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BULLETIN

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Evaluating the Impact of Digital CBT Lesson Completion on Clinical Outcomes

The Differences Between Borderline Personality and Complex Posttraumatic Stress Disorders

Cultural Influences and Heteronormativity on Experiences in Romantic Relationships

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Personal Psychotherapy as an Essential Self-Care Strategy

Social Justice and Public Policy

A Call to Action: Decolonizing Clinical Practice

Society for the Advancement of Psychotherapy

2024 VOLUME 59, NUMBER 1

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I was reminiscing just the other day. While having coffee all alone.

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PRESIDENT'S COLUMN

Tony Rousmaniere, PsyD
Sentio Counseling Center

Dear Members of the Society for the Advancement of Psychotherapy/APA Division 29,

Happy New Year! I am both honored and thrilled to begin my year as President of the Society for the Advancement of Psychotherapy (APA Division 29). I would first like to thank Jean Birbilis for her leadership in 2023. As we embark on this new year together, I am keenly aware of the responsibility and opportunity this role presents, and I am committed to advancing our shared goals in innovative and inclusive ways.

Over the past year I have met with many Society board members and domain representatives. One of the common threads I heard from these conversations was the importance of enhancing recruitment of new members, and in particular early-career and student members. Their fresh perspectives, energy, and insights are vital to the continued growth and relevance of our field. Thus, my primary goal for this year is to amplify our reach by raising awareness about our Society, particularly among early-career professionals and graduate students. To this end, I will be hosting a series of public events, including webinars and engaging in-person events at the APA annual conference in August. My hope is that these events will inspire people to consider becoming new members of the Society, in addition to being hubs for networking and community building.

Another cornerstone of my tenure will be to support and elevate the incredible work done by everyone who contributes to the Society. Your work is the lifeblood of Division 29, and I want to ensure that your efforts are recognized and your voices heard. I encourage everyone to reach out if there is any way I can assist you in your endeavors. Whether it's through providing resources, facilitating connections, or simply lending an ear, I am here to support you. Please don't hesitate to email me directly at trousmaniere@gmail.com.

I am excited about the possibilities that lie ahead for our Society. With your participation and support, I am confident that we can not only achieve our goals but also set new standards of excellence and innovation in our field. Let's work together to make this a landmark year for APA Division 29.

Thank you for your continued dedication and commitment. I look forward to connecting with each of you in the months ahead.

Warm regards,

Tony Rousmaniere
President

Society for the Advancement of Psychotherapy

ELECTRONIC COMMUNICATION EDITOR'S COLUMN

Zoe Ross-Nash, PsyD

When I committed to a three-year term as Website Editor in January 2023, I had no idea how much we would grow in the first twelve months. From this, I have been reflecting on my time in the Society for the Advancement of Psychotherapy.

I have had the pleasure of being a part of Division 29 since 2020, serving as the Associate Editor for three years, and now in my role of overseeing the Web team. It has been incredible to see the website move through so many transitions, especially in its ability to survive during a global pandemic.

Amy Ellis, a previous Editor, and current Publication & Communication Chair initially recommended me for the position of Associate Editor. After joining, I met Kourtney Schroeder, the Editor, and Olivia Carelli, the social media coordinator. I fondly reflect on our time together as a team during those years. Kourtney was instrumental in mentoring me through both of my positions, and Olivia always brought an amazing energy to every meeting we had. We created important representations of the division, including re-establishing the Instagram, authors soliciting our website for publication, and showcasing a multitude of brilliant topics for psychotherapists and laypersons to expand their knowledge.

After being invited to stay on board as the Web editor when Kourtney stepped down, we onboarded a new team for 2023. Sheela Joshi replaced me as Associate Editor and Yashvi Aware filled in for Olivia as social media coordinator. In our year together, we recruited a myriad of articles and even began integrating different languages into the website, allowing for more access to folks all around the world. We have expanded our outreach due to our social media efforts, as well. Thank you so much for your hard work.

