

Psychotherapy

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

www.societyforpsychotherapy.org

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PSYCHOTHERAPY BULLETIN

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Psychotherapy of the American Psychological Association*



2023 Volume 58, Number 4

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PRESIDENT'S COLUMN

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



As I have been reflecting on having had the privilege of serving as the president of the Society for the Advancement of Psychotherapy this year and preparing to write my last Bulletin column while in this role, I have become even more grateful for this organization and its members than I ever have been before. SAP has been my primary professional home for about 20 years, and I have made dear friends among my colleagues, many of whom stepped up and helped me with my presidential initiative. These generous and hard-working colleagues have included but not been limited to Clara Hill, Jennifer Callahan, Stewart Cooper, Barbara Thompson, Melissa Jones, Joshua Swift, Tony Rousmaniere, Jean Carter, Linda Campbell, Amy Ellis, and of course, Tracey Martin.

My goal during my presidential year has been to give back to SAP by reviewing and improving the structure and the functions of the organization to improve communication, role descriptions, collaboration, and maintenance of governance activities over time. Colleagues joined in this endeavor by serving on Task Forces, clarifying governance roles, and preparing processes to improve communication and facilitate collaboration among domains. While the initiative is still a work in progress and will continue until the February 2024 SAP Board Meeting, much has been accomplished already. The Publications and Communications Board has begun revamping its structure and functions under the leadership of the current chair, Amy Ellis, and exciting changes to the SAP Website are coming. We're very fortunate that Amy is taking this on because she created our original website

and knows how to improve it better than anyone. After last year's success in offering two free CE programs to our members, the Chair of the Education and Training Committee, Melissa Jones, created a streamlined three-step process for creating and offering more programs in the future. If you are interested in proposing a program that you would like to offer through SAP, you can find the description of the process for proposing programs and accompanying forms on our website. As I noted in my column in the last issue of the Bulletin, programs can be offered with or without Continuing Education credit, but we would really like to see more continuing education programs.

The Board gave approval in August to my Task Force to proceed with development of other recommendations for implementation, so a second task force, the Implementation Task Force, was created. It has been co-chaired by Jean Carter and Linda Campbell, and they have prepared a report to be presented at the November 17 Board Meeting. Recommendations include adoption of specific, clearer descriptions of the roles of Domain Representatives and Committee Chairs, an improved process for Onboarding new governance members, support for providing resources for upgrading our Website, and resumption of the role of an archivist/historian for SAP. Following the Boards' decisions regarding the report, the Implementation Task Force will continue its work and present its final report in February. I will write a summary for the Bulletin upon our completion and after the February Board Meeting, when I am Past-President. I'm very happy with what we have been able to do for SAP. Thank you for giving me the opportunity to serve as President and to move us forward!



EDITOR'S COLUMN

Joanna M. Drinane, PhD
University of Utah



*"No distance of place
or lapse of time can
lessen the friendship of
those who are thoroughly
persuaded of each
other's worth."*

— Robert Southey

Greetings SAP Membership,

Wishing you a happy, healthy holiday season! May you be surrounded by loved ones and enjoying time together as the winter sets in during the month of December. As you start to peruse this final issue of the year, I want you to know that there will be several transitions at the *Psychotherapy Bulletin* starting in 2024. First, is that I will be stepping down from my role as Editor. I have truly enjoyed corresponding with you these past four years. It has been my pleasure to engage with the Division's leaders, members, and contributors to produce a fun and engaging publication. In her role as Publications and Communications Board Chair, Dr. Amy Ellis has pioneered a way forward to streamline processes related to the *Bulletin* and the website. This plan, which is sure to make things run more smoothly and efficiently, will involve the definition of new roles and will come as I take some time away for parental leave. I plan to remain active in the SAP and I am confident in Dr. Ellis and her thoughtful attention to our Division and its publications.

Also transitioning away from the *Bulletin* this year are editorial assistants, Kate Axford and Sree Sinha, and internet liaison, Emma Foster. All three have been diligent contributors to the team for years and their work has been tremendous.

Thank you to these three folks for dedicating their time and energy to enhancing the quality of our publication. As this group sets off on new adventures, we wish them success and we hope they will become part of the next generation of leaders within the Society for the Advancement of Psychotherapy. Taking over in a new capacity as, "Editor of Electronic Communications," will be Dr. Zoe Ross-Nash, current Internet Editor, and productive member within the Division. Amidst all these changes, it is Tracey Martin who is truly to be celebrated for her steady and kind way of relating to each of us and for her vast skillset. The quote above is in reference to Tracey and the *Bulletin* team, whose worth I am thoroughly persuaded of and whom I will miss corresponding regularly with.

Thank you to each of you—authors, members, and readers—for your engagement with the *Psychotherapy Bulletin*. This issue is full of interesting and informative pieces that we hope you will enjoy and then share more broadly. In addition to our anticipated contribution from Dr. Jeffrey Barnett on Ethics, there are columns from the Membership and Professional Practice Domains, and many others from the larger Division 29 community. We call your attention to the work of Dr. Rochelle Cassells for a piece entitled, "Bronfenbrenner and Psychotherapy: A Tale by an Emerging Clinician" that focuses on integrating perspectives across disciplines to improve multicultural education. I know that the future *Bulletin* team will continue to seek diverse and multidimensional perspectives that change the existing narrative within our field.

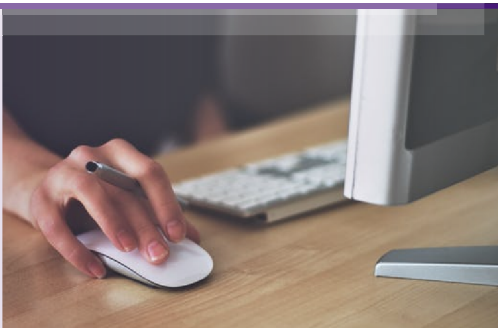
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I look forward to seeing many of you around at conferences and Division events as colleagues and friends. Please direct future *Psychotherapy Bulletin* inquiries to Dr. Ross-Nash (editor@societyforpsychotherapy.org) and do not be

a stranger if you want to collaborate on psychotherapy research projects after spring 2024 (Joanna.drinane@utah.edu).

With gratitude,
Joanna

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www.societyforpsychotherapy.org**

A MESSAGE FROM THE SOCIETY'S PUBLICATIONS AND COMMUNICATIONS BOARD CHAIR

Amy E. Ellis, PhD



Discovering My Professional Home

When guiding graduate students through their academic journeys, I consistently emphasize the importance of finding a “professional home”—an organization that not only advocates for their desires and requirements but also offers a supportive community and a wealth of information. Any one of my past students will attest to the fact that I talk with pride about finding my professional home in Division 29.

My introduction to Division 29 dates back to 2013 when, as a graduate student, I eagerly applied for a position involving the division’s website. This marked the beginning of my association with Dr. Jeffrey Barnett, the then Chair of Publications & Communications (P&C) Board, who warmly took me under his wing and provided invaluable mentorship. However, it wasn’t just Dr. Barnett; I formed collegial relationships and lasting friendships with others, creating a sense of belonging. I found myself in a space where individuals were genuinely invested in my success as both a student and an early career psychologist. These were professionals focused on building connections before productivity, fostering a welcoming atmosphere that left hierarchy at the door.

In 2014, I assumed the role of Associate Editor, progressing to the position of Editor three years later. During my tenure, I spearheaded a major website redesign, transforming the Society’s website from a stagnant bulletin board to an independent publication. This platform began featuring quality articles from esteemed luminaries and students in the field of psychotherapy research, practice,

and policy that were published every other week. As my term concluded, stepping away from a leadership role was bittersweet, akin to leaving home for a while to embark on a journey of self-discovery—the “college years,” if you will.

In October 2022, almost three years later, I was approached by President Jean Birbilis, who invited me to join the P&C once again. Thrilled to return to an advisory role overseeing the journal (*Psychotherapy*), newsletter (*Bulletin*), website (www.societyforpsychotherapy.org), listservs, and social media, I gladly accepted. Less than a year later, I was nominated and appointed as the Chair of the Board—a position that felt like returning home. It became a warm space for genuine and authentic relationships, and this time, I not only enjoy the privilege of receiving mentorship but also have the opportunity to extend it to others.

News & Updates from the P & C Committee: Looking to the Future

As the Chair of the P&C Board, I am thrilled to share the remarkable success of our publications in the past year and the exciting changes on the horizon for 2024.

1. Success of Our Flagship Psychotherapy Journal

Under the guidance of Editor Dr. Jesse Owen, the *Psychotherapy* journal has maintained its exponential success. With a high 5-year impact factor (4.6) ranking 75/131 in the Clinical Psychology portfolio, the journal’s revenue continues to contribute significantly to the division’s overall success. To further enhance scientific rigor, we will be enlisting statistical consultants on an as-needed basis for manuscripts under review. We extend our deepest gratitude to our over

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80 Editorial Board volunteers (<https://www.apa.org/pubs/journals/pst>) and eagerly anticipate thanking you all at APA's annual luncheon in August 2024.

2. Streamlining How You Get Content & Articles

We remain committed to providing expert-written, quality content that is free and accessible for both members and non-members through our website and newsletter. Accepting content for our esteemed *Bulletin* will now occur on an ongoing rolling basis (submit articles to <https://sapwebsite.wufoo.com/forms/sap-author-submission-form/>), published on our website after acceptance. All articles will continue to be featured in our newsletter PDF (<https://societyforpsychotherapy.org/psychotherapy-bulletin-archives/>). Ensure you're signed up for our newsletter here: <https://societyforpsychotherapy.org/sign-up-for-our-societys-electronic-newsletter/>

3. New Roles and Responsibilities

Current Website Editor, Dr. Zoe Ross-Nash, will now assume the role of Editor of Electronic Communications. She will oversee an Associate Editor of Content (incoming Lacy Sohn) responsible for soliciting and reviewing articles, as well as an Associate Editor of Social Media (Yashvi Aware will continue in this role). The Associate Editor of Content will collaborate with the Assistant Editor of the Website (incoming Sarah Bondy) and Assistant Editor of Newsletters (Deanna Young) to publish and distribute content.

I should note that the role of Editor of Electronic Communications is no small feat. Managing the daily updates to the website across 8 domains and 14 committees, soliciting and reviewing content for the website, maintaining listservs, putting together the newsletter, and ensuring high website performance that reaches over 400,000 individuals per year. A huge thank you to Dr. Ross-Nash for her esteemed leadership.

4. Gratitude for Outgoing Editors

We express our heartfelt thanks to outgoing 2023 Associate Editor of Content, Dr. Sheela Joshi, and the 2020-2023 *Bulletin* Editor, Dr. Joanna Drinane. As we bid farewell to Dr. Drinane, we reflect on her dedication and hard work in curating content for our psychotherapy newsletter, which has been nothing short of exceptional. Her insightful features, scientific updates, and opinions/commentary have enriched the quality of our newsletters and played a pivotal role in fostering connection among our readers. Thank you, Dr. Drinane, for your time, effort, and expertise. We wish you all the best in your future endeavors.

5. Enhanced Divisional Connection and Engagement

Stay tuned for exciting updates on how we plan to revitalize our listserv, fostering increased networking, information exchange, and overall engagement across our various domains. In the meantime, be sure to follow us on Facebook, Twitter, and LinkedIn.

A new website will also make its debut next year as we move into 2024 seeking to give a refresh, keeping the website lively, engaging, and dynamic.

In Summary

A special thank you to our P&C Board members—Drs. Changming Duan, Michelle Collins Greene, Bob Hatcher, and Bruce Liese; division administrator and institutional backbone, Tracey Martin; outgoing Society President Dr. Jean Birbilis; and the Executive Committee and Committee Chairs.

For those still seeking their professional home, reach out to me. We are always eager to welcome members looking to get more involved and engaged. My hope is to share the profound sense of “home” that I have cherished over the years with others.



FEATURE

Bronfenbrenner and Psychotherapy: A Tale by an Emerging Clinician

Rochelle C. Cassells, PhD
University of Utah



I was inspired to write this piece by my postdoctoral mentor, Joanna Drinane, who asked about the integration of my two programs of study. To make a long story short, I achieved my PhD in Human Development and Family Studies some years ago and joined the Master's in Clinical Mental Health Program at the University of Utah in 2021. In many ways, my experiences point to the inevitability of this choice, and how I arrived here is a conversation worth having another time. In this article, I hope to address Dr. Drinane's call, which I understood as: "What lens do I bring to the study and practice of psychotherapy, having come to this field from a different (but related) discipline?"

The relevance of developmental psychology may already be obvious; training programs require a lifespan development course for graduation, and although some traditions are less preoccupied with the history clients bring into the therapy room, precious few would argue against the projection of past experiences into the present, willingly or otherwise. Notwithstanding, this piece focuses on Urie Bronfenbrenner's bioecological systems theory, which has significantly influenced my professional development and scholarship. First, I will highlight a few propositions from the ecological systems approach to inspire renewed interest among scholars in psychotherapy. Next, I argue for a stronger inclusion of the theory's original formulation into discussions of multicultural

competence (MCC). Lastly, I conclude by framing psychotherapy through the lens of the theory's latter formulation (see Rosa & Tudge, 2013, for more information on the theory's phases) and offer possible directions for future research on therapeutic outcomes.

