct at time A vs. time B. For example, why a person has high depression before psychotherapy and low depression after psychotherapy. Between-person studies investigate why person A has different levels of a construct than person B. For example, why one person has clinical depression, and another person has fewer symptoms of depression. While those between-person studies are relevant to the causes and correlates of mental health, I assert that

continued on page 52

they are not relevant to treatments like psychotherapy. Finally, intervention studies testing out psychotherapist comments/questions/listening are needed. Knowing that when meaning in life increases for a person, their depression goes down is not very useful for day-to-day psychotherapy practice. The research does not indicate what comments/questions/listening by a psychotherapist can increase meaning in life. It is the difference between a naturalistic vs. intervention study. Because a construct predicts mental health at the within-person level, does not mean a "common sense" intervention based on that construct will *change* mental health (e.g. grit: telling a client it will be worth it if they don't give up; meaning in life: asking a client to identify a purpose in life for their next session; self-acceptance: telling a client to mindfully recognize their "common humanity" next time they criticize themselves).

I learned this first-hand from group supervision with licensed psychotherapists. I was a student psychotherapist who had just completed four years of quantitative research training. One of the licensed psychotherapists talked about a client with social anxiety and a hostile interpersonal style. I got very excited as my graduate school mentor had done research on this. He found ~20% of people who meet diagnostic criteria for Social Anxiety Disorder had elevated aggression and anger when compared with quiet, meek, and inhibited socially anxious clients (Kashdan et al., 2009; Kashdan & Hoffman, 2008). I proudly informed the psychotherapist of my mentor's research. He asked what my mentor recommended for treating these types of clients as a round of traditional cognitive behavioral therapy (CBT) for Social Anxiety Disorder was not working (e.g., Heimberg & Becker, 2002). I told him that my mentor did not do research on interventions for this population. His reply was, "I don't need your mentor's study to know my client has social anxiety with anger problems. You can come to my office at 3:00pm on Tuesdays and I will show you the evidence! Instead, I need to know how to treat this client." Indeed, my advisor's research did not inform his day-to-day psychotherapy practice.

2) Psychotherapy outcome research: After selecting a black box, you leave the quantitative evidence behind

My critique of basic clinical science naturally brings us to the psychotherapy outcome literature. Perhaps the most common form of quantitative evidence used to argue day-to-day psychotherapy practice can be based on science are studies of psychotherapy modality. The studies tend to be randomized controlled trials (RCTs) that are 1) research on humans that 2) look at within-person change 3) in response to interventions. The three aspects of quantitative evidence I outlined above are satisfied. In this case, the intervention is the psychotherapy modality. By psychotherapy modality, I am referring to the type of psychotherapy that might be a treatment arm of an RCT: Beckian cognitive therapy, intensive short-term dynamic therapy, exposure and response prevention, emotion-focused psychotherapy, etc. There are many psychotherapy modalities with evidence from RCTs supporting their efficacy (Wampold & Imel, 2015). *This quantitative evidence is useful for selecting a type of psychotherapy to use with a client.* After the psychotherapy modality is selected, the psychotherapist must decide how to implement the type of psychotherapy. In other words, what comments or questions the psychotherapist communicates to their clients, in what order, and how they respond to their clients' replies. These clinical deci-

continued on page 53

sions, which number by the hundreds each week, are not based on quantitative evidence.

What I am referring to arises in the most recent psychotherapy book I read: *Cognitive therapy for suicidal patients: Scientific and clinical applications* (Wenzel et al., 2009), which asserts that it is based on "scientific evidence." While the book cites RCTs that empirically support Beckian cognitive therapy for reducing suicidality (e.g., Brown et al., 2005), there is no scientific evidence for any given recommendation or suggestion by the authors. Theoretically, the recommendations in the book are things the RCT study psychotherapists did, but there was no quantitative assessment of that. For example, the authors recommend homework assignments that only contain a single component (rather than multi-component homework assignments). The authors did not present evidence correlating use of single-component homework assignments with therapy outcomes. Ideally, an RCT would be conducted that randomized suicidal clients to receive single-component or multi-component homework assignments. As presented in the book, cognitive therapy was a black box for which all the moment-to-moment clinical decisions were lost to the abyss.[1]

If clinical scientists attempted to map out the black box of cognitive therapy for suicidal patients, it would be an impossible task. An untenable number of RCTs would be required to fully study the thousands of day-to-day clinical decisions to be based on the psychotherapy outcome literature. It would take an immense amount of time and money; it is simply not a feasible program of research. Even if thousands of researchers agreed to do these RCTs, you would still have—what I have heard some refer to as—the "infinite moderator problem."[2] This is the idea that human psychology is so complex with so many variables at play that almost any main effect has a seemingly infinite number of moderators potentially impacting its magnitude. Yes, RCTs would suggest, on average, clinical decision X leads to better psychotherapy outcomes (i.e., main effect). However, there are inevitably individual differences in that effect depending on client, therapist, relationship, and other factors (i.e., moderators). This is the spirit behind the famous Gordan Paul (1969) quote "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances" (pp. 44).[3] After conducting thousands of RCTs to determine the best clinical decisions to make *on average*, researchers would need to conduct thousands more RCTs with larger sample sizes to detect the plethora of potential moderators at play. Again, it is simply not a feasible program of research.

continued on page 54

[1] To be clear, I am not saying the author's recommendations are bad, but rather they are not based on quantitative evidence.

[2] I am unsure of the origins of the term "infinite moderator problem," but perhaps one of the first times it was referenced was by Cronbach (1975) who said, "Once we attend to interactions, we enter a hall of mirrors that extends to infinity. However far we carry our analysis-to third order or fifth order or any other-untested interactions of a still higher order can be envisioned."

[3] I recently learned Gordan Paul might not have been the first psychologist to write about this idea. In 1966, John Krumboltz wrote, "What we need to know is which procedures and techniques when used to accomplish which kinds of behavior change, are most effective with what kind of client when applied by what kind of counselor."

Therefore, it is my position that Paul Meehl and colleagues' research about clinical vs. actuarial prediction (Dawes, Faust, & Meehl, 1989; Meehl, 1954/1996) is not very useful to practicing psychotherapists. Many psychotherapy outcome studies manipulate the modality, or the black box. The actuarial prediction applies when selecting which black box to open. After that, the thousands of psychotherapist decisions for each client cannot be based on actuarial prediction because there are not thousands upon thousands of RCTs done to build the actuarial prediction with. The practicing psychotherapist is forced to use clinical prediction because actuarial prediction is not available. I do not doubt that Meehl understood this idea, and that if he were around today, he would likely agree.[4] I do hear some clinical scientists talk about Meehl's research on clinical vs. actuarial prediction as if psychotherapists should be basing their moment-to-moment clinical decisions off quantitative evidence. For example, Lilienfeld et al. (2013) cited two clinical vs. actuarial prediction meta-analyses arguing for the use of quantitative evidence in psychotherapy practice. However, the first meta-analysis primarily looked at predicting future behavior (e.g., violent offense), performance (e.g., academic achievement), or prognosis (e.g., length of hospital stay) (Egisdottir et al., 2006) and the second meta-analysis primarily looked at predicting medical diagnosis (e.g., throat infection), job performance (e.g., military training) and mental health treatment outcome (e.g., psychotherapy modality) (Grove et al., 2000). The clinical vs. actuarial prediction literature support psychotherapy in general as a treatment (Wampold & Imel, 2015) and using the psychotherapy outcome literature to select a type of psychotherapy, but nothing more. Anyone who says otherwise either hasn't been a full-time psychotherapist before or simply does not understand the very limited amount of actuarial prediction available for day-to-day clinical decision making.