In August, Amy Ellis returned to Division 29 with motivation and inspiration for change. Together, we have plans to revamp and modernize the website to make it more user-friendly and improve access to information. Additionally, we have decided to combine the website and bulletin, creating one unified publication source. We hope this change will aid in improved relationships between the publication team and authors, and improve the efficiency of the publication. This has been a large undertaking and would not be possible without the guidance and support of Amy Ellis. With this change, we have developed two new positions to accommodate the larger body of articles the team will oversee. The positions Assistant Editor of the Website, and Assistant Editor of Newsletters have been created to support the changes, which will be held by Sarah Bondy and Deanna Young, respectively in 2024. Thank you, Joanna Drinane for all your previous work as the Editor of the *Bulletin*. Additionally, my title as Web Editor has changed to Editor of Electronic Communications now that the website and the *Bulletin* are one.

Thank you Sheela Joshi, who is transitioning out of her role. Lacy Sohn will be serving the position now. Sheela's yearlong term required a handful of tasks pertinent to the website that she navi-

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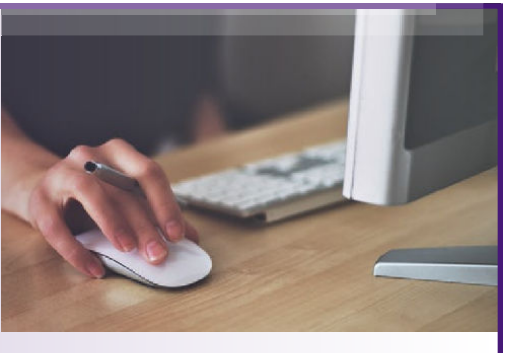
gated well. I am also looking forward to my continued work with Yashvi, our current fantastic Social Media Coordinator. With the new team coming in, I am grateful for her knowledge and passion she will bring next year. I also want to thank and dedicate my appreciation to Tracey. Her tenacity in supporting the website does not go unappreciated.

Stay tuned for an exciting year for the Society for the Advancement of Psychotherapy. We are looking forward to reading your submissions.

Society for the Advancement of Psychotherapy

Society for the Advancement of Psychotherapy



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FEATURE

The Role of Humility in Treating Suicidal Patients

Samuel Knapp, EdD

Seasoned psychotherapists have all had the experience of sitting in a room with patients who have serious thoughts of killing themselves. Some may have already had a suicide attempt or multiple attempts and continue to have access to the means to kill themselves. They may feel like others would be better off if they were dead, feel a sense of entrapment, or a belief that their emotional pain is unbearable and will never end.

Compassionate and trained healthcare professionals will immediately desire to alleviate their patient's pain. Well-trained psychotherapists will give their patients a chance to tell their stories and try to establish meaningful connections with them. Part of the treatment may be to give their patients hope that their emotional pain will end by conveying a sense of confidence in their ability to help.

Fortunately, outcome studies have identified several treatments with proven effectiveness in reducing suicide attempts (such as cognitive-behavior therapy, the collaborative assessment and management of suicide, and dialectical behavior therapy), and other interventions show promising evidence for their effectiveness as well (Calati et al., 2016). Collaboratively developed safety plans (Nuij et al., 2020) can reduce suicide attempts, and lethal means counseling can increase the safe storage of firearms (Anestis et al., 2021). Also, evidence suggests that medications can reduce suicide attempts in patients with bipolar disorders (although their effectiveness in reducing suicide attempts with other disorders is less certain; Maris, 2019).

Despite these advances, some patients will attempt suicide, and a few will die from suicide even while in treatment. Leitzel and Knapp (2020) found that 29% of psychologists had a patient attempt suicide while in treatment in the last year, and 6% had a patient die from suicide while in treatment in the previous year. One can assume that some of these deaths occurred while patients were being treated by highly competent psychotherapists using state-of-the-art interventions delivered with compassion and skill.

Suicide is a mighty foe. Psychologists and treatment providers should never underestimate its power and should be cautious about our ability to prevent suicides. Despite the advances made in the study of suicide, there is much that we do not know about suicide, except that it could follow many different pathways and involve the complex interaction of many circumstantial, genetic, and psychological factors.

Even if we did know how to prevent suicides, we cannot always identify who has suicidal thoughts or how severe those thoughts may be. Psychotherapists rely primarily on what patients tell them about their lives, but patients often withhold information or minimize the extent of their suicidal thoughts (Knapp, 2022). Family members or close friends may provide important information. Still, they are often unaware of their loved one's innermost thoughts or can only report information through their perspectives, which have limitations. Psychometric screening instruments, such as the Columbia Suicide Rating Scale or the Ask

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Suicide Screening Questions (AsQ), have a role in assessing suicidal patients. However, all have high rates of false positives or false negatives and can only supplement, not replace, the psychotherapists' judgment (Runeson et al., 2017).