Most students of psychology and related fields have been exposed to Bronfenbrenner's ecological model of human development, which depicts the developing person nested in contexts of ascending proximity (see Bronfenbrenner, 1977; 1979). Much else beyond this may be scarcely known, so I present several of its propositions with germaneness to counseling psychology to furnish a wider understanding and function. Consider Proposition 4:

"Ecological experiments must take into account aspects of the physical environment as possible indirect influences on social processes taking place within the setting," (Bronfenbrenner, 1977, p. 523).

If we substitute "ecological experiments" with "psychotherapy," we meet a useful directive (although the astute reader may ask whether psychotherapy is not also an ecological experiment?). As psychotherapists, we must never neglect the power of the physical environment and the messages it communicates to the individual. Yet, modest research surrounds the physical features of the therapeutic environment that support or hinder its processes and goals (see Pressly & Heesacker, 2001; Sinclair, 2021).

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Do therapists design the space to reflect their tastes, meet clients' needs, or both? Are clients invited to give feedback? I am curious about what insights a nationwide representative study would return. Taking the matter a step further, research in counseling psychology may benefit more generally from engaging with principles from environmental psychology. By way of illustration, where is our attention drawn when a client reports distress? Do we ask which characteristics of their environment (e.g., noise, clutter) may be contributing? If not, we may fail to capture meaningful elements useful for intervention.

Another likely familiar aspect of the theory is its terminology of microsystems, an immediate setting where a person engages in roles and activities (e.g., the therapy space is sometimes conceptualized as a microsystem). However, the theory's strength lies in articulating the interactive relations between people, places, objects, and processes. For that reason, clinical practice may profit from greater reflection on Proposition 5:

"An ecological approach invites consideration of the joint impact of two or more settings or their elements. This is the requirement, wherever possible, of analyzing interactions between settings" (Bronfenbrenner, 1977, p. 523).

Those acquainted with the model may recognize this as the mesosystem, the "interdependencies between settings" that the individual typically occupies (e.g., home, work/school). A mesosystem forms when a person enters a new setting and links are made between the systems either by the primary person or significant others. The criteria for mesosystem formation include cognitive and affective structures (McIntosh et al., 2008), such as when a client reports using interpersonal skills gained

in therapy at work. This point may appear unnecessary since this emphasis is inherent to the therapeutic process. Yet, the givens are often the first to collapse through mistaken disregard. An essential task of psychotherapy is to make the unspoken spoken.

I advance that a mesosystem focus is needed for therapy to have the greatest effect. To do so, clinicians must commit to tracking mesosystem dynamics (again, see McIntosh et al., 2008), soliciting information about how therapy influences other important settings to the client, and vice versa. One mesosystem proxy intervention is to assess changes to the home, school/work, and neighborhood environments on client forms (preferably single items). Time in session may be used to make connections to how these contexts affect clients' progress and the contributions of therapy, positive or negative. Additionally, measurements of mesosystem interaction support partnerships across healthcare settings on behalf of clients (e.g., clients seeking gender-affirmative care, support for symptoms related to premenstrual dysphoric disorder, and pre- and post-therapy related to bariatric surgeries). We can all agree that psychotherapy does not occur in a vacuum, and mesosystem measures enable clinicians and clients to make important relations to contexts outside the therapy room.

Building upon this point, the most recognized thrust of the theory is found in Proposition 8, which concerns itself with the impact of distal contexts on the individual (Bronfenbrenner, 1977). I raise it here to transition into a discussion of MCCs. Most practitioners are familiar with Sue et al.'s (1992) tripartite model of multicultural competencies. This model upholds an ambitious charge to counselors wishing to be culturally skilled. The nine competency areas are
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undoubtedly beneficial if clinicians diligently commit to them, yet limitations remain. Take the question posed by Owen et al. (2011): at what point has one procured sufficient awareness, knowledge, and skills to be culturally competent? Still, my grievance with traditional definitions of MCCs is two-fold: 1) application is difficult due to its broad scope, and 2) the emphasis on identity categories is lopsided. Both criticisms stem from a shared problem: it is unclear where the focus should be placed. I bring Bronfenbrenner's theory into the discussion to offer something concrete.

To be sure, I am not the first to discuss Bronfenbrenner's theory in conjunction with multicultural issues in counseling. The theory has been used to provide a rationale for why culturally competent therapy is needed (Greenleaf & Williams, 2009; Ratts et al., 2016) and why it works (Chu et al., 2016). I do not disagree with these uses but propose that a deeper treatment may support the development of clinicians' MCCs. The theory is, at the heart, a practical one born from a sincere desire to bring greater ecological validity to research in human development. With this understanding in mind, uses of this theory cannot remain wholly conceptual but must also include specific applications to maintain the spirit of the approach. My position is that the ecological systems theory lends itself to the dynamic sizing needed for the skillful administration of MCCs. Upon what do I base this claim? In my view, current MCC approaches are polarized into vague abstraction or rely on pre-established identity labels when what is needed is flexibility to zoom in and out. Just as the theory is neither fully macro nor micro, so too is sitting with a cultural being. Cultural conversations cannot be so distal that making it person-specific becomes unwieldy, nor can it be so proximal that the context is reduced

or ignored. I have observed that the tendency towards the micro-level often makes things personal (and subsequently about comfort), and the move towards the macro-level is often done without making matters concrete. These punctuations convey what clinicians think is most important, and needlessly separate the person from culture and culture from the person. Cultural conversations are nuanced and require movement throughout all levels, and a different way is one rooted in holding the complexity simultaneously and systematically. The ecological systems framework itself could be leveraged as a tool in this regard. For example, a clinician who uses the theory to increase their MCCs may explore the following during the intake:

- **Mesosystem:** Which spaces do you spend the most time? What people, objects and symbols come to mind when you think of these spaces?
- **Exosystem:** Can you describe your typical media consumption (i.e., how often do you engage with books, television, social media, news, etc.)? Will you tell me about your favorite media as a child / today?
- **Macrosystem:** We are all impacted by factors outside of our immediate control (e.g., the economy, politics, laws, etc.). Which of these factors most influence you and your life? What cultural celebrations do you honor?
- **Chronosystem:** What stands out to you as key transitions in your life so far? Are there any world events that hold particular significance? What does it mean for you to begin therapy at this moment in your life?

The suggested interventions are not exhaustive, and clinicians may want to

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align the questions with the presenting concern. For instance, if a person is seeking support for relational issues, then it may be advantageous to pose ecosystem questions related to the extended family. Nevertheless, what I hope is immediately clear is that a richer portrait of the person is formed, which does not rely on the counselor making judgments about cultural information based either on visible identity markers or preconceived knowledge. I believe this approach supports the invitation of cultural dialogue, and such an approach is crucial given the fraught landscape depicted by MCC research findings.

Tao et al. (2015) conducted the first meta-analysis of clients' perceptions of the therapist's MCC and its relationship to treatment outcomes and therapeutic processes. One takeaway is that MCC and other therapeutic processes work together to produce therapeutic change. This finding left open questions about the true association between MCC and therapy outcomes and the distinctiveness of MCC. A related question in the literature on multicultural counseling is who profits most from MCC, minority clients, or clients in general? A recent study suggests that MCC is a common factor but that the working alliance is impacted by MCC, especially for racial/ethnic minorities (Bathje et al., 2022). While this information adds to previous research (Drinane et al., 2016), its methods are somewhat recursive and reductive: High cultural salience was defined only in terms of race, and it was expected that MCC would not be important for White therapist-client dyads (and subsequent surprise that MCC did indeed matter to them). This work is predicated on past findings that White-White pairs do not have cultural conversations. The question becomes: if White therapists are not having cultural conversations with White clients, how will they manage these conversations with marginalized clients?

My argument is not to diminish the very real disparities in psychotherapy outcomes for marginalized clients. Instead, my aim is to point out the implications of limiting diversity to identity categories. For example, the focus sometimes turns to recommendations for identity matching, which has its own consequences: more burdens for minority clinicians and lack of accountability for clinicians with majority identities. The broader problem of limiting diversity and part of my problem with the traditional MCC approach is that it easily gives way to stereotypes and takes for granted that culture is persons in context. Moving toward intersectionality is a good approach, but focusing on interactions among identity categories is a different manifestation of the same problem. The ecological systems theory resolves this conflict by exploring interactions between identity and context. Elsewhere, I explored the heterogeneity of immigrant experiences (Cassells, 2018) and interactions between poverty and place (Cassells & Evans, 2017). The same can be restated here. A racial minority client who lived most of their life in suburbia is likely different from one who lived in an urban setting or one who migrated to the United States. Clients from resource-rich environments are different from those from resource-scarce environments, even if they hold the same gender identities or sexual orientations. Failure to consider the context alongside the person leads to the erasure of key contextual information and missed points of connection. I hasten to add that genuine empathy and validation stem from entering another's world, something that is not achieved simply by knowing about multicultural factors.

My point is that the ecological systems approach allows multicultural content to be unconstrained. A generous inter-

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pretation of why cultural conversations may be avoided in therapy or result in microaggressions is that therapists struggle to find an entry point. A clinician with an ecologically-informed perspective would pivot to mesosystem interventions during sessions. For example: "Tell me about your neighborhood during childhood/now." And "If you had to tell me one thing about your world, what it looks like, and what it means to you, what would that be?" I want to underline this point about neighborhoods because much can be known about an individual's world from viewing this context (Whipple et al., 2010). Therefore, asking questions about the neighborhood is likely to generate sociocultural content that can be used to: 1) build rapport, 2) celebrate difference, 3) discuss issues of social justice, 4) externalize experiences of oppression. As mentioned earlier, the personification of MCC makes it easy for defenses to be activated in client and counselors. My rendering of the ecological systems approach aims to arm clinicians with a technique that captures the broad array of clients' lived experiences while also minimizing the potential for resistances. Before I conclude this section, I would also like to advocate for the development of MCC measures that tap counselors' ability to invite cultural conversations, as I believe this offers a more tangible demonstration of therapists' MCCs.

I turn now to the final aim of this article. By way of framing, my singular preoccupation, personally and professionally, has centered on restoring dignity and freedom to those disenfranchised by oppressive life conditions. Coming into the counseling field, I grapple with whether the therapeutic space possesses sufficient power to withstand severe social forces. Said differently, can a strong therapeutic relationship overcome hardship outside of the room? I admit to oscillating between hope and cynicism. When I

am most hopeful, I am reminded of the charge set forth by Bronfenbrenner towards the end of his life and career. In his later writings, Bronfenbrenner issued several hypotheses for future testing by scholars of developmental science that are of equal relevance to psychotherapy research.

Unlike the original formulation of his work, the bioecological systems theory and its linchpin, proximal processes, often receive less attention (see Bronfenbrenner & Morris, 2007; Bronfenbrenner & Evans, 2000, for review). Bronfenbrenner and Ceci (1994) explain that proximal processes are the mechanisms through which the contributions of genetic-environmental interactions to development are actualized. We can thus account for human potential by examining an individual's experiences with people, objects, and symbols in their immediate contexts over time. Like interactions between parent and child during play, therapy offers similar reciprocal interactions that support competencies. From this lens, psychotherapy may be characterized as a type of proximal process. As I see it, the hope of psychotherapy is that positive psychological outcomes are possible through extended interactions in a secure environment with a trusted other. However, what happens when a person leaves that secure environment and returns to an invalidating one? To state my curiosity again: To what extent are the effects of contextual factors on psychological functioning remediated by the working alliance? Let us examine Hypothesis 3:

"If persons are exposed over extended periods of time to settings that provide developmental resources and encourage engagement in proximal processes to a degree not experienced in the other settings in their lives, then the power

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of proximal processes to actualize genetic potentials for developmental competence will be greater for those living in more disadvantaged and disorganized environments.” (Bronfenbrenner & Ceci, 1994, p. 579).

In what direction does this prediction go with respect to clients in harsh environments is a question worth pondering as a field. Will more or less time be needed with these clients? My worry has been that the most marginalized individuals may need long-term therapy (counter to Hypothesis 3), which may be difficult for those with limited resources (e.g., time, money, etc.). At the same time, it may be the case that the injection of positive proximal processes from therapy results in immediate gains (aligned with Hypothesis 3). To know more, research in the field needs to collect variables related to the person, process, context, and time. Though we tend to collect information on the setting in which psychotherapy takes place, information on the client’s environment (e.g., home, neighborhood) tends to be under collected.

Other questions relevant to psychotherapy that emerge from Hypothesis 3 are:

What are the physical and social environments like of those who benefit most from therapy?

Do clients inhabiting harsh environments benefit more from therapy than those in less harsh environments?

If we can hold the process constant (i.e., keep the therapist the same) and allow the clients’ environments to vary or remain constant, what may we learn about individuals’ differential susceptibility to therapeutic change and how much time is needed to produce change?

Are clients from similar environments experiencing similar levels of

change with the same therapist? And if not, what characteristics of the person and/or therapeutic alliance produce different outcomes?