Revenge of the psychotherapy arts: The important role of unsystematic qualitative evidence

I have argued RCTs and actuarial prediction cannot tell you what comment/question/listening to say next to your client. What does a psychotherapist use instead? I contend that the answer is unsystematic qualitative evidence. *By unsystematic qualitative evidence, I mean empirical data that is not collected in any systematic way and without assigning numbers to the data.* Clinical experience from working with clients in psychotherapy is a main source of unsystematic qualitative evidence. I added the adjective "unsystematic" to distinguish the clinical experience I am talking about from qualitative research studies that collect evidence in a systematic way (e.g., Morrison et al., 2017; Maxwell & Levitt, in press). Psychotherapists are continually absorbing unsystematic qualitative evidence from their clients. They are seeing how clients respond to comments/questions/listening during sessions, whether clients find a technique helpful, inert, or harmful, if clients' distress and impairment goes down after several weeks of an approach, etc. Most psychotherapists want to help their clients and are motivated to do so. Psychotherapists are continually getting reinforced and punished for their therapeutic behavior depending on whether their clients get better or not. Unsystematic qualitative

continued on page 55

[4] In his podcast "Talking Therapy," Marvin Goldfried reported that in the late 1950s, Paul Meehl said that he did not base his psychotherapy on research because he did not think it was possible (episode 13, "A Professional Journey to Consensus").

evidence includes more than just clinical observations though. Many specific recommendations in treatment manuals and clinical books are based on unsystematic qualitative evidence from the authors (e.g., complexity of homework assignments in cognitive therapy for suicidal patients; Wenzel et al., 2009). In addition, much of the clinical wisdom I have received from supervisors was based on unsystematic qualitative evidence. I had one supervisor who authored a well-known treatment manual. I asked if he follows his own treatment manual when doing psychotherapy with his clients. He replied, "No" and emphasized the importance of flexibility and "tailoring treatment to the individual client." Learning how to "tailor treatment to the individual client"—what some call the *art* of psychotherapy—is based on unsystematic qualitative evidence.

Unsystematic qualitative evidence—not quantitative evidence—is how new psychotherapies have developed. We learn in Psych 101 that Freud used his clinical experience to develop psychoanalysis. The same is true for Beck with Cognitive Therapy and Linehan with Dialectical Behavior Therapy (DBT). Beck used his clients' thoughts (initially dreams as well) as qualitative data and essentially conducted thematic analysis on them (a qualitative research method).[5] I have not read about the involvement of any quantitative data until Beck had already fully developed cognitive therapy for depression and then conducted his first RCT with John Rush (Rush et al., 1977). DBT had a similar trajectory. It is reported that Linehan started doing conventional behavior therapy with suicidal clients. Through clinical experience, she realized suicidal clients felt invalidated by conventional behavior therapy interventions and felt that client-centered therapy was not helpful. Linehan determined that she needed to balance both conventional behavior therapy and client-centered therapy (Linehan, 2020). Quantitative evidence was introduced to Linehan's research to test the already developed DBT psychotherapy modality.

Thus, many of the sentences in treatment manuals and clinical books—like the cognitive therapy for suicidal patients book I referenced above—are based on unsystematic qualitative evidence. However, they can be useful reading for a practicing psychotherapist. There is a reason many psychotherapists do not reference basic clinical science, RCTs, and other empirical journal articles (Morrow-Bradley & Elliott, 1986). It is more useful to hear a case study of one of the clients from an RCT than to interpret the statistical results based on the RCT's full sample. I have met people who know the science of psychotherapy research very well, but from what my colleagues and I could tell, they were not effective psychotherapists. My moment-to-moment clinical decisions as a psychotherapist *won't* be based on quantitative evidence, because they *can't* be based on quantitative evidence. As I aim to become a better psychotherapist, I will be reading treatment manuals and clinical books by expert psychotherapists who have gathered massive amounts of unsystematic qualitative evidence from seeing hundreds—if not thousands—of clients. I still feel the same way I felt on internship that "I

continued on page 56

[5] This makes me wonder if encouraging future psychotherapists to do qualitative dissertations might offer better training than traditional quantitative dissertations do. As one Clinical Psychology PhD ironically noted on Twitter, "The scientist-practitioner model of training is weird: I know what heteroskedasticity is but have never seen a client with a substance use disorder [one of the most common disorders in the United States]."

want to practice psychotherapy based on quantitative evidence," but I have now accepted it is not possible. I hear my supervisor's empathetic voice in my head—"I know you do David, I know" and then I turn to the next clinical book on my list.

References

Beutler, L. E. (2009). Making science matter in clinical practice: Redefining psychotherapy. *Clinical Psychology: Science and Practice, 16*(3), 301–317. https://doi.org/10.1111/j.1468-2850.2009.01168.x

Beutler, L. E. (1997). The psychotherapist as a neglected variable in psychotherapy: An illustration by reference to the role of therapist experience and training. *Clinical Psychology: Science and Practice, 4*(1), 44–52. https://doi.org/10.1111/j.1468-2850.1997.tb00098.x

Brown, G. K., Tenhave, T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *JAMA, 294*, 563-570.

Cronbach, L. J. (1975). Beyond the two disciplines of scientific psychology. *American Psychologist, 30*, 116-127.

Dawes, R. M., Faust, D., & Meehl, P. E. (1989). Clinical versus actuarial judgment. *Science, 243*(4899), 1668-1674.

Duckworth, A. L., Peterson, C., Matthews, M. D., & Kelly, D. R. (2007). Grit: perseverance and passion for long-term goals. *Journal of Personality and Social Psychology, 92*(6), 1087-1101.

Duckworth, A. L. (2016). *Grit: The power of passion and perseverance*. Simon & Schuster, Inc.

Egisdottir, S., White, M. J., Spengler, P. M., Maugherman, A. S., Anderson, L. A., Cook, R. S., et al (2006). A meta-analysis of clinical judgment project: Fifty-six years of accumulated research on clinical versus statistical prediction. *The Counseling Psychologist, 34*, 341–382.

Grove, W. M., Zald, D. H., Lebow, B. S., Snitz, B. E., & Nelson, C. (2000). Clinical versus mechanical prediction: A meta-analysis. *Psychological Assessment, 12*,19–30.

Heimberg, R. G., & Becker, R. E. (2002). *Cognitive-behavioral group therapy for social phobia: Basic mechanisms and clinical strategies*. Guilford Press.

Kashdan, T. B., & Hofmann, S. G. (2008). The high-novelty-seeking, impulsive subtype of generalized social anxiety disorder. *Depression & Anxiety, 25*, 535-541. doi:10.1002/da.20382

Kashdan, T. B., McKnight, P. E., Richey, J. A., & Hofmann, S. G. (2009). When social anxiety disorder co-exists with risk-prone, approach behavior: Investigating a neglected, meaningful subset of people in the National Comorbidity Survey Replication. *Behaviour Research and Therapy, 47*, 559-568.

Krumboltz, J. D. (1966). Promoting adaptive behavior: New answers to familiar questions. In J. D. Krumboltz (Ed.), *Revolution in counseling* (pp. 1-26). Boston MA: Houghton Mifflin.

Levant, R. (2004). The empirically validated treatments movement: A practitioner perspective. *Clinical Psychology: Science and Practice, 11*(2), 219-224.

Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2013). Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical Psychology Review, 33*(7), 883-900.

Linehan, M. M. (2020). *Building a life worth living: A memoir*. Random House.

Maxwell, J. A., & Levitt, H. M. (in press). How qualitative methods advance

continued on page 57

the study of causation in psychotherapy research. *Psychotherapy Research*.
McFall, R. M., Treat, T. A., & Simons, R. F. (2015). Clinical Science Model. In (Ed. R. L. Cautin & S. O. Lilienfeld) *The Encyclopedia of Clinical Psychology* (1st edition).
Meehl, P. E. (1996). *Clinical versus statistical prediction: A theoretical analysis and a review of the evidence*. Northvale, NJ: Jason Aronson. (Original work published 1954)
Morrison, N. R., Constantino, M. J., Westra, H. A., Kertes, A., Goodwin, B. J., & Antony, M. M. (2017). Using interpersonal process recall to compare patients' accounts of resistance in two psychotherapies for generalized anxiety disorder. *Journal of Clinical Psychology, 73*(11), 1523-1533.
Morrow-Bradley, C., & Elliott, R. (1986). Utilization of psychotherapy research by practicing psychotherapists. *American Psychologist, 41*(2), 188-197.
Owen, J., & Hilsenroth, M. J. (2014). Treatment adherence: the importance of therapist flexibility in relation to therapy outcomes. *Journal of Counseling Psychology, 61*(2), 280-288.
Paul, G. L. (1969). Behavior modification research: Design and tactics. In C. M. Franks (Ed.) *Behavior therapy: Appraisal and status* (pp. 29-62). New York, NY: McGraw-Hill.
Rush, A. J., Beck, A. T., Kovacs, M., & Hollon, S. (1977). Comparative efficacy of cognitive therapy and pharmacotherapy in the treatment of depressed outpatients. *Cognitive Therapy and Research, 1*, 17-37.
Teachman, B. A., Drabick, D. A. G., Hershenberg, R., Vivian, D., Wolfe, B. E., & Goldfried, M. R. (2012). Bridging the gap between clinical research and clinical practice: Introduction to the special section. *Psychotherapy, 49*(2), 97–100. https://doi.org/10.1037/a0027346
Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.
Wenzel, A., Brown, G. K., & Beck, A. T. (2009). *Cognitive therapy for suicidal patients: Scientific and clinical applications*. American Psychological Association.