All effective interventions with suicidal patients have some limitations as well. Although they can significantly reduce the risk of a suicide attempt, they cannot prevent all attempts. For example, cognitive behavior therapy shows it is one of the most effective and well-researched treatments for preventing suicides. Nonetheless, some patients receiving cognitive behavior suicide from competent providers will still attempt suicide (Rudd et al., 2015).

Furthermore, every psychotherapist has limitations, and no one can be equally proficient in all areas of practice. For example, Kraus et al. (2011) evaluated the performances of psychotherapists across 12 domains of problems and concluded that effectiveness as a psychotherapist was not a global construct. Instead, a psychotherapist could be proficient in one practice area but lack proficiency in another. Those who were effective in treating anxious patients, for example, might not be equally effective in treating suicidal patients.

Even psychotherapists who are proficient in treating suicidal patients need to ensure that their skills do not degrade over time. The knowledge base for psychology is constantly changing. Neimeyer et al. (2014) estimated that it takes about nine years for half of the knowledge base of a psychologist to become obsolete. However, the length of time could become shorter in the future and could vary according to specialty. Probably nowhere is this truer than in the study of suicide, where research has expanded rapidly in recent years.

Finally, all psychotherapists are susceptible to thinking errors or may have implicit biases outside their immediate awareness that could limit their effectiveness. They may engage in confirmation bias, sunk-cost bias, the availability heuristic, or other cognitive shortcuts that could lead to inaccurate interpretations of information. They may, despite good intentions, show implicit biases against persons of different ethnic, linguistic, or cultural backgrounds or those who do not conform to their preferred notions of sexual or gendered behavior.

Effective Psychotherapists Show Humility

An acceptance of the limitations of our ability to prevent suicides does not mean that we should just throw up our hands in despair. Paradoxically, psychotherapists can enhance their effectiveness by recognizing their limitations and adopting an attitude of humility.

Davis et al. (2017) defined humility as "having an accurate view of oneself, particularly of one's limitations" (p. 243), and DuBois et al. (2013) added that humility involves "self-knowledge and an openness to the perspectives of others" (p. 925). It seems likely that seeing oneself and one's capabilities accurately, knowing one's limitations, and being open to other perspectives should help psychotherapists deliver a higher quality of service.

Humility is implicit in the title of an article by Nissen-Lie et al. (2015): "Love yourself as a person, doubt yourself as a therapist" (p. 48). The title implies that psychotherapists should engage in a non-judgmental evaluation of their skills, recognizing that they may have limitations and motivating them to seek feedback or the perspectives of others to improve their performance.

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Galef (2021) described the importance of humility by using the metaphor of scouts and soldiers. Scouts question the accuracy of their information and continually strive to make their "maps" more accurate. Soldiers, on the other hand, adopt strategies to reach their goals and conscientiously pursue them. Scouting psychotherapists will solicit new information, question the information that they have, and change their interpretations as new evidence arises. Soldiering psychotherapists prioritize adherence to a treatment plan, even at the risk of minimizing or ignoring disconfirming evidence. No effective psychotherapist always has a complete scout or soldier mindset, and effective psychotherapists probably have a mixture of both. But problems can occur if psychotherapists fail to incorporate the scout mindset into their decision-making. Scouting psychotherapists will acknowledge their limitations, continually solicit patient information, and keep their optimism grounded in reality.

Acknowledge Limitations

Patients also benefit when psychotherapists ask questions or solicit information about them, including their cultural background and how it may influence their life circumstances. Part of working effectively with cultural minorities is to adopt an attitude of cultural humility, wherein, among other things, psychotherapists welcome their role as a learner.

Effective psychotherapists welcome feedback from patients and others as a way to continually self-monitor and improve. Getting routine, standardized feedback from patients appears to improve outcomes (McAleavey et al., 2019), and psychotherapists may even benefit by routinely asking patients about their experiences in sessions, such as whether they got to talk about things that were important to them (Sparks & Duncan, 2019).