The reader may also want to consider the notion of inverse proximal processes (Merçon-Vargas et al., 2020) and what the impact of repeated microaggressions in therapy may engender. My goal is to inspire myself and other researchers in the field to imagine creative research designs that may answer the questions above and, more broadly, provide insight into the persons and conditions that contribute to therapy’s effectiveness.

I would be remiss if I concluded without acknowledging my mentors, Drs. Gary Evans and Lorraine Maxwell, who taught me what it truly means to view humans in context. I hope this piece is useful to psychotherapists and researchers seeking to see the fullness of a person and what supports they need to promote healthy growth.

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FEATURE

Making Mental Health More Accessible: Importance of Consulting in Psychology

Shaakira Haywood Stewart, PhD



Mental health is a global concern with profound societal and individual implications. According to the World Health Organization (WHO), depression affects over 264 million people worldwide, making it the leading cause of disability. Anxiety disorders aren't far behind. To tackle this growing crisis, we need to highlight the role of consulting psychology in improving mental health accessibility. This bulletin will delve into the crucial impact of consulting psychology on enhancing mental health accessibility.

In recent years, consulting psychology has been on the rise (Lowman, 2016). Psychologists have always had a hand in consulting with organizations and systems, but recently, they've expanded their reach to popular brands and companies. As a counseling psychologist in NYC, I've carved out a unique niche, consulting with brands on subjects like mental health, wellness, diversity, equity, and inclusion. My passion for consulting stems from my work in private practice, where I assist BIPOC folks dealing with the complexities of life. Many of my clients face challenges like depression, anxiety, self-esteem issues, relationships, and even trauma. While one-on-one therapy is fulfilling, I'm driven by the belief that my purpose extends beyond individual sessions. I'm on a mission to reach a broader audience and make a more significant impact on mental wellness.

Consulting with brands like Omnicom Group or L'Oréal represents a ground-

breaking approach to promoting mental wellness through everyday experiences. For instance, I might conduct workshops with DEI leaders to discuss compassion fatigue, burnout, and multiculturalism within the workplace. Furthermore, I might join a panel to talk about how a specific dermatology product can boost self-esteem and reduce depression and anxiety. Consulting offers another way to provide services and make mental health more approachable.

Unfortunately, mental health concerns often carry a stigma, and many individuals are hesitant to seek help. Consulting psychologists play a pivotal role in bridging this gap by providing a safe and confidential space for people to discuss their mental health concerns. Through psychotherapy and counseling, they help individuals manage their emotions, alleviate symptoms of mental illness, and develop effective coping strategies.

One of the most significant roles of consulting psychology is to close the treatment gap. The World Mental Health Survey Initiative reports that nearly 76-85% of people with severe mental disorders in low- and middle-income countries receive no treatment for their condition (WHO, 2023). Consulting psychologists, with their expertise, can help identify and address these treatment gaps, making mental health services more accessible.

Furthermore, consulting psychology extends beyond traditional therapy and is

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integral in workplaces, schools, and community settings. My consulting work has often focused on improving workplace environments by enhancing employee well-being, boosting productivity, and promoting compassion among co-workers. This fosters a healthier work environment, ultimately contributing to job performance and job satisfaction.

To make mental health more accessible, it's essential for organizations and brands to partner with psychologists. Organizations should invest in mental health programs and ensure that insurance coverage includes mental health services. This not only removes the stigma around seeking help but also makes it financially viable for more people.

In conclusion, consulting psychology

plays a critical role in addressing mental health concerns, empowering individuals to seek help, and providing essential support for those facing mental health issues. By integrating consulting psychology into various aspects of society, we can make mental health services more accessible, ultimately enhancing the well-being of individuals, communities, and the world around us.

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FEATURE

Patient Suicides: Preparing Students for Difficult Challenges

Samuel Knapp, EdD, ABPP



Having a patient die from suicide is one of the events most feared by psychotherapists, yet a recent survey found that 6% of psychologists had at least one patient die from suicide while in treatment in the last year (Leitzel & Knapp, 2021). The ongoing possibility of a patient's suicide prompted Simon (2011) to write "There are two types of psychiatrists—those who have had patients die from suicide and those who will" (p. 177).

Of course, more competent psychotherapists are less likely to have patients die from suicide. Nonetheless, many psychotherapists who had patients die from suicide were delivering high-quality, evidence-based services. For example, cognitive behavior therapy is a highly researched and effective treatment for suicidal patients that outperforms treatment as usual in clinical trials. Even so, in one important study, 8 of the 76 participants receiving cognitive behavior therapy attempted suicide during the study (Rudd et al., 2015). Although this was far fewer than the number of suicide attempts in the treatment as usual condition, it shows that even patients receiving state-of-the-art services have a risk of attempting suicide.

Patient suicides can occur under many circumstances. Sometimes, the psychotherapist had just met the patient; at other times, the psychotherapist had been treating the patient for a long time and had a considerable emotional investment in their relationship. Sometimes, the psychotherapist was the sole

treatment provider; at other times, the psychotherapist was only one provider in a multidisciplinary treatment team. Sometimes, the psychotherapist knew that the patient had suicidal thoughts; at other times, the suicide came without warning. Sometimes, the psychotherapist and the family shared their grief; at other times, family members blamed the psychotherapist for the suicide (e.g., "If it wasn't for you, my parent/spouse/child would still be alive today!").

Although every psychotherapist's reaction to their patient's suicide is unique, some common themes emerge. Psychotherapist survivors of patient suicides often feel great emotional distress. Upon learning of the suicide of their patients, most mental health professionals felt shocked and stunned, and between 12% and 53% developed symptoms such as depression or anxiety that lasted for months or even years (Sandford et al., 2020). The impact may be especially hard on trainees still developing their professional identities (Gill, 2012). Psychotherapists are secondary victims of patient suicide but have unique factors that complicate their grief. Some may believe that their grief is less important than the grief experienced by others. Also, they may not have the same rituals available to other grieving persons, such as attending the deceased's funeral. They often feel deep regret or guilt that they could have done more to save their patient or missed some essential facets of care in some way linked to their patient's death. Finally, the grief may be complicated by a fear of being accused of negligent conduct.

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The suffering may be reduced if the psychotherapists received social support following the suicide. Social support protects against professional burnout (Yang & Hayes, 2020) and is even more important following a professional crisis such as a patient suicide. One psychologist-in-training reflected on the support he received from his supervisor: "If I hadn't received such positive support, I might have quit" (DeAngelis, 2001, p. 71).

Other psychotherapists changed their practice patterns following a patient's suicide. Some became more thorough or cautious when working with suicidal patients and sought more continuing education on suicide (Furqan et al., 2023). Nevertheless, the changes were not always positive. Reflecting on one's practices may be helpful, but brooding or feeling shame is not. Others reported being less willing to treat suicidal patients or felt less effective with their suicidal patients. One professional wrote, "I felt though I was not as emotionally available as I normally am for patients and did not give hope with the same conviction as I normally would" (Croft et al., 2023, p. 249). Another psychiatrist stated, "I think I was more hesitant to discharge people who were suicidal for some time after that and, you know, that's like 60% of my patients. . . I don't think it was a positive" (Furqan et al., 2023, p. 193).

In addition to the grief following the suicide of a patient, psychotherapists often fear that they will be sued or otherwise disciplined, even though the number of malpractice suits for outpatient suicides is rare (Knapp et al., 2013). Of course, a few psychotherapists may have acted with egregious disregard for the well-being of their patients, such as casually dismissing the concerns of patients who disclosed thoughts about suicide (e.g.,

"If you were serious, you would have killed yourself already"). Nonetheless, as noted previously, the death of a patient does not necessarily mean that a psychotherapist acted negligently. Many patients died from suicide while receiving evidence-based services from competent and compassionate professionals. Absent egregious behavior, we do not want to compound the death of a patient by an unwarranted assumption of guilt or an unjustified fear of an allegation of unjustice.

Four Steps to Prepare Students for a Patient Suicide

Although a patient suicide is a possibility for all psychotherapists, training programs can reduce the likelihood of a patient suicide and also prepare their students for the possibility of a suicide by ensuring that their students can identify their professional obligations accurately and learn the competencies necessary to treat suicidal patients, including risk management strategies and self-care skills.

Ensure Competence

Trainers can ensure that they teach the essential topics about suicide assessment and prevention (e.g., Cramer et al., 2013) and that their trainees have basic competencies in treating suicidal patients. (To facilitate learning about suicide prevention, I have developed a suicide glossary and test questions that I will share with any interested reader. Contact me at Samuelknapp52@yahoo.com). The research is clear that certain evidence-supported practices can save lives (e.g., Bryan, 2021; Nuij et al., 2021). Ensuring trainee competence would reduce the likelihood that the trainee would have a patient die from suicide. Also, if a patient were to die from suicide, the trainee would have the assurance that they delivered a high quality of service to their patients. That knowledge

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may reduce the likelihood of unwarranted guilt on top of the natural grief that all psychotherapists would feel in these circumstances.

Focus on the Role of Psychotherapists

Trainers can teach their students about the proper role of a psychotherapist. No psychotherapist can prevent all suicides, and no psychotherapist can guarantee that their patients will live. They cannot monitor their outpatients 24 hours a day and have no or minimal control over external events in their patients' lives. They cannot, for example, know if a factory will close down, resulting in a layoff for their patient, whether the patient's spouse will leave them, or whether investments will suddenly decrease in value, resulting in a patient's bankruptcy.

Jobs (2023) stated "While we cannot guarantee a nonfatal outcome, we can nevertheless provide the *best possible clinical care* to every patient, including those with suicidal thoughts" (p. 60, italics in original). I initially had difficulty accepting this perspective because I misinterpreted it and assumed that I was relinquishing all responsibility for the patient's well-being or exonerating myself for clinical errors. Nonetheless, upon reflection, I found the perspective of Jobs to be liberating. It expresses an appropriate level of humility. It recognizes the limitations of the psychotherapist's ability to stop all suicides yet acknowledges the power of psychotherapists to help patients make positive changes. It allows psychotherapists to focus on their patient's needs, empowering them, and respecting their decision-making without continually second-guessing everything they do.

Jobs also emphasized direct honesty with patients and acknowledged that they have the final decision on whether they want to live or not. In an example

of his informed consent process, Jobs wrote, "I would rather not debate with you whether you can kill yourself. Instead, I would propose that we consider a proven treatment that is designed to decrease your suffering and help save your life. The clinical treatment research shows that most people who are suicidal respond quickly to this treatment... So why not give it a try" (2023, p. 7).

Teach Risk Management Strategies

Trainers can teach their students about ethically based risk management principles that focus on anticipating problems, such as listening carefully to patients when conducting a thorough evaluation and explaining treatment processes clearly to their patients. They can also teach students the importance of collaborating with their patients and detecting problems early in treatment by routinely asking patients about their perceptions of the treatment process and their progress toward reaching their goals (Knapp, in press). Finally, students can learn to seek consultation whenever the risk of a treatment failure arises and to document services carefully, especially in high-risk situations (Knapp et al., 2013).

Promote Self-Care

Trainers should emphasize self-care. Although having high standards and engaging in self-reflection is good, excessive self-criticism, perfectionism, or the lack of self-compassion are associated with psychotherapist burnout (Yang & Hayes, 2020), and the death of a patient can activate these maladaptive schemas.

Working with suicidal patients can be difficult because of the high stakes involved and because many patients lack social resources or have comorbidities that make treatment difficult. Even a nonfatal suicide attempt can be jarring for psychotherapists. Although some anxiety when working with suicidal

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patients is inevitable, students with adequate training and professional resources should feel confident that they can deliver high-quality services. Joiner (2005) identified the harmful attitudes of being dismissive (that denies or minimizes the threat of suicide) or alarmist (which overreacts to any suggestion of suicide). A third and helpful attitude is *concerned alertness*, which shows attention to the risk of suicide but responds with measured concern (Knapp, 2022).

The proper way to handle fears and anxiety when working with patients, especially suicidal patients, is to admit and talk about those feelings. When painful emotions arise, it is best to process them by identifying, labeling, and sharing them. As Sternlieb (2013) has written, “You have to name it to tame it.” In addition, seeking out social support and connecting with others at this time is highly important; again, as Sternlieb has written: “You have to share it to bear it” (2013, p. 21).

Summary

The death of a patient by suicide is a painful possibility, even for experienced psychotherapists delivering high-quality services. Nonetheless, trainers can prepare their students by teaching them

- The competencies necessary to treat suicidal patients.
- To adopt an attitude of humility when treating suicidal patients, which means recognizing that they should focus on delivering high-quality services and cannot guarantee that their patients will live.
- To rely on ethically based risk management strategies that focus on the quality of patient care.
- To promote self-care by practicing self-compassion and recognizing and sharing their feelings in a protective social network.

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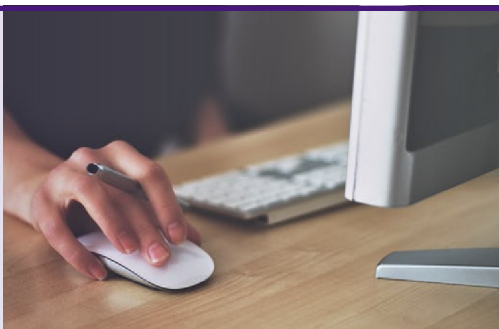
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FEATURE

Education in Suicide Prevention Should Be Required in the Training of All Healthcare Psychologists

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Over the last 20 years, the rates of suicidal ideation, suicide attempts, and suicides have rapidly increased in the United States (Garnett & Curtin, 2023). At the same time, evidence has developed that interventions can effectively reduce the risk of suicide (Calati et al., 2018). Given these changes, it is time for

APA to require competence in suicide prevention for all graduates of programs that train healthcare psychologists and in all APA-accredited internships and postdoctoral residency programs.