WASHINGTON SCENE

"Love as fresh as the morning air"

Pat DeLeon, PhD
Former APA President

APA/APA Services' Exciting Virtual Advocacy Summit: Alix Ginsberg, Senior Director Congressional & Federal Relations: "On March 26-27th, APA/APA Services' hosted its first Virtual Advocacy Summit of 2023, 'Strengthening the Psychology Workforce to Improve Health Equity.' This Summit included over 200 psychologists from 49 states, as well as Puerto Rico and Washington, DC, and represented 13 APA Divisions and 44 State, Provincial, and Territorial Psychological Associations (SPTAs). After a day of programming, interactive trainings, and meetings with their state delegations, advocates held meetings with their Congressional delegations to advocate for several policy solutions to help strengthen the psychology workforce, reduce health disparities, and help meet the nation's growing demand for mental and behavioral health services.

"On March 26th, APA President Thema Bryant and APA CEO Arthur Evans gave opening remarks, which were followed by a presentation on current political dynamics in the 118th Congress by APA Chief Advocacy Officer Katherine McGuire. Summit participants then heard from experts through targeted panel discussions titled, *Addressing Obstacles and Barriers to Health Equity in Underserved Areas* and *Reducing Health Disparities by Strengthening Support for Psychology Trainees*. These panels were moderated by APA President-Elect Cynthia de las Fuentes and D.C. Psychological Association President-Elect Jessica Smedley.

"On March 27th, Summit participants met with Members of their Congressional delegations to advocate for three important legislative requests that would strengthen the psychology workforce. These legislative requests included supporting the Increasing Mental Health Options Act (S. 669), which was recently introduced by Senators Brown (D-OH), Collins (R-ME), Heinrich (D-NM), and Mullin (R-OK). S. 669 would allow psychologists in Medicare to practice independently in all covered treatment settings, as they are allowed to do under private sector health plans, in TRICARE, and within the VA. Currently, Medicare does not allow psychologists to practice independently in an all Medicare-covered treatment setting. They can practice independently in office-based settings, but for patients in skilled nursing facilities, partial hospitalization programs, outpatient rehabilitation facilities, home health agencies, and hospice programs patients need to obtain a physician referral before seeing a psychologist. This creates unnecessary delays in treatment for Medicare patients in these settings. In addition, advocates asked legislators to support legislation that would authorize reimbursement for supervised services provided by advanced psychology trainees in Medicare, which is expected to be introduced by Senators Barrasso (R-WY) and Bennet (D-CO) soon. CMS has already approved reimbursement for these services in 28 states in Medicaid. Finally, advocates also asked their Members of Congress to support increased FY24 funding for the Graduate Psychology Educa-

continued on page 59

tion (GPE) and Minority Fellowship Program (MFP). These critical programs would strengthen our nation's supply of health service psychologists trained to provide culturally competent, integrated mental and behavioral health services."

Psychology's Increasing Expansion into the Health Care Arena: One of the most enjoyable aspects of being involved with the National Academy of Medicine (NAM) of the National Academies of Science, Engineering, and Medicine (NASEM) is the opportunity to learn from distinguished colleagues in other disciplines. This is especially relevant for psychology's continuing expansion as a primary health care provider and our active participation in team-based care. It is the essence of Interprofessional Practice and Education (IPE).

During one of our recent Global Forum on Innovation in Health Professional Education meetings, Kim Dunleavy, of the College of Public Health and Health Professions at the University of Florida and representative for the American College for Academic Physical Therapy Education, presented the perspective of the importance of interprofessional management for addressing "the high prevalence and major impact of pain as the number one cause of disability around the world." Her editorial in the *Journal of Interprofessional Education & Practice* stressed the importance of moving beyond society's current focus on opioid use disorders to a more comprehensive prevention and use of best practices for pain management orientation, while noting that "health professionals are often ill prepared to assist patients effectively."

Highlights: The delivery of effective pain management can be complex, requiring collaborative approaches that exceed the expertise of any one profession to manage the cognitive, physical, and psychosocial aspects of pain management in a coordinated team approach. Accordingly, interprofessional teamwork is critical for seamless, high quality patient care and effective management of pain. Shared decision making with empathy and compassion is a core element of optimal interprofessional collaborative practice, as is respect for one's colleagues. Involving patients is especially important and developing effective training modules is a distinct challenge. The professions involved in pain management at lease include chaplaincy, counselling, dentistry, medicine, medical assistants, nursing, pharmacy, physical therapy, psychology, public health, occupational therapy, and social work. Some of the future directions emphasized in this special edition are an emphasis upon experiential learning, involving patients in co-creating and delivering effective services and learning experiences. And these should include individuals who have *lived experiences* with pain. The need for continuous evaluation of the various educational activities is important in developing data-based best practices. Interestingly, our long-time colleague Bob Frank served as Dean of Kim's College in 1995. He was subsequently selected as a Robert Wood Johnson Health Policy Fellow and President of the University of New Mexico. Most impressively, the College endowed the Dean's Chair in his name.

With the increasing and transformative utilization of cutting-edge technology, including telehealth services as described by Kim, licensure mobility has become a significant policy issue confronting the various health professions. At the recent 40th annual Practice and State Leadership Conference (PLC/SLC), Alex Siegel, Director of Professional Affairs at the Association of State and Provincial Psychology Boards (ASPPB), reported that an increasing number of the other health professions are in the

continued on page 60

process of adopting a Compact approach for their membership, similar to the Psychological Interjurisdictional Compact (PSYPACT) which has now been adopted in 35 jurisdictions, 33 of which are currently effective. Alex further noted the growing interest of the health professions community in working to modify the current reimbursement/payment system to emphasize demonstrable quality outcome measures, rather than continuing to relay upon the historical volume of services provided.

Changing Times: Lucinda Maine, retired CEO of the American Association of Colleges of Pharmacy (AACP): "The College of Psychiatric and Neurologic Pharmacists (CPNP) was founded on March 24, 1999, when the network of pharmacists, formerly known as the Conference of Psychiatric and Neurologic Pharmacists, became a professional society. The formation of CPNP was the cumulation of the efforts of many pharmacists practicing in the psychiatry and neurology specialties over the past 30 years. In 2022, 50 years after the first psychiatric pharmacy residency was established, CPNP was renamed the American Association of Psychiatric Pharmacists (AAPP) to provide a clarity of purpose, enhance advocacy efforts, streamline planning strategies, and allow the organization to proceed with passion, focus, and authenticity. AAPP serves a membership of nearly 3,000 individuals [https://aapp.org/about].

"During his AACP Presidency, J. Lyle Bootman reached out to national organizations and AACP joined forces with the American College of Clinical Pharmacy to market and launch a visionary initiative under which the NAM hosts a Pharmacy Health Policy Fellow. The Fellows will tell you that it transformed their careers!" This is a sentiment deeply shared by Bob Frank. For those colleagues interested in psychology's RxP quest, Bob McGrath, the founding chair of the RxP training program at Fairleigh Dickinson University, estimates that 7.33% of our nation presently has access to prescribing psychologists. About half of whom are in Illinois, thanks to Beth Rom-Rymer's continuing efforts.