Accept the Patients as Experts

Effective psychotherapists consider patients to be the co-creators of the psychotherapeutic experience. Often, psychotherapists will use a narrative approach to assessment, giving patients the time to tell their stories at a comfortable pace (Bryan & Rudd, 2018). These psychotherapists seldom interrupt their patients and prioritize open-ended questions during the process. The underlying belief is that the patient is "the expert in his or her own experience" (Michel, 2011, p. 6). Patients often feel great relief when their psychotherapists stop trying to be the expert on everything and allow them to tell their own stories in their own words. Patient contributions are also seen as essential to effective treatments. Jobes (2023) tells his patients that the answers to their problems are within them. They and their psychotherapists will collaborate as partners in treatment to help them identify solutions and create lives worth living.

Recognize Our Skills and Ability to Help

Humility means an accurate understanding of oneself; it does not mean debasing one's skills unnecessarily. Well-trained psychotherapists using evidence-informed treatments should have confidence that they can save lives and improve patient well-being. Therefore, psychotherapists can give hope to their suicidal patients by accurately reviewing the outcome data on how these treatments may help them. As Jobes wrote, "while we can never guarantee a nonfatal outcome, we can nevertheless provide the *best possible clinical care* to every patient, including those with suicidal thoughts (2023, p. 60, italics in original). This brief quotation has substantial implications for psychotherapists. It accepts the limits of our power:

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we cannot prevent a suicide attempt; only our patients can do that. Yet it promises that we have much to offer our patients by delivering high-quality services resulting from years of study, supervised practice, and a mindful concern for our patients.

Summary

The ever-present risk of a patient's suicide forces psychotherapists to accept their role with humility, recognizing that even the most effective and conscientious psychotherapists cannot guarantee that they can save the lives of every patient. Nonetheless, effective psychotherapists can turn the recognition of their limitations into helpful strategies by

- Continually seeking feedback from patients on their progress and their experiences in psychotherapy and
- Recognizing patients as the experts on their own experiences while nonetheless
- Valuing their contributions in providing high-quality and evidence-supported interventions and
- Knowing that they can help many suicidal patients create lives worth living.

Citation

Knapp, S. (2023, December). The role of humility in treating suicidal patients. [Web article]. Retrieved from http://www.societyforpsychotherapy.org/the-role-of-humility-in-treating-suicidal-patients

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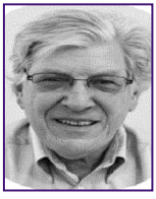
Society for the Advancement of Psychotherapy

FEATURE

Evaluating the Impact of Digital CBT Lesson Completion on Clinical Outcomes

George (Jeb) S Brown, PhD
Edward Jones, PhD



Abstract
This paper reports the latest results from a series of studies investigating predictors of outcomes for users of an online, self-guided Cognitive Behavioral Therapy (CBT) platform. Each disorder-specific module on the platform consists of lessons with educational slides that include interactive exercises. This study investigates the number of slides completed for each lesson and the associated improvement. Outcome questionnaires are completed at every lesson in the module. The results indicate minimal variability in the number of slides completed, as users generally complete a high percentage of the slides in each lesson. The resulting outcomes, reported as an effect size, were comparable to results from a large sample of adults receiving eight sessions or less of general outpatient psychotherapy.

Introduction
Research into the clinical value of behavioral health products known as Digital Therapeutics (DTx) has matured over the past decade. A series of studies into one such digital product, Learn to Live, has demonstrated generally high levels of effectiveness compared to benchmarks, along with variability in results depending on the degree of personal support received by the user and the number of homework assignments completed (Brown & Jones, 2021; Brown & Jones, 2022a; Brown & Jones, 2022b; Brown & Jones, 2022c).

In addition to referencing published research, benchmarks have been established based on a large proprietary database of individuals in general outpatient psychotherapy generated by the ACORN Collaboration. Several thousands of mental health providers over the past 15 years participated in the ACORN Collaboration by submitting patient self-report measures of outcome at every session, resulting in what is arguably the largest database on mental health outcomes available for analyses by independent researchers.

The ACORN database provides the routine outpatient real-world psychotherapy sample outcome benchmark against which the Learn to Live results are compared (Brown et al., 2015a; Brown et al., 2015b; Brown et al., 2020; Mahon et al., 2023). The benchmark for the results of well-conducted clinical trials is derived from Wampold and the comprehensive analysis by Wampold & Imel (2015).