The American Psychological Association (APA) Commission on Accreditation (CoA) has identified nine profession-wide competencies in the Standards of Accreditation required for all students who graduate from doctoral and internship programs accredited in health service psychology. Postdoctoral residency programs have a separate list of competencies. Programs must provide opportunities for all of their students to achieve and demonstrate each required profession-wide competency. Each competency listed in the Standards of Accreditation is considered critical for graduates in programs accredited in health service psychology (APA, 2015). If competence in suicide prevention was added to the list of profession-wide competencies re-

quired for accreditation, every graduate of an accredited program would receive this training.

Health Care Psychologists Will Encounter Suicidal Patients

All psychologists delivering health care will likely encounter patients with suicidal thoughts. Suicide is the 11th most common cause of death in the United States (National Center for Health Statistics, 2021). A survey by Leitzel and Knapp (2021) found that 88% of the members of the Pennsylvania Psychological Association had encountered at least one patient with suicidal thoughts in the last year. The survey included all psychologists, including those not delivering health care services. If the results were limited to healthcare psychologists, the percentage would likely be closer to 100%.

Not only will psychologists encounter patients with suicidal thoughts, but they also risk having a patient die from suicide. We could not find recent data on the percentage of psychologists who experienced a patient suicide throughout their careers. However, Leitzel and Knapp (2021) found that 6% of the members of the Pennsylvania Psychological Association had at least one patient die from suicide in the last year. Even 30 years ago, before suicide rates began dramatically climbing, 11% of psychology trainees had a patient die from suicide (Kleespies, 1993). Although patient suicides are very

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upsetting for all psychologists, they may be especially traumatic for trainees or early career psychologists who have not yet developed a solid professional identity (Gill et al., 2012). Nonetheless, conversations with and studies concerning doctoral students and interns in psychology indicate that many feel unprepared to treat suicidal patients and reduce their risk of suicide (see, for example, Cramer et al. [2023], Hagwood et al. [2021], and Jahn et al. [2017]).

Suicidal thoughts and attempts have recently increased by about 35% from 2001 to 2023 (Garnett & Curtin, 2023). The increase in suicidal thoughts is exceptionally high among adolescents. According to the latest Youth Risk Behavior Survey, in 2021, more than 14% of high school boys and almost 30% of high school girls had serious thoughts of suicide in their lifetimes (Gaylor et al., 2023). One would be hard-pressed to find a psychologist who works with adolescents who does not need to have proficiency in assessing and treating suicide.

Psychologists frequently treat disorders, such as depression, anxiety, or trauma where suicidal thoughts are common (about 85% of psychologists frequently or very frequently treat anxiety, 84% frequently or very frequently treat depression, and 57% frequently or very frequently treat trauma; Stamm et al., 2018). According to APA's practice guidelines for depression, for example, the prevalence of suicidality among depressed adults "underscores the need for adequate assessment of the presence and degree of suicidality when working with depressed adults" (APA, 2019, p. 23). Suicide prevention is so important that several state boards of psychology now require continuing education in it as a condition of licensing renewal.

Training in Suicide Prevention Will Improve Public Health

Training all healthcare psychologists in suicide prevention will benefit the public because it would be an important step in reducing the number of persons who live with suicidal thoughts, make suicide attempts, or die from suicide. Various interventions have shown effectiveness in reducing suicidal thoughts and behaviors, such as safety plan-type interventions, lethal means counseling, dialectical behavior therapy, cognitive behavior therapy, the collaborative assessment and management of suicide, and others (Calati et al., 2018).

It is true that no one, not even the most competent psychologist, can guarantee they can prevent suicide (Jobes et al., 2023). Nonetheless, those who implement evidence-supported treatments for suicide prevention using sound clinical judgment and recognizing patient preferences and needs will significantly reduce the likelihood of a patient suicide. This is especially important since many psychotherapists still use unproven or potentially iatrogenic interventions (Rozek et al., 2023).

Mandating competence in treating suicidal patients will help increase the public's confidence in the ability of psychologists to deliver good care. Many patients do not reveal their suicidal thoughts to their psychotherapists (Hom et al., 2017). Some have realistic fears-based on past experiences- that their psychotherapists will shame them for their thoughts or impose unwanted interventions such as a non-consensual disclosure of their suicidal thoughts to loved ones or seeking hospitalization against their will (Hom et al., 2020). Unfortunately, many psychotherapists use less-than-optimal interventions with suicidal patients, including those prior-

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itizing external control of the patients as opposed to the more effective interventions that make patients partners in treatment and motivate them by accommodating treatment to their personal needs and goals. If training in suicide prevention was mandatory for all healthcare psychologists, then the workforce would be less likely to use outdated and sometimes iatrogenic interventions.

In addition, requiring training in suicide prevention may help to reduce the stigma associated with suicidal thoughts, as it would convey to those with suicidal thoughts that having suicidal thoughts does not make them abnormal or deviant. Finally, psychologists who are more knowledgeable about suicide prevention can influence others in their work environment to become aware of the importance of identifying and responding to suicidal thoughts and behaviors.

Fortunately, resources exist for psychology trainers to use in guiding their educational program, such as Cramer et al.'s (2023) curriculum or Rudd et al.'s (2008) core competency model, and in evaluating the outcomes (Sandford et al., 2023).

Addressing Arguments Against Mandating Suicide Training

Opponents of mandating suicide prevention may argue that the doctoral program requirements are designed to address general issues, such as assessment or interventions, without identifying specific diagnoses or symptom patterns. Identifying suicidal behaviors as a target of doctoral program training may, they could argue, open the door for other groups to advocate for specific training in their areas of interest, leading to an endless proliferation of requirements that would ultimately water down all of them. Furthermore, they could argue that targeting specific categories would limit the flexi-

bility of doctoral programs to tailor their curriculum to emerging societal needs. Finally, they could argue that training programs are already moving toward including suicide prevention within their curriculum, so why should we fix a problem that is already fixing itself?

However, one has to look at the purpose of accreditation. APA states that one of its accreditation goals is to ensure "outstanding, evidence-based clinical services to ensure the wellbeing of the public" (APA, n.d.). If APA wants to ensure public well-being, it should ensure adequate instruction in healthcare issues of high social importance, such as the prevention of suicide, which is the third leading cause of death among Americans aged 14 to 18 (Gaylor et al., 2023). Flexibility in standards is important, but flexibility should not be revered so much that it undercuts accreditation goals or minimizes crucial social needs.

Of course, a line has to be drawn on what doctoral programs must require. However, the burden of mandating suicide training might not be as high as some might suspect. Most programs already teach suicide prevention to some extent. Indeed, the number of doctoral programs that include suicide prevention in their curriculum has increased to more than 90% in 2023 (Kleespies et al., 2023), far ahead of the 40 to 50% three decades ago (Bongar & Harmatz, 1991).

The problem is that the quality of the training varies from minimal and likely inadequate (only a few lectures) to exemplary (an entire semester course including skills training and supervised experience). Monahan and Karver (2021) found that doctoral students in psychology received an average of less than 11 hours of training in suicide assessments, and many students did not

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feel adequately prepared to work with suicidal patients. It would be better if the students received more extensive education, including skills-based training (Bryan, 2021). Mandating competence for all doctoral programs could upgrade the quality of education in those programs that currently provide only minimal instruction.

Conclusions

Suicide is a significant health concern within the United States, and the prevalence of suicidal behavior continues to increase. Psychologists regularly encounter suicidal patients, yet many have not had the training needed to treat them adequately. To promote public well-being, the APA CoA should include proficiency in identifying and treating suicidal persons as one of the competencies necessary for accreditation. Although most programs offer at least some training in suicide prevention, the training requirements could be upgraded to ensure sufficient competence in assessing and treating suicidal patients.

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FEATURE

The Pennsylvania Psychological Association's Practice Research Network

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History teaches us that some professions have not survived the test of time as well as the profession of psychology. One example of a failed discipline is the antique science of phrenology, the study of skull protuberances. Phrenology posited that skull characteristics reveal a person's character and mental capacity. The reader may not be aware that only two hundred years ago there were departments of phrenology at some of the world's major universities. However, practitioners of phrenology extended their practice too far beyond the available data, which resulted in phrenologists developing a well justified reputation as charlatans. Their profession eventually withered, and all the departments of phrenology vanished from those august centers of learning. Who knows, perhaps if phrenologists had based their work on better research, they would have developed neuropsychology a hundred years before psychologists did. But they didn't and phrenology was eliminated as a science and as a profession, which proves that natural selection works in various venues! We in psychology must be careful not to repeat the phrenologist's errors.

One way to do that is through what's called a Practice Research Network (PRN). The Pennsylvania Psychological Association (PPA) once had an active PRN. The idea of developing a Practice Research Network originally grew out of discussions held at Board meetings of PPA in the early 1990s. The organization's leadership was looking for a way to strengthen the bonds between academic researchers and practitioners.

Of course, on some level, psychologists

recognize that science and practice must advance hand in hand for both to thrive. Clearly, psychology's research heritage has provided a scientific foundation that allowed psychology to leap ahead of all other mental health professions over the past 50 years. However, psychology must continue to nurture the dynamic interaction between practice and research for our field to thrive as a viable science and profession.

Twenty-five years ago, with financial support from APA's Committee for the Advancement of Professional Practice and the Pennsylvania State University, the Pennsylvania Psychological Association established a unique network of practitioners and researchers who were interested in the application of outcome and other clinical research. The PRN's initial efforts lasted for a decade and resulted in interesting findings published in a variety of publications in our professional journals, such as those listed below (Borkevec et al., 2001; Castonguay, Boswell, et al., 2010; Castonguay, Nelson, et al., 2010; Ruiz et al., 2004). Our science continues to grow as Psychotherapy Research publishes some Phase 3 research stemming from our original effort (Castonguay et al., 2023)!

Since PPA's initial exploratory effort, a variety of psychological PRNs have popped up, some of which were encouraged, if not inspired, by our efforts in Pennsylvania. For example, a PRN in Canada is discussed at McGill University's website (McGill, n.d.). This project currently receives financial support from the Canadian Psychological Association.

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ciation. Another is an active Marriage and Family Therapy PRN supported by Brigham Young University (Brigham Young University, n.d.). These are also representative of the knowledge currently being developed using the psychological PRN concept.

As we come out of the social isolation that accompanied COVID-19, maybe it will be time to emerge from our air-purified protected office environments and renew the idea of psychological PRNs. It's important to remember what's already been done as well as what could lie ahead for at least three important reasons. First, a PRN provides a channel for unification of psychology's practice and research communities while energizing a newly defined scientist-practitioner model. Second, a PRN generates uniquely practical research results developed from entirely naturalistic settings. Third, the basic PRN model can be repeated anywhere in response to a wide variety of critical clinical questions. There is so much for us to learn! Imagine the data that would come from 100 such projects over 10 years or 20 years. Allow your imagination to consider a rebirth of practical psychological research and envision the potential significance of every psychological Practice-Research Network.

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Being Informed About Informed Consent: A Four-Part Series

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Part One: Foundational Issues

The informed consent process is an essential component of ethical, legal, and clinically effective practice by psychotherapists. Yet, how we engage in this process can have significant implications for the unfolding professional relationship and for the assessment, treatment, or other professional services provided. This is the first of four consecutive articles that will address various aspects of informed consent.

Case Example

Viewing informed consent as a legal requirement to be met quickly so that the real work of treatment may begin, a psychotherapist includes detailed information about treatment on their website. Not wanting to waste precious treatment time on such issues, the psychotherapist refers clients to the website whenever questions arise. Whenever a misunderstanding about an important issue such as confidentiality, fees, and financial arrangements arises, the psychotherapist states that it is each client's responsibility to educate themselves about these issues.

Historical Antecedents

The doctrine of informed consent has a long history that dates back to the Nuremberg Trials of 1947 and the resultant Nuremberg Code, which while focused on research with human subjects, laid the foundation for current standards in health service delivery today (Shuster, 1997). Among other standards,

the Nuremberg Code required voluntary consent of the participant before an individual may participate in research (for the 10 standards of this code see: <https://www.imarcresearch.com/blog/bid/359393/nuremberg-code-1947>).

The requirements of the Nuremberg Code have been updated and refined over the years to include in the Declaration of Helsinki in 1964 (World Medical Association, 2018) and the Belmont Report of 1974 (HHS, 2020) which first articulated the basic ethical principles of respect for persons, beneficence, and justice that are familiar to all psychologists in the General Principles of the Ethical Principles of Psychologists and Code of Conduct (APA Ethics Code; APA, 2017). The Belmont Report also established the standard that practitioners should "reveal the information that reasonable persons would wish to know in order to make a decision regarding their care." It also addressed the issue of comprehension by the recipient of services, stating that "the manner and context in which information is conveyed is as important as the information itself," and that based on each individual's needs and differences, "it is necessary to adapt the presentation of information to the subject's capacities."