Ron Levant, former APA President: "Morgan Sammons and I have been discussing the need to re-envision the doctoral curriculum. It takes about seven years to get a Ph.D. in health service psychology (i.e., counseling or clinical), because the curriculum is largely geared to training people for academic careers. Yet very few graduates go into the academy. The PsyD was intended to be a corrective, yet due to the requirements of the APA Commission on Accreditation, it has largely failed to do that. That is, it has shaved very little off the time, taking about six years for the PsyD. At the same time, master-level mental health professions (LCSW, LPC, MFT) are turning out scores of practitioners who provide psychotherapy, but not the advanced psycho-diagnostic and health-related services that psychologists are trained to provide.

"In the meantime, medicine has dramatically revamped its curriculum, taking the two-year basic science curriculum and condensing it down into 11 months, and making it much more clinically relevant. Morgan, in his role as CEO of the National Register, has been writing about this. One of his columns can be found at [https://www.national-register.org/eo-desk-apr-2022-doctoral-curriculum/]. Both Morgan and I are retired, but we still want to do what we can to stimulate discussion of this matter. As former University Deans, we would appreciate learning your thoughts [Levant@uakron.edu]."

continued on page 61

Exciting Opportunities for the Next Generation: CPT Airyn Nash, USU Psychology Graduate Student —"This was my first-time attending APA's Practice Leadership Conference (PLC/SLC), and it was so inspiring to see the people and brains behind the policies and advocacy for psychologists throughout our nation. As a first-year graduate student, I was extremely impressed by the APAGS representatives from each state and grateful that I could contribute to the conversations with some military experience and insight for a largely civilian population. Among discussions for ways to increase access to care for those most at risk and impoverished, students also discussed ways to maximize therapy practices at both the master's and doctoral level. Most important of all, the care and passion for others and their well-being was tangibly present, and it left me hopeful for the continued future leadership of APA.

"For myself, this was such a great opportunity to network and connect with psychologists who are interested in gaining prescriptive authority for their states. I gained such a better understanding of the thought processes that go on behind the scenes to make change not only within the APA, but also in the state and federal legislations. I cannot recommend this experience enough, especially for graduate students, in order to peer into the workings of our future profession. I am deeply humbled by the opportunity to attend and be among peers and leaders within this field, and I would like to extend a 'thank you' to Dr. Abrahamson and the rest of the APA organizers for putting on a great event." "Ageless and ever evergreen" (Barbra Streisand).

Aloha,

Pat DeLeon, former APA President – Division 29 – April 2023

WASHINGTON SCENE

"I've seen it rainin' in the sky"

Pat DeLeon, PhD
Former APA President

Advocating for Youth Mental Health Research and Stronger Protections for Children on Social Media:
Alix Ginsberg, Senior Director of APA Congressional & Federal Relations—"On June 15th nearly 60 APA member psychologists participated in 150 meetings with their Members of Congress on Capitol Hill to advocate for youth mental health research and stronger protections for children online. APA celebrated this as the first in-person fly-in since the COVID-19 pandemic. The mental health aspects of social media and the need for more research in this and other areas impacting children are topic where policymakers, regulators, parents, and APA have recently highlighted the need for change. These meetings worked to raise the profile of psychology, stressed the need for greater research funding, and secured additional cosponsors for legislation aimed at curtailing the harms of social media on children.

"To prepare for their Hill meetings, participants gathered the day before for an in-person briefing during which they learned about the *Kids Online Safety Act* (S. 1409) and draft legislation to authorize funding for a Youth Mental Health Initiative. APA President Thema Bryant gave welcoming remarks, which were followed by a presentation from APA Chief Advocacy Officer Katherine McGuire on the shifting political landscape and what psychologists can do to meet the moment. Throughout the day, participants heard from expert members on the impacts of social media on a child's brain, recommendations included in the recent *APA Health Advisory on Social Media Use in Adolescence*, and the need for federal oversight on social media. Notably, APA was pleased to welcome Federal Trade Commission (FTC) Commissioner Alvaro Bedoya for a conversation on the role that psychology can play in shaping federal policy around social media.

To close out the day, Thema and Katherine presented awards to members whose advocacy efforts have elevated the voices of those from underserved communities and advanced the discipline of psychology. The first Presidential Citation was given to Diana Prescott for her commitment to the underserved rural health community, her leadership in federal advocacy, and her contributions to the APA Board of Directors. The second Presidential Citation was awarded to Brendesha Tynes, for her scholarship in developmental psychology, her leadership in advancing digital equity in schools, and her commitment to protecting children from racial discrimination in the digital world. Katherine then presented the APA Services Advocacy Award to two federal advocacy coordinators. The first awardee was Amy Beck for her dedicated advocacy at both the state and federal levels, her participation in diverse coalitions to elevate different facets of children's mental and physical well-being, her efforts to find new allies for psychology from different sectors to support legislation led by the Missouri

continued on page 63

Psychological Association (MOPA), and her leadership in training advocates to speak up on important social issues, including organizing MOPA's first member-wide legislative day. Molly Gabriel-Champine, from the Michigan Psychological Association, was then honored for her work at the intersection of psychology and medicine, her leadership in the successful push to enact legislation promoting the full range of evidence-based models of integrated care, including the Primary Care Behavioral Health model, as well as her work to gain Medicare coverage for advanced psychology trainees.

"Katherine then presented Congressional Champion Awards to Senator Marsha Blackburn (R-Tennessee) and Senator Richard Blumenthal (D-Connecticut) for their work on the bipartisan Kids Online Safety Act (KOSA). Both Senators have worked tirelessly to elevate the importance of youth mental health, recruit a robust and bipartisan collection of cosponsors for KOSA, and met with diverse stakeholders to continually improve the legislation."

Collectively Addressing a Pressing Societal Issue: *The American Psychological Foundation (APF)*—Former APF Chairperson and former APA President, Dorothy Cantor recently announced that APF, in conjunction with the Fund Organizing Committee and Division 55 (the Society for Prescribing Psychology), has established the APF Psychology of Antisemitism Fund. This effort will support annual grants for psychology researchers to use psychological theory and evidence to develop or implement interventions aimed at the reduction of antisemitism and/or mitigating its effects. Laura Barbanel, who convened the Organizing Committee: "With the appalling and frightening rise of antisemitism in the United States and around the world, it seemed vital that psychologists be brought together to address the growing problem. Psychologists are the experts on human behavior and our hope is that their expertise can help mitigate the problem."

Dorothy: "I am excited to see organized psychology come together for the first time to address the horrific problem of antisemitism. APF is the right organization to tackle the problem because of its vast reach to researchers and clinicians who will take advantage of the funding opportunities, and because of its capacity for disseminating the results to the broader public. This fund will support the APF Psychology of Antisemitism Grant which will award applicants who design, develop, or implement existing programs that are set up to reduce antisemitism or mitigate its effects." APF President Terry Keane: "We are proud to partner with the Fund Organizing Committee and Division 55 on this important cause. The rise of antisemitism worldwide is a pressing concern, and we look forward to funding programs that will successfully combat this trend."

Richard Lerner: "After World War II, psychologists were part of a multidisciplinary team that explained to the world the nature, developmental bases, and dangerous implications for world peace, democracy, and social justice of the authoritarian personality and of the fascist and white-supremacy ideas harbored by such individuals. Today, with the resurgence of fascism, white nationalism, and anti-democratic ideologies and actions besetting the world and American government and civil society, psychologists are again being asked to focus their expertise on ways to understand the roots of antisemitism and fascism and to contribute to eliminating it from our nation. As they did almost 80 years ago, psychological science will meet this

continued on page 64

challenge, and the APF Psychology of Antisemitism Fund will significantly help enable them to make this contribution to democracy and the well-being of all people in our nation." The Fund's inaugural Breakfast will be at the convention on Friday, August 4, 7:30 a.m. to 9:30 a.m. in the Division 55 Hospitality Suite at the Marriott Hotel.

The National Academy of Medicine (NAM) – Soon after the Supreme Court decision in *Students for Fair Admissions, Inc. v. President and Fellows of Harvard College*, Victor Dzau, President of the National Academy of Medicine, shared the June 30, 2023 statement by himself and his fellow Presidents of the National Academy of Sciences and National Academy of Engineering (NASEM): "Yesterday the Supreme Court issued a ruling to restrict affirmative action that will present challenges to efforts to diversify the nation's colleges and universities. We strongly believe that the nation should remain committed to these efforts and find solutions that address racial inequities, including past and current racial discrimination and structural, systemic, and institutional racism in education.