Previous studies have documented how outcomes are favorably impacted by personal coaching (Brown & Jones, 2021), automated text message support (Brown & Jones, 2022a), and support from family and friends ("teammates") who encourage program completion (Brown & Jones, 2022b). These studies found independent benefits from each form of support.

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Having established that users improved outcomes significantly with each type of support, the next research question was how outcomes vary according to the utilization of platform resources. Learn to Live's clinical modules present therapeutic exercises based on Cognitive Behavioral Therapy (CBT) for specific disorders. Completion rates for "homework" or practice exercises were studied, and higher levels of completion were associated with better outcomes (Brown & Jones, 2022c). The current study expands on how engagement in therapeutic work—or using platform resources—impacts clinical outcomes.

This study evaluates how outcomes vary by the extent to which each lesson in a clinical module is completed. Lessons are broken down into interactive screens or "slides," each consisting of over 20. Slide completion measures the degree to which the user completed each lesson. The first hypothesis is that there is significant variation among users in the average number of slides completed for each lesson. The second hypothesis is that outcomes improve according to the number of slides completed. Outcomes are measured by pre-post change at the last lesson completed.

Description of the sample

The sample selected from the Learn to Live database includes all users who enrolled between 12/1/2022 and 6/30/2023. In addition, users had to complete at least two lessons (and the accompanying clinical measure) in a clinical module. A minimum of two scores is needed to calculate pre-post change and the Severity-Adjusted Effect Size (SAES), which has been used in all previous articles.

A total of 2,882 users met these selection criterium criteria. Of these, 2,143 (74%) had intake scores in a clinical range, indicating a level of symptoms significantly higher than the general population. This ratio is typical of individuals seeking outpatient mental health care.

Method

Learn to Live uses three different questionnaires depending on the lesson modules: depression (PHQ-9; Kroenke et al., 2001), social anxiety (SPIN-17; Conner et al., 2000), and general stress and worry (GAD-7; Spitzer et al., 2006). Consistent with the methodology used in meta-analyses of multiple studies using different questionnaires, the pre-post change is reported as effect size, which in this case was calculated by dividing the pre-post change by the standard deviations of the questionnaires.

The current study includes a new statistic. A general linear model calculates a residual slide completion score at each session. This statistical method estimates how much each user's number of completed slides differs from the average at each lesson, thus enabling testing of the hypothesis that greater than average slide completion is associated with greater clinical change.

Results

The average effect size for the entire sample is .59, with users completing an average of 3.7 lessons comprising over 80 slides. However, these aggregate numbers only tell part of the story of how utilization and outcome vary. Users completing five or more lessons showed much more change, with an average .98 effect size. The benchmark from well-conducted clinical trials is an effect size of .8, comparable to results in the ACORN database for therapy clients completing five to eight sessions. Furthermore, while 27% of the users completed at least five lessons in the Learn to Live sample, an identical percentage

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of ACORN clients completed this number of sessions.

Table 1 provides the results for users in the Learn to Live sample. By comparison, Table 2 summarizes results for psychotherapy patients in the ACORN database. These results are broken down by completion levels and range from two to eight lessons or sessions.

Table 1: Learn to Live sample

Last lesson completed	2	3	4	5	6	7	8
N	984	339	225	154	81	31	329
% of all users	46%	16%	10%	7%	4%	1%	15%
Effect size	0.35	.51	.73	.87	.90	1.27	1.02
Total slides completed	44.00	65.21	82.10	102.08	117.54	145.71	166.24

By way of comparison, table 2 provides results of patients in the ACORN database ending therapy after completing two to eight sessions.

Table 2: ACORN database comparison sample

Last session completed	2	3	4	5	6	7	8
N	44709	26043	17125	13096	8768	6721	5289
% of Sample	37%	22%	14%	10%	7%	6%	4%
Effect Size	.58	.76	.93	0.89	.94	.94	.97

The Learn to Live slide completion analysis suggests that users completed slightly fewer slides as they worked through the modules and completed more lessons. The average number of completed slides per session was over 22 during lessons two and three. However, this fell to an average of 20 for all subsequent final lessons—a relatively minor decrease.