The Role of Case Law

Despite the presence of these foundational standards for research with human subjects, the early history of health care is filled with examples of patients being treated as passive recipients of professional services provided by experts who made all treatment-related

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decisions on their patients' behalf (Welfel, 2006). The results of malpractice lawsuits have created legal precedents that have advanced required standards of professional practice. Examples include that clients must understand the information presented to them for the informed consent to be considered valid (Salgo v. Stanford, 1957); the minimal information a reasonable person would need to make an informed decision must be provided and the opportunity to ask questions and to receive explanations must be provided (Canterbury v. Spence, 1972); and clients must be provided with information about reasonably available relevant treatment options, to include no treatment, and their relative risks and benefits (Osheroff v. Chestnut Lodge, 1985).

These various historical rulings and standards have profoundly impacted how we obtain each client's informed consent today. Their presence can be seen in the dictates of the APA Ethics Code in Standards 3.10, Informed Consent; 8.02, Informed Consent to Research; and 10.01, Informed Consent to Therapy. Standard 10.01 provides specific requirements for obtaining each client's informed consent to treatment "as early as is feasible in the therapeutic relationship," and that information shared should include "the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality," and that each client should be afforded the opportunity to have all their questions about this information answered (APA, 2017).

While having this understanding of informed consent from historical, ethics, and regulatory perspectives is important, questions about how to implement these requirements in one's clinical practice may be challenging. There are many details relevant to how one applies these requirements with clients that may

prove vexing and additional guidance should be of assistance. Part Two of this article addresses these challenges.

For Your Consideration

Do you obtain each client's informed consent prior to providing professional services? If so, how does this process comport with the guidance described in this brief article? Do you view the informed consent process as an obstacle to overcome or a perfunctory process to quickly complete so that the real work of treatment can begin? What advice do you have for the psychotherapist in the case example?

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Part Two: Informed Consent in Clinical Practice

Case Example

A psychotherapist who works for an agency knows that informed consent issues are addressed by clinicians who do initial assessments before the clients are assigned to their treating clinician. The psychotherapist always looks in the client's treatment record to ensure that the informed consent document is signed, dated, and witnessed so that there "won't be any difficulties later." Feeling confident that this requirement has been met, the psychotherapist moves forward with providing treatment. When modifications to the treatment being offered are indicated the psychotherapist makes these changes, feeling confident in doing so, knowing that they have the client's best interests in mind.

Informed Consent Basics

Informed consent should be an ongoing process, not a one-time event. After the initial informed consent agreement is reached, it should be updated anytime a substantive change to the agreement is being considered or proposed. Ethical and legal standards require that informed consent be obtained verbally and in writing. Simply having a client sign a document is not sufficient. Similarly, a verbal review of the required information to be shared is not sufficient either. A combined approach is recommended to help promote each client's understanding of the information being shared so they can make the best decision possible on their own behalf. It is further recommended that beyond the signed document by the client, psychotherapists include documentation of the informed consent process in the

treatment record to reflect that all relevant standards have been met.

Informed Consent Requirements

Based on case law and other legal and ethical requirements, a valid informed consent process will include four key components:

- The consent must be given voluntarily.
- The individual must be competent to give consent and have the legal right to do so.
- We must actively ensure their understanding of the information being shared (simply asking if they have any questions is insufficient.).
- The informed consent information should be provided both verbally and in writing, and the process should be documented in the treatment record.

Informed Consent Documents

Care should be taken to ensure that informed consent documents are written at a level appropriate for the vast majority of clients. Noting that approximately 50% of adults in the U.S. read at the ninth-grade reading level or below, professional terminology and jargon should be avoided and psychotherapists should endeavor to ensure that these documents are written at the sixth to eighth grade reading level so that the vast majority of potential clients will be able to comprehend the information in these documents (Walfish & Ducey, 2007). Psychotherapists may assess the reading level of a document utilizing the Flesch-Kincaid Grade Level Equivalency in Microsoft Word (see <https://www.techlearning.com/news/determine-fleschkincaid-reading-levels-using-microsoft-word>).

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One study found that of the Notice of Privacy Forms assessed, 91% of them were written at or above the reading level of medical literature or legal contracts (The Numbers Game, 2005). Another study found that of the informed consent documents assessed, the average reading grade level was 10.6 (Paasche-Orlow et al., 2003). We should ensure that informed consent documents are written at a reading level likely to be comprehended by most clients.

Information Sharing Challenges

It may be challenging to know how much information to share when. Attempts to share all relevant information at the beginning of the initial session might be overwhelming to a client, might be off putting, and for clients experiencing emotional distress or who are in crisis they might not be able to process and comprehend the implications of the information being shared. In addition to sharing the written proposed informed consent agreement with clients prior to meeting with them, it may be more effective to review the most relevant and important aspects of informed consent initially, to share additional information at the end of the session and at subsequent sessions, and to recommend that clients review the written materials between sessions to aid in subsequent discussions. Prospective clients have consistently wanted to know initially about fees and financial arrangements, confidentiality and its limits, and the likely course of treatment (Claiborn et al., 1994; Miller & Thelen, 1986). While additional information is relevant, important, and required, psychotherapists are guided to be thoughtful about which information and how much information to share at different points in time and by different means (verbally and in writing).

Rather than viewing informed consent as a burden or as a hurdle to clear to get

to the real work of treatment, it should be seen as an important part of the treatment process. How the informed consent process is carried out has significant implications for the treatment relationship and process to follow. As Snyder and Barnett (2006) explain, there are many potential benefits of the informed consent process to include:

- Empowering clients and promoting their autonomy.
- Laying the foundation for a collaborative working relationship.
- Demystifying and improving the therapeutic relationship.
- Reducing anxiety, stress, and misunderstandings.
- Reducing the risk of exploitation of or harm to clients.
- Promoting ethical practices and the underlying values of our profession.

Essential Information to Include

While each psychotherapist should exercise their professional judgement regarding the need to include additional information when it is relevant and might reasonably be expected to have the potential to impact a client's ability to make an informed decision about participation in the professional services being offered, the following information should be included in all informed consent agreements:

- Nature, purpose, and anticipated course of treatment
- Reasonably available options and alternatives and their relative risks and benefits, to include the treatment being proposed and no treatment at all
- The right to refuse participation
- Confidentiality and its limits
- Fees and financial arrangements (to include billing and insurance)
- Involvement of third parties
- Recording (if relevant)
- Emergency contact information

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- Termination process and conditions (Barnett, 2020)
- When applicable, the use of technology and electronic communications should be thoroughly addressed

No One Size Fits All

The informed consent process should be modified as may be needed based on the client's particular needs and circumstances. Examples include the role of age and developmental level such as with the treatment of minors; the treatment of couples, families, and groups; when a client may have cognitive deficits that impact their ability to comprehend the information being shared; with clients of diverse backgrounds; and when third parties are involved such as in forensic situations.

In each of these circumstances how confidentiality is handled may vary: the psychotherapist may have potentially competing obligations to multiple individuals, something that may result in negative outcomes if not adequately addressed in the informed consent process; other individuals may need to provide consent on a client's behalf; clients will need to know the parameters of the professional relationship and who may have access to treatment-related information; and factors such as language fluency, disability, and cultural differences may necessitate the need to modify informed consent procedures so that clients' individual differences and needs are respected. How each of these issues is addressed will likely have a significant impact on the quality of the treatment relationship and effectiveness of the treatment process that follows. Issues relevant to informed consent and the treatment of minors will be addressed in part three of this article.

For Your Consideration

Are there any ways you plan to modify your informed consent process and procedures based on what you have read in this article? If so, what are they and why will you be making these changes? What are your thoughts about the case example? What are your recommendations for this psychotherapist?

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Part Three: Informed Consent and The Treatment of Minors

Case Example

Two parents meet with a psychotherapist to seek treatment for their 14-year-old adolescent. The parents review their goals for their child's treatment with the psychotherapist and express their desire to receive weekly updates on their child's treatment, to include any negative statements the adolescent makes about their parents and any disclosures about acting out behaviors. The psychotherapist agrees to all this and after the parents sign the informed consent document and the financial responsibility form, the initial treatment session for the adolescent client is scheduled.

Minors and Informed Consent

The age of majority is defined in relevant state laws but may vary by state so psychotherapists should review their state's applicable law. Additionally, exceptions to these statutes regularly exist to such as for minors who are in the military or are married to consent on their own behalf and for minors who are parents to consent on their own and their children's behalf. Some states also have laws that specify that minors of certain ages may consent to their own mental health care and to certain types of health care. Thus, familiarity with the applicable laws in one's state is essential to ensure that clinical services are provided to those who have the legal right to consent to them.

Informed Consent Versus Assent

With this information in mind, in general psychotherapists must receive consent from the parent or guardian prior to providing professional services to a minor. Yet, this does not mean that minors should be excluded from the informed consent process or that their opinions or preferences should be overlooked or ignored. While parents or

guardians typically have the legal right to consent (it should be confirmed that the parent or guardian actually has this legal right, something especially important in divorce and custody situations) and thus to reach agreements on the parameters of the assessment or treatment with the psychotherapist, overlooking the minor's role in the process may jeopardize the treatment relationship and the success of treatment.

It is therefore recommended that a process of assent occur with all minors. Assent is a process of sharing relevant information with the minor that occurs in conjunction with the informed consent process with the parent or guardian. The ethical obligation for this is seen in Ethical Standard 3.07, Third Party Requests for Services, requires that "psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved" (APA, 2017). Additionally, when more than one person is involved in the treatment being provided (e.g., parents, guardians) we should clarify from the outset our obligations to each party (Fisher, 2009).

A Developmental Perspective to Assent

A developmental approach to assent is recommended in which the information sharing is done at a level commensurate with the minor's ability to understand the implications of the information. Thus, how a psychotherapist shares information about their role, the treatment to be offered, limits to confidentiality, and related issues will vary significantly for a five-year-old, a nine-year-old, a 13-year-old, and a 17-year-old, for example. Additionally, the minor client's ability to participate in decision-making relevant to the informed consent process changes dramatically as they go through this

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developmental progression (McCabe, 2006). Researchers have found that minors at the formal operations stage of development (approximately 12 years of age) typically possess the same ability as adults to understand the implications of decisions they make (Redding, 1993), but psychotherapists should assess this with each minor client before making decisions on consent versus assent.

While in most situations the parent or guardian has the legal right to give informed consent, to include the right to access to all treatment-related information, as psychotherapists we understand that parents asserting this right with a five- or seven-year-old child is likely very different than with many adolescents. In fact, to be able to provide effectively provide treatment to an adolescent, and to help ensure their willingness to participate in treatment in a meaningful way, it often is necessary to renegotiate parental rights, such as setting treatment goals and regulating access to treatment-related information. Without a legitimate promise of some degree of confidentiality many adolescents will either not willingly participate in treatment or for those who do, may be very guarded about what they disclose to the psychotherapist, potentially greatly limiting the psychotherapist's ability to provide meaningful and helpful treatment.

Renegotiating Parental Rights

Thus, minor clients should be included in informed consent discussions to the extent possible based on their developmental level. For those with the ability to understand the consequences of their decisions, and who likely are developmentally at a place where independence from their parents is relevant, parental rights to treatment-related information should be openly discussed and renegotiated. As Koocher explains, "Parents can often be persuaded to agree to respect

the privacy of the treatment relationship, particularly if they feel that the psychotherapist shares their interest and values with respect to their child's safety" (In Barnett et al., 2007, p. 12).

Parents and their adolescent children cannot reasonably be expected to just trust the psychotherapist to make decisions about what information should or should not be shared with the parents. During the renegotiation of parental rights during the informed consent discussion the psychotherapist can provide overarching guidance on what information will be kept private and what information will be shared, with representative examples provided. An example would be that the psychotherapist will share information of direct relevance to the minor client's safety and welfare such as issues of dangerousness, while keeping private the adolescent's opinions, complaints, and descriptions of frustrations with parents. The psychotherapist can also highlight how treatment can be used to promote greater and more effective communication between the minor client and their parents.

Additionally, with parental permission many minor clients can participate in decision-making relevant to the informed consent process. While the parent or guardian has the legal right to give consent and to make relevant treatment-related decisions, inclusion of their developmentally advanced minor child in the decision-making process (at least to seek their opinions and input, and giving these consideration) can be a significant and positive way to begin the treatment process, helping to set it up to be more successful.

Custodial Arrangements and Parental Legal Rights

As every psychotherapist who assesses and treats minor clients knows, parental

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legal rights due to custody arrangements may vary. It is essential that psychotherapists confirm parental rights from the outset of the professional relationship. In intact families either parent may consent to their minor child's assessment or treatment. But, in certain custody arrangements one parent may have full legal custody (only that parent may give consent), both parents may share joint legal custody (consent from both parents is needed), or there may be other arrangements such as joint physical custody with only one parent having legal custody. It is certainly possible to have a non-custodial parent with visitation rights bring their child for evaluation or treatment when their child is visiting with them and these parents do not have the legal right to consent to any evaluation or treatment on their minor child's behalf. In custody situations being a biological parent is not sufficient, one must be granted this legal right by the court.