"A 2011 National Academies report stated that policies that have included affirmative action are fundamentally important to increasing the participation of members of historically underrepresented racial and ethnic minority groups at the postsecondary level across all fields. The report further states that increasing their participation and success contributes to the health of the nation by expanding the science and engineering talent pool, enhancing innovation, and improving the nation's global economic leadership. A National Academies report issued in February 2023 recommends that leaders of organizations, including colleges and universities, take action to redress both individual bias and discrimination as well as review their own processes to determine whether they perpetuate negative outcomes for people from underrepresented racial and ethnic minority groups at critical points of access and advancement.

"It is essential that our nation extend the opportunity for a college education to all, enhance diverse learning experiences for all students, and create equitable pathways to grow a highly skilled workforce and to solve our most complex problems. Diversity is crucial to the success of our society and our economy. We must also remain committed to advancing diversity, equity, and inclusion efforts within our own institutions. We will continue to examine the implications of the decision for our staff and our work as an institution, our relationships with partners and volunteers, and our essential work of providing evidence-based advice to our nation on issues related to science, engineering, and medicine."

Ever Steady RxP Progress: Beth Rom-Rymer—"In celebration of the many advances that we are making in building Prescriptive Authority (RxP) Movements around the globe, I am chairing an international panel of psychologists at our 131st annual APA Convention. The psychologists will be speaking about RxP Movements that they are leading in their countries, including Canada, South Africa, Jamaica, Brazil, and Poland, as well as the role that our training programs play in the proliferation of international Movements. As a further celebration, I have organized a gathering at my Virginia home, immediately following the close of our Convention, featuring speeches by our international panelists; the CEO of national NAMI, Dan Gillison; and Izzeldin Abuelaish, a Palestinian/Canadian OBGYN and public health professor at the University of Toronto, who will speak about the dire

continued on page 65

need for global alliances, especially among healthcare providers, in the Movement to tamp down rising sectarian violence around the world.

"On August 25th, I will be chairing a panel of psychologists and psychiatrists at The Chicago School of Professional Psychology, who have created and who staff the innovative healthcare program in the Illinois Department of Corrections, that serves the psychological and medical needs of transgender folks who are incarcerated in the Department of Corrections. The panelists will discuss the conceptual development of such a Program and how it is being so successfully implemented. The Program will be hybrid and is open to healthcare professionals as well as the general public.

"Finally, on August 26th, I will be chairing my 14th biannual RxP networking hybrid dinner (held every six months) at my home in Chicago, at which we will have prescribing psychologists and prescribing psychologists-to-be talk about their studies and their work. We will be featuring Jeff Singer, Arizona general surgeon and senior research fellow at the CATO Institute, whom we will honor for his many contributions to our legislative advocacy for RxP. It is particularly gratifying to work with interdisciplinary teams of healthcare providers, all concerned about access to mental healthcare for the most vulnerable in our communities. Not unlike other challenging historical eras, we are, as a global community, today, facing serious existential threats."

That All-Important Personal Experience: As our generation of colleagues becomes increasingly senior, personal stories begin to surface describing how difficult it can be to receive quality, patient-center holistic health care for one's loved ones or oneself. New Hampshire's Sandy Rose experienced a rare genetic mutation, resulting in the growth of neuroendocrine tumors which ushered her down this unexpected path. Prior to her illness, she owned a multidisciplinary behavioral health practice which she merged into a Federally Qualified Health Center (FQHC). She helped to develop peer recovery programs to assist patients manage their illnesses. "So, I thought I knew how to be a 'successful' patient. I didn't.

"Dear Valued Health Care System. Thank you for sending your survey for feedback on my outpatient encounter. As the format box was too small for elaboration, I hope you don't mind these suggestions to improve my experience as a patient. *Know me*—How ironic you ask my name and DOB repeatedly during rooming, procedures, and checkout, but you have so little knowledge of who I really am, even what I prefer to be called (Sandy). Please get to know my values when it comes to quality of life, and my preferences for care. Am I an internal control kind of person who prefers immediate test results and data to inform my decisions, or am I overwhelmed and prefer to wait for providers who take the lead to guide me through decisions? Can pre-surgery questionnaires include the quality of the deal breakers for surgery (will this extend my life but reduce its quality), or whether I would prefer to preserve my swallowing nerves and leave the tumor next to them if it comes to a choice? Shared decision making requires factoring in treatment options that truly weigh the risks and benefits <u>to the patient</u>, not always the same criteria that the surgeon feels is best. Make time for providers to really listen to, and respect what patients have to say about their bodies, as this can provide insight that no one else will have.

continued on page 66

"*My place or yours*—Whenever possible keep me home, avoiding hours of commuting, travel and parking expenses and missed work for myself and caretaker(s). Equal the playing field—sitting around home at least allows me to do the laundry, or work at my home office and take out the dog while you see other patients, write notes, take calls. This also avoids sitting alongside others with various stages of who-knows-what germs. Legislation should facilitate interstate licensing to enable telehealth where the patient is. If it can be done so easily during the pandemic, why is it not available now? When I routinely wait for an hour or more to see a provider, or even half an hour, I realize that the office does not care about my time, comfort or in the case of a crowded wait rooms, safety. Invest in technology to improve efficiency and eliminate the need for archaic phone calls that are missed, involving long waits while rerouted to various departments, and/or require me to be tethered to my phone all day to wait for call backs.

"*Identify what matters to me* and incorporate this in the design as well as evaluation of care. Please ask me for input before protocols are designed for accessing care, workflow, new scans and especially reimbursement systems that drive practice. Use this data to identify values that will weigh importantly in practice, as they would for provider and funder measures of care. At the least, if I'm going to take the time to communicate my experience, can someone write back or at least let me know who reads this and why? In other words, I want my experience to matter, and not be limited to post encounter surveys designed to merely and vaguely, fix problems that may not be my priorities, after they occur. Thank you very much for caring enough to ask about my experience. Your time is very important to us." If *we* do not accept the responsibility for addressing Sandy's experiences, who will? "Friends around the campfire and everybody's high" (Rocky Mountain High, John Denver).

Aloha,

Pat DeLeon, former APA President – Division 29 – July 2023

2024 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 2024 are:

- President-elect
- Treasurer
- Domain Representative for Membership
- Domain Representative for Psychotherapy Practice
- Domain Representative for Education & Training
- Domain Representative for Diversity

All persons elected will begin their terms on January 2, 2025

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).ich 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 November 1, 2023.

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. Stewart Cooper, at Stewart.Cooper@valpo.edu

Sincerely yours,

Jean Birbilis	*Tony Rousmaniere*	*Stewart Cooper*
President	President-elect	Chair, Nominations Committee

- - - - - - - - - - - - - - - NOMINATIONS - - - - - - - - - - - - - -

President-elect

_____

_____

_____

Treasurer

_____

_____

_____

Domain Representative Membership

_____

_____

_____

Domain Representative Psychotherapy Practice

_____

_____

_____

Domain Representative Education & Training

_____

_____

_____

Domain Representative Diversity

_____

_____

_____

Name (Printed) _____

Signature _____

Fold Here

_____

_____

_____

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

GRANT WINNERS

Please join us in honoring these recipients of the Society's 2023 grant program

Society for the Advancement of Psychotherapy Norine Johnson Psychotherapy Research Grant

Dr. Anna Babl holds a 2-year postdoctoral mobility scholarship from the Swiss National Science Foundation to work on the project "understanding and training the therapeutic alliance via rupture and repair processes" at the Adelphi University in New York. She has extensively investigated the interpersonal aspects of psychotherapy and published 20 articles in high-impact peer-reviewed international journals. Her most recent publication as a first author was recognized with the most valuable publication in Psychotherapy by the American Psychological Association.

Throughout the last 5 years, she was awarded the European- and International Student Award by the Society for Psychotherapy Research, the Collaborative Small Research Grant and the Emerging Scholar Award three consecutive years.