The research hypothesis was that users completing more slides per session would have better outcomes. However, this hypothesis must be rejected because there was no meaningful association between the number of slides completed and the outcome. The reason for this is telling—contrary to assumptions, the variability in the number of slides completed was insufficient to have predictive power.

Learn to Live users tended to complete virtually all slides in each lesson. This uniform diligence was unexpected. It may indicate that the interactive experience of working through these digital lessons is compelling, but of course, additional study is needed to understand this finding.

Discussion and implications for quality improvement

This study rejects the hypothesis that slide completion per lesson is associated with outcome and the assumption behind this hypothesis. It was assumed there would be enough variance in slide completion to enable correlational analyses. Without this variability, the power of statistical modeling is severely limited. The goal was to supplement and add to previous Learn to Live analyses regarding the impact of resource utilization on clinical outcomes. However,

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this study suggests that there may be something unique about using digital resources needing further exploration.

This study's finding is encouraging. Users find the slides useful throughout the lessons of a clinical module, and they tend to complete a high percentage of slides with each lesson. This finding's implications relate to two fundamental issues for digital therapeutics products: enrollment and engagement.

DTx companies focus on increasing enrollment and engagement rates using the platform once enrolled. If the findings here are corroborated with further study, the more critical goal is enrollment. The challenge of increasing enrollment is more manageable than that of engagement. The reason for this is simple. Because most digital health users complete the clinical modules without external support or encouragement, the resources must be inherently engaging so that people complete the lessons on their own. This is an essential dimension of the digital experience to understand.

Citation

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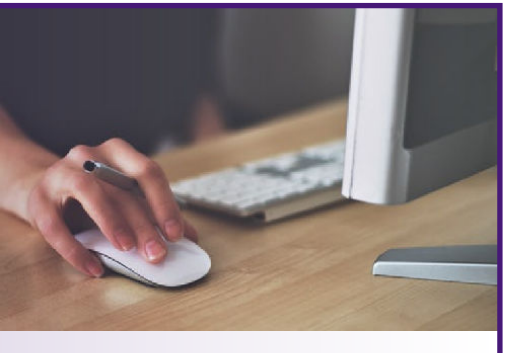

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FEATURE

The Differences Between Borderline Personality and Complex Posttraumatic Stress Disorders

Why do Borderline Personality Disorder and Complex Posttraumatic Stress Disorder Get Confused?

Simona Stoian, MS
Amy Ellis, PhD

The World Health Organization's 11th revision of the International Classification of Disease defines Complex Posttraumatic Stress Disorder (CPTSD) as meeting full criteria for PTSD plus symptoms of disturbances in self-organization. Disturbances in self-organization can best be categorized as experiencing strong emotional dysregulation, negative self-concept and poor identity formation, and interpersonal difficulties in the form of intimacy and trust. If that sounds familiar, it's because it is, and points to a long discussion in the field about the distinctiveness of CPTSD from Borderline Personality Disorder (BPD). Because BPD is also characterized by difficulties in interpersonal relationships, emotional regulation, and self-image (American Psychiatric Association, 2013), the overlap of these two disorders is quite large, making it difficult to discern the two.

CPTSD and BPD's overlap of symptoms can lead to diagnostic uncertainty. Distinguishing between these disorders, particularly in individuals with a trauma history, can aid in formulating precise client conceptualization to provide beneficial and accurate treatment (Ford & Courtois, 2014). The focus of and duration of treatment will differ and depend on the distinct symptom profiles of either CPTSD or BPD (Cloitre et al., 2014).

Although they present similarly, the etiology of CPTSD and BPD are different. Trauma is central to the diagnosis of CPTSD; however, while trauma is highly comorbid with BPD, it is not a requirement of the diagnosis (Ford & Courtois, 2014). The most predominant theory behind CPTSD is the role of an inadequate and invalidating family-or-origin environment which contributes to disturbances in self-organization (DSO) as the **child** fails to receive the transmission of daily skills, emotion regulation strategies, proper reflection of their sense of self, and so on. The DSO combined with the impact of the trauma(s) leads to the unique constellation of complex traumatization symptom presentation (Gold & Ellis, 2017). On the other hand, the prevailing theory of BPD is that of Marsha Linehan's biosocial theory, which suggests that BPD is a disorder of emotional dysregulation resulting from both biological vulnerabilities and environmental influences (i.e., invalidating childhood environments; 1993).