Whenever considering offering professional services to, or that include, children it is recommended that psychotherapists ask about custody arrangements at the initial session and when the existence of one is acknowledged, not to schedule any additional appointments until proof of the custody arrangement is received. Receipt of a copy of the court order that stipulates the custody arrangement is recommended, with this being maintained in the client's treatment record. Relying on a parent's verbal understanding or recollection of the court order should not be considered sufficient. These recommendations will hopefully help prevent psychotherapists from violating any person's legal rights when

attempting to provide needed mental health services.

For Your Consideration

How might you modify your informed consent and assent process and procedures for minors of different ages and developmental levels? When might you offer the minor the opportunity to provide their preferences for treatment and its goals? Have you ever negotiated parents' rights with them for the benefit of their minor child in treatment? What has your experience with this been? What are your recommendations to the psychologist in the case example?

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Part Four: Special Considerations

Case Example

A psychotherapist received a referral from an agency to provide treatment to a recent immigrant family that is experiencing significant difficulties acclimating to their new life in America. The psychotherapist is happy to accept this referral and looks forward to the initial session, but is surprised when three generations of the family, an agency translator, and the agency's staff member show up for the first session. The psychotherapist is unsure of how to proceed and wonders who should provide the informed consent and how should it be obtained.

When Informed Consent Must be Modified

There are a number of circumstances where how informed consent is obtained, and several important details of its content, must be modified. Some examples include when offering treatment to couples and families; when treatment is ordered or recommended by a third-party; and when individual differences necessitate flexibility in how informed consent is obtained so that important individual differences and needs are respected.

Informed Consent with Couples and Families

Regardless of one's theoretical orientation or treatment approach when treating multiple individuals such as couples and families, as Knapp and VandeCreek (2003) recommend, at the outset of the treatment process psychotherapists should "clarify their roles and relationships with all parties" (p. 148). This is consistent with Fisher's (2009) suggestion that rather than focus solely on "who is the client?" psychotherapists ask instead "Exactly what are my ethical responsibilities to each of the parties in this case?" (p. 1). Thus, psychotherapists should not rely on obtaining informed consent from selected individuals but

should include all those participating in treatment in this process, to include obtaining minors' assent for family therapy. In fact, as Barnett and Jacobson (2019) explain, it is important not to assume that the individual who makes initial contact to request treatment services will be the client. This individual's stated goals and objectives may not be the same as those of all who will participate in the treatment. Thus, it is important to ensure that no commitments or decisions about the planned course of treatment be made until the input of all relevant parties is obtained.

A key issue to consider when offering treatment to couples and families is that one person typically may not waive privilege for another. Thus, it is important to ensure that all those involved in treatment understand how documentation will be done and how access to treatment records, and how any requests to release treatment-related information will be addressed. In essence, it is the couple or the family that is the client, not specific individuals as would be the case when offering treatment to an individual. Ensuring each party's understanding of this and its potential implications at the outset of the professional relationship can help minimize the risk of many difficulties and misunderstandings later.

Also consistent with a focus on the couple or family being considered the client, it is recommended that the informed consent discussion include a policy on extra-therapeutic contacts, to include communications in between treatment sessions to which each participant agrees (Kuo, 2009). Such a policy will typically specify that should any such communications or contacts occur, the psychotherapist will disclose them in full to the other treatment participant(s) at the next scheduled appointment.

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All of the above is consistent with Ethical Standard 10.02, Therapy Involving Couples and Families (APA, 2017a) which states:

When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained.

Third Party Requests for Services

At times, psychotherapists will receive referrals from individuals or organizations to evaluate or treat another person. Examples include when an individual is court-ordered to be evaluated or to receive treatment, when a family is court-ordered for a custody evaluation, when a police department refers an officer for a fitness for duty evaluation following an incident such as discharging their firearm in the line of duty, and when a legal guardian (either an individual or an agency) refers an individual for evaluation or treatment.

In these situations, the person who the psychotherapist is evaluating or treating may not actually be "the client." It is important that psychotherapists clarify from the outset their responsibilities to each of the parties involved. In many situations, the person being evaluated or treated may assume they have certain confidentiality rights, that they may participate in decisions on treatment goals and on who will have access to treatment information or evaluation results, and they may not understand the consequences for them of a failure to participate as requested or ordered by the referral source.

Ethical Standard 10.07, Third Party Requests for Services (APA, 2017a) requires that the informed consent process address each party's roles and responsibilities, clarifies who is the client, and "probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality." For example, when an evaluation is court ordered, the court is the client and the individual being evaluated needs to understand that all information they share and all evaluation results will be sent directly to the court, and that the results of the evaluation will not be shared with this individual by the psychotherapist, regardless of who is paying for the evaluation. Additionally, the consequences of a refusal to participate fully in the evaluation should be clarified at the outset. As Melton and colleagues (2007) recommend, psychotherapists should "make bona fide efforts to assist the defendant in understanding the parameters of the evaluation and to obtain his or her assent to proceed" (p. 158).

Informed Consent and Individual Differences

The APA Ethics Code (APA, 2017a) makes clear that psychologists must be "aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups."

Each of these aspects of diversity, alone and in combination, may impact how psychotherapists will conduct the informed consent process. Modifications in one's usual informed consent process may need to be made to ensure that these individual differences and client needs are respected and so that informed consent is obtained in the manner most meaningful and relevant to the client.

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The APA's Multicultural Guidelines (APA, 2017b) specify that multiculturalism be integrated into all aspects of psychologists' roles and interactions with clients, to include informed consent, and that doing so should be considered an essential aspect of each psychotherapist's multicultural competence.

Relevant examples include the following:

- Gender roles and religion: A female client may report that her religious beliefs dictate that her husband makes all decisions for the family, to include mental health treatment. In this case the husband would provide informed consent for his wife even though she is an adult with the legal right to provide her own consent. Respect for their wishes based on these religious beliefs may be necessary for the wife to be able to receive needed mental health treatment.
- Culture: An adult client from an Eastern or collectivistic cultural background may request that their parent, grandparent, or a community elder provide consent to their treatment. Many treatment approaches and many psychotherapists may take a primarily Western approach or perspective that would be inconsistent with respecting the cultural values of such clients.
- Language: When the psychologist and client are not fluent in the same language, the use of an interpreter may be needed in order to provide the needed treatment. In these situations, it is important to address in the informed consent process the role of the interpreter, how confidentiality will be addressed, and the like. Further, a separate agreement should be reached between the psychotherapist and the interpreter prior to providing the services to ensure expectations for accurate translation, maintaining confidentiality, and the roles of each individual.

For Your Consideration

Many other examples are possible and it is recommended that psychotherapists keep diversity factors in mind when considering how best to obtain informed consent from clients. For each of the many diversity factors included in the APA Ethics Code, how might you need to modify how you engage in the informed consent process? Do you have any examples from your practice that you can share? What are your recommendations for the psychotherapist in the case example?

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PROFESSIONAL PRACTICE

Psychotherapy Practice over the Lifespan

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As members of the Professional Practice Committee of the Society for the Advancement of Psychotherapy, we are tasked with meeting the needs of private practitioners. In our monthly meetings, we noted how the needs and experiences of practitioners change as one matures into the role of a psychotherapist. Since our committee has a diverse combination of members from different developmental stages, we thought it would be useful to survey our small committee about these needs and experiences. The results of the survey identified some of the challenges, opportunities, and issues and concerns confronting therapists at these different stages of practice. The nine participants

consisted of three Late Career (more than 20 years practice), two Middle Career (10-20 years), and four Early Career (less than 10 years) who completed a Google Form survey in September 2023. Each participant was asked what they saw as the challenges, opportunities, and unique concerns related to their respective stages of development. Below is a summary of our findings. As you read through these findings, we encour-

age you to reflect on your current stage of practice and consider the challenges and opportunities relevant to you at this time.

Profession Practice Challenges

Our **early-career** practitioners expressed challenges in balancing family and work, while growing one's practice "simultaneously." One participant expressed difficulties "balancing financial pressures of student loan debt" while struggling to "meet the needs of clients served." Another participant, still in graduate school, talked about struggling with all the expectations of graduate school, engaging in "diverse scholarly work on top of intensive clinical training" while not being paid, or paid very little, for the internships.

Mid-career participants mention finding a balance in their work and personal lives. For example, "balancing demanding day to day practice responsibilities with other valuable and desirable professional activities such as continuing education, teaching, presenting, volunteering, committee involvement," as well as building a practice and having "clients that can pay" the participant's fee.

Late-career participants reflected on the challenge of eventually retiring; what that would look like, the practicalities related to slowly reducing caseloads, and developing professional wills. In addition, one participant mentioned feelings of loss and isolation due to "colleagues

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dying or becoming seriously ill (Alzheimer's, stroke etc.).” Balancing life priorities with practice priorities were also mentioned as a challenge along with shifting their focus to self-care and recognizing one's “time is limited” and wanting to make the best of the time they had left personally and professionally.

Professional Practice Opportunities

Early and mid-career participants expressed a need for support and mentorship, but generally felt it was available. While late-career participants felt they had expertise to share, including gained wisdom and opportunities to mentor. Nearly all participants reported appreciating being involved with other professionals in the field and working in many different capacities as a psychotherapist.

More specifically, **early-career** participants identified planning for “longevity” which involved having a “professional plan” thinking that one would have years ahead to continue working. This also involved looking for opportunities “to continue to learn and hone my craft clinically and also make long term business plans.” One participant talked about the variety of “professional opportunities and autonomy” available at this stage. Another participant mentioned having “robust opportunities” to deeply learn research, practice, and teaching. This idea was expanded by a participant who talked about the “opportunity to be involved with other professionals in organizations...acquiring mentorship and feedback from mid-level to late career psychologists” to help find “my footing in the field.” Opportunities with diverse mentors helped another participant learn to do “great work” while “navigating the systemic hurdles that mental health professionals face.”

Mid-career participants noted opportunities for “connections with other thera-

pists,” having the opportunity to create a solid referral base, and being able to share “professional knowledge, mentorship, and guidance based on my expertise.”

Late-career participants talked about feeling they were able to be “better clinicians” in part by feeling more calm and less stressed from challenges during the earlier part of their career. One participant noted having gained “wisdom about certain client issues and about life” and feeling like she had “a unique opportunity to share with others what I have learned in my long life and my long experience working with clients.” This was echoed by another participant who talked about appreciating opportunities to “mentor and supervise young clinicians” and noted her increased competence about “therapy, life, and about running a business.” This participant also mentioned the benefits of having a referral base from a “word-of-mouth reputation.” Like another participant at this stage, she noted that she had become “a more effective writer, speaker, teacher, trainer, consultant and advocate.”

Issues or Concerns Unique to Each Stage of Professional Practice

Themes in this area differed by stage with early career participants having concerns about money and career path decisions, while mid-career participants were dealing with issues of burnout and income. In contrast, late career participants noted issues around generativity, retirement, closing a practice, staying relevant, and more focus on personal interest areas reflected in the clients they work with.

Early-career participants talked about balancing priorities in terms of starting a family, building financial security and the growing needs for mental health clinicians. Being able to prioritize training needs with time for family and main-

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taining a financially secure client load were touted as issues. In addition, one participant felt graduate school had not provided adequate preparation on opening a private practice while one prepares to pay back student loans. Another participant talked about “the most unique challenge to this stage is associated with the rising student loan debt burden and navigating through those difficulties.” Another very early career participant noted concerns around “[making] career decisions but having limited time to reflect on their career issues given the high workload” as a trainee.

Mid-career participants were mostly concerned with avoiding “burnout” and having enough income.

Late-career participants wondered about issues such as creating “a professional will” as well as “when and how to retire” and “how to share your wisdom.” Participants talked about how things had changed since beginning their careers and the need to manage the “generational cultural gap.” Still, they felt that with time and experience, they had become more effective therapists.

In our last set of questions, we asked specific questions targeted to each practice stage. The questions and some of their responses are below.

What did early-career participants want to ask of mid to late career psychotherapists?

Responses indicated these participants needed guidance on career path options, managing finances and debt, and on doing the work long-term in a sustainable way. Echoing responses from earlier in the survey, they were curious about the “necessary components to achieving longevity in this field that help to make it a sustainable career given the draining and underpaid work of being a practitioner.” These partici-

pants also wondered about financial strategies related to high student loan debt and having a living wage. They also expressed interest in how one decides to go down the private practice career path, and to know more about “how to” develop a private practice as a viable business.

Mid-career participants shared one thing they were glad they did or wished they had done when starting their practice. Participants noted the value of networking and the importance of professional self-esteem. “I’m glad I went all in making connections and participating in non-income generating activities which I think all grew my referral base” and “I wish I had valued myself more and had more insight as to how to do what I see colleagues do.”