Dr. Babl has been a therapist for integrative Cognitive-Behavioral Therapy since 2016, with additional training in Emotion-Focused Therapy, Dialectical Behavioral Therapy, and Alliance-Focused Training. This drives her curiosity and interest in the therapeutic alliance and therapist training, both theoretically and practically. ■

Society for the Advancement of Psychotherapy Charles Gelso Psychotherapy Research Grants (Three awardees)

Juan Martin Gomez Penedo is an Associate Professor at University of Buenos Aires with a full-time research position granted by the National Scientific and Technical Research Council of the Argentine Government. He is license in Psychology (Universidad de Belgrano) and specialized in Cognitive Psychotherapy (Universidad Nacional de Mar del Plata, Argentina). He had published more than 60 papers (25 as first author) in peer-review journals in Spanish, Portuguese, and English. His research interests are circumscribed to developing evidence-based criteria for treatment personalization at the process and mechanisms level based on patients transdiagnostic characteristics. ■

continued on page 70

Society for the Advancement of Psychotherapy Charles Gelso Psychotherapy Research Grants (Three awardees)

Lauren M. Lipner, Ph.D. is a tenure-track assistant professor at Long Island University (LIU), Post Campus where she maintains an active research, teaching, and clinical supervision career in addition to her private practice. She completed her doctoral training at Adelphi University in 2020 under the mentorship of Drs. J. Christopher Muran, Catherine Eubanks, Jacques Barber and the late Jeremy Safran. Her doctoral dissertation focused on the identification of clinically significant therapeutic alliance ruptures, findings from which have been published in both *Clinical Psychology & Psychotherapy* and *Psychotherapy*. She completed postdoctoral research fellowships at Mount Sinai Beth Israel and Adelphi University. Lauren received a 2021 Society for Psychotherapy Research (SPR) Small Research Grant to fund her research on the relationships between therapeutic alliance rupture, therapist technique use, and premature treatment termination during her fellowship year. The proposed project is part of a larger line of research in the assessment of unilateral termination that is supported by the Brief Psychotherapy Research Program at Mount Sinai Beth Israel in collaboration with Dr. J. Christopher Muran and Dr. Catherine Eubanks. ■

Society for the Advancement of Psychotherapy Charles Gelso Psychotherapy Research Grants (Three awardees)

Elizabeth Li, MSc, is a PhD Candidate (Sep 2019-expected Dec 2023) at University College London (UCL) Department of Clinical, Educational, and Health Psychology and Anna Freud National Centre for Children and Families, London, the United Kingdom. She was an exchange scholar (Apr-Sep 2022) at Yale University Department of Psychology, New Haven, Connecticut, the United States.

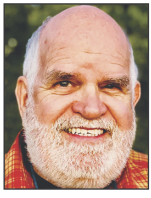
Elizabeth primarily focuses her research on early adversity, psychological mechanisms, mental disorders, and psychotherapy process and outcome. Specifically, her PhD research looks at epistemic trust and mistrust, unmet mental health needs in vulnerable individuals, and psychotherapy process.

Her background involves developmental psychology and psychotherapy. She completed an undergraduate degree in social work, specialized in counselling and psychotherapy and an MSc in Children and Young People's Mental Health and Psychological Practice. Elizabeth started practicing counselling and psychotherapy in 2016.

Elizabeth is the awardee of two research grants: the Charles J. Gelso Psychotherapy Research Grant from the Society for the Advancement of Psychotherapy (APA Division 29) and the International Psychoanalytical Association (IPA) Research Grant in 2023 and the winner of the British Association for Counselling and Psychotherapy (BACP) New Researcher Award in 2022. In addition, Elizabeth has received awards and funding from multiple British charity trusts. ■

CONGRATULATIONS TO THE 2023 SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY AWARD WINNERS!

Society for the Advancement of Psychotherapy Distinguished Psychologist Award And 2023 Rosalee Weiss Lecturer



Danny Wedding, PhD, MPH

Dr. Danny Wedding retired from the American University of Antigua, a Caribbean medical school, where he was Chair of the Department of Behavioral Science & Neuroscience. He previously served four years as the Associate Dean for Management and International Programs with the California School of Professional Psychology, Alliant International University. Although based at the San Francisco campus, he was responsible for psychology training programs in Tokyo, Hong Kong and Mexico City. Danny has also worked in a variety of roles or the American University of the Caribbean in Sint Maarten.

Danny spent two decades teaching for the University of Missouri-Columbia School of Medicine where he was Professor of Psychiatry and Director of the Missouri Institute of Mental Health (MIMH). He has also served on the faculty of three other medical schools: East Tennessee State University, Marshall University, and the American University of the Caribbean (Sint Maarten). Danny is a retired Captain in the U. S. Navy Reserves, and he spent two years working for the U.S. Congress.

Danny has published a dozen books; his books include the 11th edition of Current Psychotherapies and the 5th edition of Movies and Mental Illness. He recently published the 6th edition Behavior and Medicine, a widely used medical school textbook. He was the longtime editor of PsycCRITIQUES, APA's weekly journal of book and film reviews, and he edits the Society of Clinical Psychology book series titled Advances in Psychotherapy: Evidence Based Practice.

Danny is now retired, but he still enjoys consultation, travel, lecturing, writing and editing. He is married and the father of two sons. ■

SAP/APF Early Career Award

Simon Goldberg, PhD

Dr. Goldberg is an Assistant Professor in the Department of Counseling Psychology and Core Faculty at the Center for Healthy Minds at the University of Wisconsin – Madison. He conducts research on psychotherapy, with a specific emphasis on the effects of and mechanisms underlying meditation- and mindfulness-based interventions. He is currently completing a 5-year, NIH-funded K23 award focused on the delivery of meditation training through mobile health technology. He was the recipient of the Society's prestigious 50th Anniversary Research Grant, a one-time grant of $30,000 given in 2018. He has clinical experience working with military veterans and conducts research on veteran mental health. He has served on the editorial board for the Journal of Counseling Psychology, Psychotherapy, and Psychotherapy Research. ■

continued on page 72

SAP/APF Early Career Award

Simon Goldberg, PhD

Dr. Goldberg is an Assistant Professor in the Department of Counseling Psychology and Core Faculty at the Center for Healthy Minds at the University of Wisconsin – Madison. He conducts research on psychotherapy, with a specific emphasis on the effects of and mechanisms underlying meditation- and mindfulness-based interventions. He is currently completing a 5-year, NIH-funded K23 award focused on the delivery of meditation training through mobile health technology. He was the recipient of the Society's prestigious 50th Anniversary Research Grant, a one-time grant of $30,000 given in 2018. He has clinical experience working with military veterans and conducts research on veteran mental health. He has served on the editorial board for the Journal of Counseling Psychology, Psychotherapy, and Psychotherapy Research. ■

Society for the Advancement of Psychotherapy Distinguished Award for the International Advancement of Psychotherapy

Carol Falender, PhD

Carol Falender, PhD is co-author/editor of seven books on competency-based clinical supervision and consultation and has presented workshops on clinical supervision, consultation, multicultural supervision, and decolonizing supervision. She directed APA accredited internship programs for over 20 years and was Chair of the Supervision Guidelines Task Force of the American Psychological Association (APA). She was recipient of a Presidential Citation from APA for innovative contributions to the theory and practice of clinical supervision, nationally and internationally and recipient of the 2018 Distinguished Career Contributions to Education and Training in Psychology Award from APA. She has conducted supervision workshops and symposia internationally. Dr. Falender is a Fellow of APA, Adjunct Professor, Pepperdine University; Clinical Professor, University of California Los Angeles, Psychology Department. ■

Society for the Advancement of Psychotherapy Mid-Career Award for Distinguished Scholarship Contributions to the Advancement of Psychotherapy

James Boswell, PhD

James F. Boswell, PhD, is Associate Professor of Clinical Psychology and Graduate Program Director at the University at Albany, State University of New York. He is also an associate of the Center for the Elimination of Minority Health Disparities. He received his PhD in Clinical Psychology from The Pennsylvania State University. Dr. Boswell has received the Early Career Award from the American Psychological Foundation/American Psychological Association (APA) Division 29, the Outstanding Early Career Achievement Award from the Society for

continued on page 73

James Boswell, PhD, continued

Psychotherapy Research, the David Shakow Early Career Award for Distinguished Scientific Contributions to Clinical Psychology, the Dissertation and Marvin R. Goldfried New Researcher Awards from the Society for the Exploration of Psychotherapy Integration, and a Rising Star designation from the Association for Psychological Science. He is also a Fellow of the APA and serves as President of the North American Society for Psychotherapy Research. Dr. Boswell has published extensively in the areas of psychotherapy process and outcome, measurement-based care, and practice-oriented research. His work has been funded by the Patient Centered Outcomes Research Institute, National Institute of Mental Health, Robert Wood Johnson Foundation, and APA. In addition, he served as a technical expert panelist on the government-sponsored white paper prepared for the U.S. Department of Health and Human Service and the Office of the Assistant Secretary for Planning and Evaluation on Strategies for Measuring the Quality of Psychotherapy. Dr. Boswell is also on the Editorial Board of the Journal of Consulting and Clinical Psychology, Behaviour Research and Therapy, Behavior Therapy, Psychotherapy Research, Psychotherapy, Clinical Psychology and Psychotherapy, Cogent Mental Health, and the Journal of Clinical Psychology. ■

Society for the Advancement of Psychotherapy Award for Distinguished Contributions to Teaching and Mentoring

Linda Campbell, PhD

Dr. Campbell is a Professor in the Counseling and Human Development Department at the University of Georgia. She is also the Director of the Center for Counseling which is the training clinic for doctoral students in Counseling Psychology.

Dr. Campbell serves as Vice-President of the Georgia Board of Examiners of Psychology and is the Chair of the APA Ethics Code Task Force to revise the APA Ethics Code. Dr. Campbell is first author of the *APA Ethics Code Commentary* and the more recent *Casebook on Telepsychology*. She has authored numerous texts and books chapters in the area of ethics and is an associate editor of *Practice Innovations* . She was Co-Chair of the APA Telepsychology Guidelines Task Force and Co-Chair of the APA Assessment and Evaluation Guidelines. Additionally, she is a past chair of the APA Board of Education and the APA Ethics Committee and was a member of the APA Board of Directors from 2014-2016. Dr. Campbell is a native of West Virginia and lives outside of Atlanta near Athens with her husband Alan and their Cavalier King Charles, Maggie. ■

continued on page 74

Society for the Advancement of Psychotherapy Mid-Career Practitioner Award

Matt Hersh, PhD

Dr. Matt Hersh is a licensed clinical psychologist in private practice in the Boston area. He is a diplomate of Comprehensive Energy Psychology, a certified Koru Mindfulness teacher, and a YogaBody Certified BreathWork coach. Matt integrates mindfulness, self-compassion, values work, and Energy Psychology into his psychotherapy practice for teens and adults. For the past decade, he has also been a Harvard University-based consulting mindfulness teacher, facilitating classes within the Kennedy School of Government, Medical School, and the undergraduate and graduate populations. Matt is the founder of The Thriving Therapist, an online resource for mental health practitioners' self-care support and burnout prevention. From this platform, he has created courses and given talks on self-care to both practicing clinicians and clinical psychology trainees. Matt is the author of a recently published book, The Thriving Therapist, that aims to promote sustainable self-care for psychotherapists. ■

Society for the Advancement of Psychotherapy Distinguished Practitioner Award

Michael Wannon, PhD

Dr. Wannon received his doctorate at the University of Rochester and began his career as a Staff Psychologist at the University of Rochester's Mental Health Service, and as an Instructor in the Department of Psychiatry. In 1994, he moved to the DC area and took a position as the Associate Director of the University Counseling Center at Catholic University. Since 1997, he has been in full-time private practice, while concurrently serving as an active teacher and supervisor at the Institute for Contemporary Psychotherapy and Psychoanalysis (ICP&P).

Dr. Wannon has been an instructor and Co-Chair of ICP&P's psychotherapy program, and is currently the Chair of the Institute's Couples Program. He has presented at both national and international conferences on Couple treatment, and the integration of Object Relations and Self Psychology in relational systems. He has mentored and supervised young graduates from many local universities including the George Washington University, Georgetown University, Catholic University, and the University of Maryland. He also runs several consultation groups for established clinicians, focusing on integrating psychodynamic theory and the practice of individual, couple, and group psychotherapy. Based on nominations from other therapists, the Washingtonian voted him Top Psychologist for his work with couples. ■

continued on page 75

Society for the Advancement of Psychotherapy Early Career Practitioner Award (two Awardees)

Natalia Baez-Powell, PsyD

Natalia Báez-Powell (she/her/ella) is a queer, Latinx, licensed clinical psychologist living in the United States. Her work in relational psychodynamic therapy with young adults focuses on issues of relationships, identity development, racial and sexual trauma, and immigration. She provides forensic assessments for individuals seeking asylum in the United States and is passionate about social justice, seeking to make therapy and training more accessible across populations. ■

Society for the Advancement of Psychotherapy Early Career Practitioner Award (two Awardees)

Julia Mackaronis, PhD

Julia Mackaronis is a licensed clinical psychologist who completed her Ph.D. in Clinical Psychology from the University of Utah in 2014, and her fellowship in Interprofessional Couple and Family Health at the VA Puget Health Care System – Seattle Division in 2015. She lives on the coast of the Olympic Peninsula in Washington State, and works as the lead mental health provider for the Roger Saux Health Center of the Quinault Indian Nation. Julia also spends time on research collaborations, freelance consultation, clinically-oriented writing, and is an active member of multiple professional organizations, including having served as president of the Washington State Psychological Association in 2020. Julia identifies as a generalist, with specific areas of expertise include working with couples, trauma, sexuality, and members of the queer community. She works by integrating behavioral, acceptance, attachment, and interpersonal processes, and is passionate about the craft of psychotherapy. ■

Society for the Advancement of Psychotherapy

CONGRATULATIONS TO THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY 2023 STUDENT AWARD WINNERS!

Donald K. Freedheim Student Development Paper Award

Frederik Wienicke

My name is Frederik (Fritz) Wienicke and I am a Ph.D. student at the Behavioural Science Institute of Radboud University (the Netherlands). My research focuses on investigating the efficacy of short-term psychodynamic psychotherapy (STPP) for depression through individual participant data meta-analyses. I am determined to shed new light on the ongoing debate surrounding the evidence base of STPP among scientists, policymakers, and clinical practitioners. Beyond examining the efficacy of STPP for depression, I also explore patient characteristics as treatment effect modifiers (referred to as 'moderators') and predictors of depression relapse after therapy. Through this research, my goal is to contribute to future treatment selection models and enhance our ability to prevent depression relapse, ultimately reducing the burden of this disorder. ■

Mathilda B. Canter Education and Training Paper Award

Jackie Davis-Wright

Jacqueline (Jackie) Davis-Wright obtained her Ph.D. in Clinical-Community Psychology from DePaul University in 2022. She completed internship at the West Los Angeles VA Healthcare Center, where she is now a Trauma Psychology postdoctoral fellow. After fellowship, she will join the Brooklyn VA Medical Center as a staff psychologist. Dr. Davis-Wright is passionate about providing evidence-based treatment for trauma, substance use disorders, and related conditions, as well as increasing access to and engagement with mental health services. Her research aims to promote competency-based, multiculturally-oriented supervision within health service psychology to enhance training and patient outcomes. ■

Student Diversity Paper Award

Vineet Gairola

Vineet Gairola is a Ph.D. Candidate in Psychology at the Indian Institute of Technology, Hyderabad, where his research focuses on ritual practices and processional worship/journeys of *devī-devtās* (Hindu deities) in India's Garhwal Himalayas. His research interests focus on cultural psychology, the link between Jung and India, music psychology, psychological perspectives from India, and the correspondence between spirituality, psychopathology, psychoanalysis, and analytical psychology. He is the winner of the APS 2023 Student Grant Competition by the Association for Psychological Science (APS), the Excellence in Research Award by IIT Hyderabad, the Stephen Mitchell Award given by APA (Division 39), the

continued on page 77

Vineet Gairola, continued

Psychoanalytic Research Exceptional Contribution Award by IPA, the Student Research Award from APA (Division 36), and the Asian Student Membership Scholarship from ANHS. He continues to see the mystical and spiritual experiences prevalent across the Himalaya as a way to encourage a more diverse range of people to understand the psychosocial nuances that such experiences have to offer. He endeavors to bring such profound and hidden psychological nuances from Garhwal within the discipline of psychology and expand the horizons of the discipline itself. ■

Student Excellence in Practice Paper Award

Jared Boot-Haury

Jared Boot-Haury is a dedicated and accomplished Doctor of Psychology student in the final year of his program. He specializes in Clinical Psychology at the Michigan School of Psychology. Jared's clinical experience has focused on addressing the mental health needs of minoritized and overlooked populations. As a Doctoral Intern at the APA-accredited University Counseling Center at Bowling Green State University, he has provided individual, couples, and group counseling, including process and RO-DBT groups. He also provided case management, emergency services, consultations, and outreach activities. Jared also offered clinical supervision to graduate assistants and actively participated in the Counseling Center Diversity Committee, displaying his commitment to culturally affirming care. He recently facilitated a campus workshop introducing students to intuitive eating where they participated in mindful eating practice after cooking in the campus teaching kitchen. This event aimed to reach the high population of students struggling with disordered eating and size stigma on college campuses who are often overlooked.