Late-career participants shared what they wished they had known earlier related to growing and maintaining a professional practice. Participants generally wished they had more information and support to focus on building a practice. One participant wished that she had “been a bit more intentional in developing my practice” including spending more time formally or informally talking to others who were also building a practice. Similarly, another participant mentioned wishing “I had met with a lawyer earlier in my career to set up a different type of business (LLC) that may have been easier on taxes and would have been easier to bring other therapists into my practice.” Finally, another participant talked about wishing she had started her practice sooner and noted feeling “intimidated by the idea of running my own business.” She thought that she “needed to know everything and didn’t realize that she “could continue to figure it out” after she got started.

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Discussion

In reflecting on our survey results, we noted that our participants expressed concerns about finances and balancing life priorities across all the different stages. Other researchers have examined developmental stages of psychotherapists. For example, Skovholt and Rønnestad (1992) developed a Lifespan Development Model and Orlinsky and Rønnestad's (2005) example how psychotherapists develop. It was interesting to us, in reflecting on these other excellent resources, that these models did not focus as much as our participants did on concerns about finances and balancing life priorities at different stages.

It seems for our participants that the practical and financial issues involved in practice-building are not given enough attention in training. As one participant remarked, "these questions... made me aware of the gaps in training for psychotherapists." In addition to having to acquire a unique set of business skills, there is considerable financial risk involved in establishing a private practice. The psychotherapist needs to have the resources to invest in space, utilities, marketing, equipment, wages, subscriptions, supplies, insurances, licenses, and other unplanned expenses. This might be particularly true for those living in single income households, for those starting new families, and/or those who are carrying huge student loan debts.

Based on our survey responses it appeared that new practitioners without pre-existing financial resources were not able to afford the startup costs involved in setting up an office, or the time required to build it. A perspective represented by our survey participants was that building a practice around the demands of a full-time job and starting a young family was financially, physically, and emotionally difficult. Some respondents named "income" and "burnout"

as their main concerns. One respondent commented on the low insurance reimbursement rates and questioned "how to navigate high student loan debt in higher cost of living areas."

Although the survey responses related to financial concerns represent those of many, if not most, psychotherapists across the practice lifespan, they highlight the importance of addressing systemic issues that create unique financial barriers to Black, Indigenous and People of Color (BIPOC) psychotherapists at all stages of practice. One BIPOC respondent clearly noted the negative impact of "the structural barriers that exist within the field." According to Helen Park, licensed therapist and fellow at the Ackerman Institute for the Family, "The cost of post-graduate training opportunities, and preparation for licensing is ...a challenging hurdle for aspiring BIPOC therapists." Park went on to say that "...the pressing need for therapists of color is only amplified by the systemic issues that prevent them from breaking into the field in the first place" (Onque, 2022).

The sharp increase in racial and ethnically motivated hate crimes and the myriad of social, political, and economic stresses impacting BIPOC communities have led to an exponentially increased demand for culturally competent services. Given this need, and the growing changes in the face of the profession, it is prudent to consider how to actively deconstruct these barriers. Dr. Whitfield at North Carolina A&T State University suggests recruiting more students and faculty from marginalized groups (Whitfield, 2021). Park sees that private practices can contribute to the deconstruction, by actively seeking to hire aspiring BIPOC therapists into their group and offering them justifiable compensation (Onque, 2022).

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This survey was a quick sampling of the experiences of psychotherapists in private practice across the stages of practice. While our work is cursory, the general themes and concerns that emerged may be representative of the challenges and opportunities faced by other psychotherapists. Hopefully our work here has helped you to reflect on the concerns as well as potential opportunities we may encounter as psychotherapists and to help inform the education and training of psychotherapists.

Acknowledgements:

Michelle Joaquin, Ph.D.

Tameeza Samji, Ph. D.

Cordaris Butler, MS

David Friedman, PsyD

Rosemary Adam-Terem, PhD

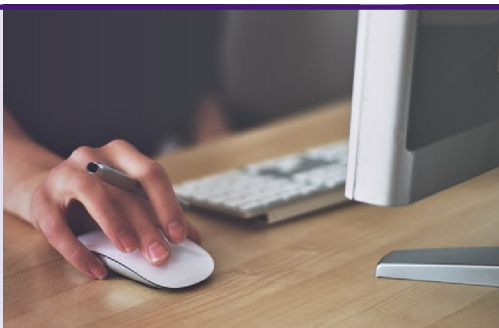
Mira An, BA

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MEMBERSHIP

Considerations in Trauma-Informed Training

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In this article, we propose a trauma-informed lens as an essential ingredient of clinical competency. We draw from established trauma theory and research (e.g., Levine, 2010; Mate & Mate, 2022; Menakem, 2017; van der Kolk, 2014), including that specific to graduate and post-graduate supervision (e.g., Courtois, 2018;

Knight & Borders, 2018; McChesney, 2022) to explore systems-level issues in establishing such a model within the university setting.

While there are diverse perspectives on trauma, we gravitate towards those viewing trauma as embodied and involving not only the big T events (as in PTSD mapped out in the DSM) but the “small T” (often harder to identify) and complex traumas (e.g., racialized, attachment, and developmental trauma). Clinical therapist Resmaa Menakem conceptualizes trauma—including its racialized forms—as the body’s reflexive response to a shocking event, with individuals’ trauma responses unique. Bessel van der Kolk, author of *The Body Keeps the Score*, notes that trauma - an experience overwhelming the central nervous system - is marked by internal suffering rather than defined by the narrative of the event. Gabor Maté adds that trauma “is not the sexual abuse... not the war...not the abandonment... not the inability of your parents to see you for who you were. Trauma is the

wound that you sustained as a result” (Maté & Maté, 2022, p. 20). Psychotherapist Peter Levine similarly emphasizes that trauma is held in and can be healed through the body. His somatic experiencing therapy frames trauma as the body’s inability to complete the fight, flight, or freeze response, and it uses bottom-up (versus top-down cognitive) processing to direct the client’s attention to and learn to regulate internal sensations linked with the traumatic event.

Given that 70.4% of individuals will experience trauma at some point in their lives (Kessler et al., 2017), statistically speaking, a significant proportion of our counseling trainees will not only work with clients experiencing trauma but also themselves had or will have their own lived experience of it. Trauma is relevant and upfront for our trainees.

In 2013, the Substance Use and Mental Health Services Administration (SAMHSA) joined a task force offering recommendations for best practices in working with individuals and families experiencing trauma. This working group developed an outline of trauma-informed care and specific guiding principles. According to SAMHSA (2014):

“Trauma-informed care (TIC) views trauma through an ecological and cultural lens and recognizes that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. TIC involves vigilance in anticipating and avoiding institutional processes and in-

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dividual practices that are likely to re-traumatize individuals who already have histories of trauma. TIC upholds the importance of consumer participation in the development, delivery, and evaluation of services.”

Trauma-informed care (TIC) involves best practices across sectors (e.g., healthcare, emergency services, social work, education), and their integration offers a proactive approach to attenuate the impact of trauma. In this article, we discuss SAMHSA’s six guiding principles: safety, trustworthiness, peer support, collaboration, empowerment, cultural, historical and, gender issues (SAMHSA, 2014; 2023), and we identify three areas relevant to delivering TIC in graduate training: A) faculty level; B) departmental /university level; and C) licensing bodies.

A) Faculty Level

Given the prevalence and impact of trauma, there is a great need to provide content information to trainees who will later serve this population (and who may have or will experience trauma themselves). A content course may define and describe trauma (types, signs, symptoms, prevalence), provide information about trauma-informed care (e.g., SAMHSA’s six guiding principles), and introduce trauma interventions.

An academic course on trauma may or may not be trauma-informed depending not only on whether trauma-informed care is covered but also on whether the faculty holding the classroom environment is conveying the SAMHSA principles of TIC (e.g., safety, trustworthiness, etc.). Just as it is important that clinicians be well-versed in both case conceptualization and technique, it is critical that we go beyond an intellectual understanding of trauma to model trauma-responsive practices. Without fully understanding what it means—and feels in their bones—

to be trauma-informed, graduate students may bypass the important lived experience of co-creating a space marked by safety, trustworthiness, peer support, collaboration, empowerment, and attention to cultural, historical, and gender issues (SAMHSA, 2014; 2023). We can help trainees create a holding environment by guiding them to identify their own barriers to compassionate and culturally responsive care.

Graduate students’ own trauma may be activated by course material, class discussions, and/or interactions with clients. Yet, we cannot avoid difficult topics; it is not only unrealistic given the content of courses, but it also does not prepare trainees to effectively (and ethically) work with clients. It risks their misunderstanding, bypassing, and/or shutting down clients’ thoughts, feelings, and experiences. We seek to invite students into a process—showing what it means to be trauma-informed in an experiential manner.

Graduate students lacking this trauma-informed and process framework may have insufficient understanding of and tools to support clients who exhibit signs of trauma. Without such a process lens, providing treatment can be overwhelming for the graduate student and/or be [re]traumatizing for the client. For example, trainees may unknowingly opt for brief therapies, lacking the safety of the therapeutic relationship as a vehicle for establishing trust (see Norcross & Lambert, 2019). Furthermore, their countertransference may become evident (via ostensible irritation or confusion, pathologizing or assigning responsibility to the client for “slow progress,” victim blaming, and/or through projections). Many years ago, one of our supervisees expressed frustration at his client’s avoidance of emotions, insisting he was unable to

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help her (thus risking abandonment, which not ironically was one of her trauma symptoms). It became evident that the trainee changed the subject when his client got close to expressing sadness. In this way, the graduate student's own barriers around vulnerable emotions not only invalidated his client's experience but also risked re-traumatization by his distancing and blaming her for that which was his unexplored wound.

What does it *actually mean* to be trauma-informed? Many of our graduate students have not heard of this term and those who have to find it abstract, ill-defined, and difficult to operationalize. We relate. For years, we saw signs and posters ("We are trauma-informed") peppering our clinical offices, and we heard only vague references to trauma-informed care before we understood what it meant and how to apply it. We need to be well-informed, to be explicit, and intentional about teaching, modeling, and practicing TIC. Here are some concrete strategies we have used to translate the SAMHSA trauma-informed guidelines into our graduate courses:

1) *Safety*: These practices contribute to a sense of well-being in the physical and interpersonal environment. To foster this, we sit in a circle which develops community and connection. We offer an introduction survey, inviting students to privately share their preferred name, gender pronouns, instructional needs, and any concerns about the course. In addition, we co-create community agreements—guidelines (reviewed in each class) to facilitate trust and safety in sharing. These agreements include confidentiality (to allow for authentic and vulnerable sharing), speaking from our own experience, avoiding advice or crosstalk, and holding space for others' feelings without trying to fix them.

Students may pause the class to request a grounding exercise if they are activated. We utilize "oops/ouch" to encourage a safe, collaborative, and process-oriented space, inviting students' reactions ("ouch") to cue a peer's repair ("oops"), genuinely apologizing for the ways that their intention did not match the impact. The Move Up, Move Up tool, an anti-ableist alternative to "Step Up, Step Up," involves sharing the floor; it emphasizes that all voices are valued and contributes to building group knowledge.

2) *Trustworthiness and Transparency*: We do this through modeling authenticity, providing a clear and transparent rationale for course requirements, and recognizing the humanity of students and clients alike (e.g., taking a non-pathologizing lens). Given the interpersonal breach of trust experienced by trauma survivors (i.e., no safe person with whom to share their experience, Levine, 2010), we are especially invested in timely repairs (Tatkin, 2012) in the event of a rupture. We model this by checking in, inviting a process, honoring trainees' feelings, and making needed corrections.

3) *Peer Support*: This may involve classroom (or supervision) activities to support students' awareness of and ability to sit with their own and their classmate's feelings. Regardless of the graduate course or training site, the holding space in the group shows trainees how to stay with what is hard. In addition, classroom agreements, making space for students' feelings and reactions, and the "ouch/oops" process engage peer support. We also use a variety of arrival and grounding exercises (e.g., mindfulness). This assists with - and models - noticing and naming thoughts, feelings, and sensations (which they may opt to share with peers) and facilitates emotional

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awareness and distress tolerance, which trainees can carry into their own sessions (Harris, 2019). This empowers graduate students to identify and take ownership of their internal states (reducing the likelihood of projection onto peers or clients).

4) *Collaboration*: This is evident in many of the aforementioned areas, including our co-creating class agreements at the start of the semester. In addition, we regularly engage students in dyadic exercises to practice skills experientially as well as support one another in processing reactions to the material.

5) *Empowerment, Voice, and Choice*: We help trainees connect with their resiliency by highlighting their strengths and abilities (this is particularly supportive for those lacking confidence) and by creating opportunities to reflect on their growth. We engage in “checking in/checking out,” taking the temperature of the class before moving into course content. Students are invited to share feelings and experiences they are bringing into the space from their “outside” lives. Checking out, we can explore shifts in their acceptance and ability to stay with difficult feelings—in line with their value of learning (Harris, 2019). We recognize the diverse ways that students learn best and participate in class discussions, and we offer opportunities to convey understanding via various channels (e.g., dyadic and small group work, individual reflections and exercises, eye contact, and nodding). The choice may involve options for assignments and a choice of grounding exercises. Finally, we invite trainees to develop an individual care plan, identifying three actionable steps to take over the semester (e.g., seeking therapy, time with friends, mindfulness practices, and exercise). We check in with each student over the semester to support their progress towards these goals.