Jared's passion for supporting minoritized and overlooked individuals in their mental health journey started with his master's level practicum experiences. At the Center for Relationship and Sexual Health in Royal Oak, he facilitated a men's sexual assault survivor therapy group and provided individual therapy for adults, families, and couples. He also played a crucial role in increasing the number of cultural competency seminars at the center for therapists working with the LGBTQIA+ community. Furthermore, his work at Affirmations, an LGBTQIA+ community counseling center, involved leading support groups and individual therapy sessions, where his work focused on LGBTQIA+ identity affirmation and reducing the impact of minority stressors. Jared Boot-Haury is committed to making a lasting impact through psychotherapy practice by promoting inclusivity, mental well-being, and social change. ■

SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY APA DIVISION 29 AWARD PROGRAM FOR 2024
NOMINATE BY DECEMBER 31, 2023

The Society will present two awards in 2004 – one for distinguished professional contributions and one for an early career psychologist (within 10 years of doctorate).

Call for Nominations
Distinguished Psychologist Award

The APA Society for the Advancement of Psychotherapy (APA Division 29) invites nominations for its Distinguished Psychologist Award, which recognizes lifetime contributions to psychotherapy, psychology, and the Society. Established in 1970 as the Distinguished Professional Award in Psychology and Psychotherapy. At the Mid-Winter meeting in 1984, the Board of Directors changed its name to Distinguished Psychologist Award for Contributions to Psychology and Psychotherapy. The awardee will receive a certificate and award of $500 as well as up to $500 reimbursement for qualified expenses to attend the Society's Awards Ceremony to be held at the annual APA Convention.

NOMINATION REQUIREMENTS

- A nomination letter outlining the nominee's career contributions (self-nominations are welcomed)
- A current Curriculum Vitae.

SUBMISSION PROCESS: Deadline 12/31/2023

Submission Process: All items must be sent as electronic files in PDF format. Letters of nomination outlining the nominee's credentials and contributions (along with the nominee's CV) should be emailed to the Chair of the Professional Awards Committee, Dr. Gerry Koocher at: koocher@gmail.com.
Submission Deadline: December 31 (annually).

Call for Nominations
The APA/Society For The Advancement Of Psychotherapy Early Career Award (Formerly, The Jack D. Krasner Award)

This award supports the mission of APA's Society for the Advancement of Psychotherapy (Division 29) by recognizing Society members who have demonstrated outstanding promise in the field of psychotherapy early in their career. The awardee will receive $1,000.

ELIGIBILITY REQUIREMENTS

Nominees should be a member of the Society for the Advancement of Psychotherapy and within 10 years of receiving their doctoral degree.

continued on page 79

EVALUATION CRITERIA
Nominees will be rated on accomplishment and achievement related to psychotherapy theory, practice, research, or training.

NOMINATION REQUIREMENTS
- Nomination letter written by a colleague outlining the nominee's career contributions (self-nominations not acceptable).
- A current Curriculum Vitae.

SUBMISSION PROCESS: Deadline 12/31/2023
Submission Process: Nominations must be submitted online:
https://www.grantinterface.com/Home/Logon?urlkey=apa&.

CALL FOR FELLOW APPLICATIONS!

Apply for APA Fellow Status Through the Society

Each year, by December 15, the Society for the Advancement of Psychotherapy's Fellows Committee welcomes applications for APA Fellow Status through our Division. The Committee warmly encourages members who would value APA Fellow status to apply. Over the past 10 years, many SfAP members have become APA Fellows; some are initial Fellows, and others are Fellows in other APA divisions whose accomplishments qualify them to be Fellows through SfAP as well. The core APA criteria for Fellow status are outstanding or unusual contributions that have had demonstrable impact on the field at a national or international level in domains encompassed by the division. Although this may sound intimidating, please know that applicants do not have to be at a senior leve—many of our successful applicants have been relatively early in their careers.

If you are interested in pursuing initial APA Fellow status, please have a look at the APA's Fellows webpages at https://www.apa.org/members/your-membership/fellows, and the SfAP Fellows criteria, which can be found in the Fellows folder at http://societyforpsychotherapy.org/members/. The APA website offers clear, useful, and important instructions for the application process, including detailed guidance at http://www.apa.org/membership/fellows/help-applicants.pdf.

The application process involves a CV, a self-statement, and endorsement by 3 current Fellows, at least 1 of whom is a Fellow in SfAP/Division 29. Application is made through the APA Fellows Online Application Platform, which is accessed through the APA Fellows website noted above.

SfAP members who are already Fellows in another division and who wish to become Fellows in our Division follow a less elaborate process; if you are interested, please contact the Fellows Committee Chair, Robert Hatcher, Ph.D., at rhatcher@gc.cuny.edu for details of the application process.

Society For The Advancement Of Psychotherapy

THE ONLY APA DIVISION SOLELY DEDICATED TO ADVANCING PSYCHOTHERAPY

MEMBERSHIP APPLICATION

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

JOIN THE SOCIETY AND GET THESE BENEFITS!

FREE SUBSCRIPTIONS TO:

Psychotherapy
This quarterly journal features up-to-date articles on psychotherapy. Contributors include researchers, practitioners, and educators with diverse approaches.

Psychotherapy Bulletin
Quarterly newsletter contains the latest news about Society activities, helpful articles on training, research, and practice. Available to members only.

EARN CE CREDITS

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

DIVISION 29 PROGRAMS

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

SOCIETY INITIATIVES

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

NETWORKING & REFERRAL SOURCES

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

OPPORTUNITIES FOR LEADERSHIP

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

DIVISION 29 LISTSERV

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

VISIT OUR WEBSITE

www.societyforpsychotherapy.org

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

Name _____ Degree _____

Address _____

City _____ State _____ ZIP_____

Phone _____ FAX _____

Email _____

If APA member, please provide membership #

Member Type: ❑ Regular ❑ Fellow ❑ Associate
❑ Non-APA Psychologist Affiliate ❑ Student ($29)
❑ Check ❑ Visa ❑ MasterCard

Card # _____ Exp Date _____/_____

Signature _____

Please return the completed application along with payment of $40 by credit card or check to:

The Society for the Advancement of Psychotherapy's Central Office,
6557 E. Riverdale St., Mesa, AZ 85215

You can also join the Division online at: www.societyforpsychotherapy.org

PUBLICATIONS BOARD

EDITORS

PSYCHOTHERAPY BULLETIN

Psychotherapy Bulletin is the official newsletter of the Society for the Advancement of Psychotherapy of the American Psychological Association. Published online four times each year (spring, summer, fall, winter), *Psychotherapy Bulletin* is designed to: 1) inform the membership of Division 29 about relevant events, awards, and professional opportunities; 2) provide articles and commentary regarding the range of issues that are of interest to psychotherapy theorists, researchers, practitioners, and trainers; 3) establish a forum for students and new members to offer their contributions; and, 4) facilitate opportunities for dialogue and collaboration among the diverse members of our association.

Psychotherapy Bulletin welcomes articles, interviews, commentaries, letters to the editor, book reviews, and 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).

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

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

www.societyforpsychotherapy.org

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

We'd love to hear from you!