6) *Cultural, Historical, and Gender Issues*: This involves actively moving past cultural stereotypes and offering gender-responsive services, leveraging the healing value of traditional cultural connections, and recognizing and addressing historical trauma. We invite students to engage in self-reflection (whether private journaling, dyadic work, and/or classroom discussion) related to their social identities. When and how did they develop and/or become aware of these identities? How have they benefited from or been disadvantaged by them? In what ways do these social identities offer power and privilege? How does this affect who they are as a therapist? In addition, students reflect on their family history: How were emotions handled? What was welcomed/tolerated/forbidden? What have they learned about communication and emotional responsibility? Such reflective and experiential activities build students’ awareness of and care for the diversity of human experience and foster their holding space for their classmates and clients.

B) University/Departmental Level

Changing the culture in an individual course is foundational, though these classrooms risk becoming silos unless there is departmental and university reinforcement. Academic freedom allows faculty to teach in a trauma-informed manner—or choose not to do so; there is no mandate to teach in a trauma-informed way or to gain continuing education in this area. So, in addition to implementing a trauma-informed framework in individual academic classes and supervision, we advocate for programmatic change. A trauma-informed lens (across courses) does no harm yet helps many—by providing brave and inclusive learning environments marked by nurturance, respect, and support from educators and

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peers. Moving towards this framework does not place an undue burden on universities or compete for the resources within higher education. Because trauma-informed training is culturally responsive, inclusive, fosters students' well-being, and is equitable, its adoption at the university level—beginning with the admissions process and later matriculation—supports diverse graduate student cohorts as they arrive in our programs and throughout their training. Trauma-informed care recognizes the prevalence of trauma, honors diverse identities by deepening awareness of issues of power and privilege, and prepares trainees to respond respectfully and appropriately to people of all cultures and other diverse backgrounds in a way that acknowledges, affirms, and values their client's worth—all of which benefit graduate students and their clients.

We are grateful for the departmental and university support of a trauma-informed lens in our own teaching and supervision, as well as for the rich discussions about the benefits of graduate requirements to include such a framework (which can be implemented across courses and supervision). And, for the university to additionally require a trauma content class (with an explicit focus on trauma signs, symptoms, prevalence, impact, and interventions) presents some practical problems (i.e., more requirements translating into higher tuition, increased time in the program and longer to enter the workforce, with delays in attending to the mental health needs of the public). To offer trauma coursework as an elective fosters students' choice and empowerment, but it neither establishes it as a priority nor reaches each and every student (can a program say they are trauma-informed if they do not require a trauma course?). Although there are certificate programs focused on trauma, we believe that each

and every counseling/clinical program should include a trauma-informed lens and trauma coursework (process and content, respectively). Trauma is ubiquitous. As such, there is a need for *all* graduate trainees in counseling/clinical programs to engage in this important work rather than certificate programs offering it post hoc.

C) Licensing Bodies

At the broader level are the licensing bodies which determine content areas required for credentialing. These areas may differ depending on the state (and country) and the type of program (MA, LSW, Ph.D., Psy.D., Ed.D.). We encourage these boards to require coursework in trauma-informed practice (including information about trauma, how it resides in the body and affects the individual, as well as trauma-responsive care and a process orientation). Without such a mandate, it is left to the individual university, which may be already struggling to balance the financial and time needs of its consumers (e.g., calling for shorter graduate programming) with the ethical issue of providing such training.

In this article, we have presented the need for trauma-informed graduate training and supervision, and we have discussed several systems-level issues involved. We are left with some questions: How can we add trauma course requirements to graduate training without creating undue burdens (e.g., financial) for our students? What are we willing to give up (e.g., elective courses) or revamp (e.g., the current core curriculum) in order to make this happen? While it may be that graduate programs address this on an ideographic basis, we hope that this article inspires conversations across training sites and licensing bodies to best support our trainees and the clients they serve.

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WASHINGTON SCENE

“Please don’t take him just because you can”

Pat DeLeon, PhD

Former APA President



2018 Was A Great Year:

In March, the APA Practice Leadership Conference (PLC) celebrated its 35th anniversary with over 300 colleagues honoring Katherine Nordal during her final PLC. “During my career, I have tried to embody and facilitate this affirming, strategic collaboration between practice and other parts of our discipline, connected groups and organizations, policymakers and stakeholders. It is with gratitude and great pleasure that we bring to you this conference whose theme, Advancing Practice Together, synthesizes my past, our experience and your future. Thank you for your many contributions to professional psychology and to the patients and public we serve.” APA President Jessica Henderson Daniel and CEO Arthur Evans paid a well-deserved warm tribute to Katherine. The Congressional Honorees that year were U.S. Senator Christopher Murphy and Representative Judy Chu.

Robin McLeod, now the Inaugural Senior Director for Strategic Relations and Leadership for APA, led a discussion on Pathways to Advocacy highlighting personal stories of association membership engagement, talking about how they became personally and professionally involved in regulatory and legislative advocacy in their SPTAs and APA. Elena Eisman focused upon How Psychology Is Responding to the Opioid Crisis: State, Federal, and Professional Responses. And, Beth Rom-Rymer hosted, along with Hawaii’s Ray Folen, The Revolution

in Health Care: Prescribing Psychologists. “In 1998, Guam passed its prescriptive authority legislation. This United States territory was the first United States entity to pass legislation that would give psychologists, with specialized training, the authority to prescribe psychotropic medications.... (T)he prescriptive authority movement is moving ahead, if not with alacrity, then with steadfast progress. In 2002, New Mexico was the first state to give psychologists prescriptive authority. Louisiana became the second state in 2004. It took another ten years, but Illinois became the third state, in 2014, to give psychologists, with specialized training, prescriptive authority. Then, in quick succession, came Iowa in 2016 and Idaho in 2017. Hawaii is hoping to pass its prescriptive authority legislation in 2018 and Connecticut (among other states) is hoping to introduce prescriptive authority legislation in 2018.... However, we who have fought the battle and won, understand that each state is unique in its prescriptive parameters.... (Legislative advocacy is forever).”

Appreciating the Societal and Public Health Benefits of RxP:

Bob Ax, longtime Bureau of Prisons psychologist, and “Dr. Bob” Resnick, former APA President, appreciate how psychology obtaining RxP would significantly benefit those who have all too often been underserved or unable to obtain needed care, primarily due to their environmental or social circumstances. Most recently, they have been working within

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the Division 55 (Society of Prescribing Psychology) governance to formally urge the APA Committee on Accreditation to require a 3-credit hour course in clinical psychopharmacology and urging that the VA and federal Bureau of Prisons follow DOD's lead. This reflects an internal grassroots effort enthusiastically supported by Susan Farber, Kevin McGuinness, Kathy McNamara, Division President David Shearer, Randy Taylor, and Mike Tilus.

Taking an interprofessional perspective, they have noted that within social work education, courses exist in Social Work Practice and Psychopharmacology. From a historical frame of reference, decades ago when the NIMH first proposed support for exploring non-physician RxP educational endeavors, only social work applied for funding. Under David's leadership, Division 55 has begun awarding Honorary Fellowship to colleagues who have made an unusual and outstanding contribution to the maturing field, including Michael Smyer, who chaired the original APA ad hoc Task Force on Psychopharmacology; John Sexton, one of the first two DOD Prescribing Psychologists; and the late Floyd Jennings, who was the first authorized federal Prescribing Psychologist back in 1989, then within the Indian Health Service.

Steve Ragusea consistently points out that when those from other disciplines who oppose RxP for psychologists testify before their state legislatures, they almost never proffer objective data supporting their position and often seem to ignore or seriously downplay the difficulties that many marginalized members of society have in obtaining mental health care. During the Pennsylvania legislative session this Fall, the President of the Pennsylvania Medical Society submitted testimony for the record consistent with Steve's observation. "The House Professional Licensure Committee recently held

a public hearing on the merits of House Bill 1000, a measure that would grant prescribing privileges to psychologists. While the Pennsylvania Medical Society (PAMED) is sensitive to the challenges patients face when seeking mental health care services, we strongly disagree with the notion that allowing psychologists to prescribe psychotropic medications will have any positive impact on improving access to care and could potentially be detrimental."

"We agree that there is a shortage of all providers of mental health services.... Each of these professionals plays a role in the continuum of patient care with each having their own unique set of clinical skills. Although these individual disciplines see patients with mental health challenges, they are not universally interchangeable.... (I)t is important to remember that the connection between mental health and physical health is undeniable, with each often manifesting itself in the other.... Make no mistake, psychologists play a critical role in helping patients through a multitude of mental health challenges and are adept at recognizing when a patient may benefit from medical intervention through medication. In today's practice climate, coordinating care, where a physician and a psychologist work together to optimize mental health treatments, is very common.... This model of coordinated care, having been adopted by many healthcare systems across the Commonwealth, is having a positive impact. PAMED believes that embracing this care model, and further expanding its reach, is a far more effective approach than simply expanding the number of prescribers. In the end, what is most important is that patients receive the highest quality of care possible and that their treatment is appropriate for both their physical and mental well-being."

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Steve responds: "These are the same arguments organized medicine made more than 50 years ago when psychologists sought and obtained independent licensure and the same arguments used when psychologists sought and obtained third party reimbursement. During that half century, psychologists have proven to be premier mental health providers. And, during the last 25 years, doctors of psychology have been prescribing safely and effectively in other states as well as in the military. It's no longer a hypothetical argument, we have proven our competency as prescribers. The arguments from organized medicine are old, worn out, and spurious."

A Living Legacy: We were very pleased to learn that our longtime colleagues Alan Kraut and his wife Jane Steinberg have established a Family Fund which recently donated \$100,000 to support an Association for Psychological Science (APS) annual convention plenary session showcasing how psychological science can contribute to the public good. APS President Wendy Wood noted: "This gift will help APS highlight the many ways that psychological science contributes to human well-being and the resolution of significant problems facing individuals, communities, and organizations around the world."

The first program will be scheduled next year during the APS Annual Convention in San Francisco. It is expected to feature an invited speaker or speakers. Topics might include the use of psychological science in improving public policy, education, business, information technology, the environment, or health. The program might explore successful widespread dissemination efforts that improve public awareness of high-quality psychological science, including psychological research that has been strengthened through collaboration with scientists from other disciplines or

with members of the public to better inform the nature and methods of research questions and approaches.

For over 35 years, Jane was senior staff at the National Institute of Mental Health and the NIH National Center for Advancing Translational Sciences. And Alan, after serving at APA for nine years, during which time he hosted APA's first convention \$1,000 a plate Black Tie Fundraiser dinner and was APA's first Executive Director for Science, became the founding APS Executive Director where he served for nearly 30 years, retiring in 2016. His retirement "gig" was another six years at the helm of the Psychological Clinical Science Accreditation System (PCSAS), a system that recognizes PhD programs in clinical psychology that adhere to a Clinical Science training model.

The National Academy of Medicine (NAM): Victor Dzau, NAM President, recently reasserted NAM's commitment to reducing greenhouse gas emissions as a foundational action to ameliorate climate change and its adverse impact on human health and equity. "The National Academy of Medicine (NAM) is fully committed to the reduction of emissions of CO₂ and other greenhouse gases as the single most important step all organizations must take to slow the pace of climate change. The vast majority of CO₂ emissions stems from the combustion of fossil fuels and deforestation. The 2024-2028 NAM Strategic Plan (forthcoming in January) calls for the Academy to address climate change as an urgent, existential threat to human life, health, and well-being as a top priority. The NAM's internal organizational commitment is to reduce emissions by 50 percent by 2030 and achieve net zero emissions by 2050. Accordingly, the Academy is working with the National Academies of Sciences, Engineering,

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and Medicine, the broader organization of which it is a part, to reduce the organization’s scope 1, 2, and 3 emissions and divest from fossil fuel interests.”

“Externally, the NAM launched the Action Collaborative on Decarbonizing the U.S. Health Sector in 2021 with the goal of significantly reducing the 8.5 percent of the U.S. carbon emissions currently generated by health care institutions and the health industry’s supply chain organizations. The Action Collaborative has published a list of Key Actions to Reduce Greenhouse Gas Emissions by U.S. Hospitals and Health Systems and hosted a series of recorded Carbon Accounting 101 Clinics for health care delivery organizations. In 2024, public and private leaders of the Action Collaborative are embarking on an ambitious national effort to mobilize the entire health sector to reduce emissions. Together with the National Academies, the NAM is participating in the new Climate Crossroads initiative, which will take a powerful multidisciplinary approach to address-

ing the climate crisis. Extensive resources on decarbonization and other climate change issues are available from the National Academies....”

2023 Has Been a Very Special Year: Longtime VA psychology historian Rod Baker was pleased to announce that his colleague Walter Penk was one of seven individuals chosen to receive the Spirit of Hope Award from the Department of Defense this Fall at the Pentagon. This special recognition honors individuals and organizations whose work benefits the quality of life of Service Members and their families. A pioneer in developing the scientific foundation for the designation of PTSD, Walter is the first psychologist to be so recognized. “My happiness depends on you. And whatever you decide to do” (Jolene, Dolly Parton).

Aloha,
Pat DeLeon, former APA President – Division 29





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Want to share your exciting news with your fellow members? Four times throughout the year, the newsletter 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!