CPTSD and BPD: Self-Concept

Although both disorders are characterized by individuals exhibiting a negative self-concept, individuals with BPD have an unstable sense of self where they alternate between having a grandiose

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sense of self to quickly possessing a highly negative sense of self (Giourou et al., 2018).

In contrast, individuals with CPTSD do not fluctuate in their self-concept as it stays consistently low, marked by viewing themselves as defeated, worthless, and shameful (Ford & Courtois, 2014; Giourou et al., 2018).

CPTSD and BPD: Emotion Dysregulation

Concerning emotional dysregulation, individuals with BPD are impulsive, experience disproportionate distress in response to stressors, and have difficulty distinguishing between reality and their own beliefs (Ford & Courtois, 2014). Furthermore, individuals with BPD are more likely to utilize self-harm or suicidal behaviors to regulate their emotions in comparison to individuals with CPTSD (Powers et al., 2022).

While those with CPTSD also struggle with emotional dysregulation, it is marked by emotional numbing, inability to experience positive emotions, and problems in experiencing and recognizing emotions (Ford & Courtois, 2014).

CPTSD and BPD: Interpersonal Relationships

Individuals with BPD often exhibit a **disorganized attachment** style that fluctuates between extreme idealization to devaluation of others, fear of rejection or **abandonment**, and the experience of relationships being rapid and intense (Ford & Courtois, 2014; Giourou et al., 2018).

However, individuals with CPTSD are often detached from others, demonstrate an avoidant attachment style, and avoid having close relations with others due to their hypervigilance defense of being harmed and fear of trusting others (Cyr et al., 2022; Ford & Courtois, 2014; Giourou et al., 2018). Another important distinguishing feature is that these interpersonal experiences are stable – unlike BPD in which their interpersonal experiences are transient and alternate between extremes.

Treatment Implications: Why Diagnosis Matters?

The overlap of CPTSD and BPD's symptoms can lead to diagnostic uncertainty, inaccuracy, or limit the aptitude in which clinicians target individuals' symptomology. Dialectical Behavioral Therapy can be a useful treatment modality for both disorders, so why is differentiating between these diagnoses being emphasized? Distinguishing between CPTSD and BPD—particularly in individuals with a trauma history—can aid in formulating precise client conceptualization to provide beneficial and accurate treatment (Ford & Courtois, 2014). The focus of and duration of treatment will also differ (Cloitre et al., 2014).

For CPTSD, evidence-based treatments follow the three-phase model pioneered by Herman (1992): establish safety and stabilization (or skills acquisition for emotion regulation), trauma processing, and re-integration into a life worth living. Clinicians must utilize skill-building related to DSO to aid these individuals in developing an identity, regulating their affect, and building secure relationships—which in turn—develops resiliency and a baseline functioning so that trauma processing can begin (Gold & Ellis, 2017).

When working with individuals with BPD, constructs targeted first include life-interfering behaviors (i.e., self-injurious behaviors and suicidality), establishing a stable sense of self, and targeting an individual's fear of abandonment (Cloitre et al., 2014; Linehan, 1993). Efficacious treatment for individuals with BPD requires a focus on theEir

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alternating idealization and devaluation in their interpersonal relationships by targeting their affect dysregulation (Ford & Courtois, 2014).

Summary

CPTSD and BPD's similarities are accompanied by nuanced differences in clients' self-concepts, interpersonal difficulties, and emotional dysregulation. These differences impact clinicians' conceptualization and the course of treatment.

Citation

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FEATURE

Cultural Influences and Heteronormativity on Experiences in Romantic Relationships

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Romantic relationships are influenced by various concepts, including the dominant discourses in society, cultural norms, and heteronormativity. One's interpretation and connection to their significant other is informed by their childhood and family influences, the historical context and geographical location of their upbringing, along with the persistence of religiosity and the corresponding practices. Considering religion, heteronormativity plays an integral role in informing what the rules and regulations of a romantic relationship looks like. This in turns excludes all other expressions of gender and sexuality, subsequently reinforcing homophobia and adhering to, oftentimes, destructive messages and norms. Considering the growing numbers and outward expression of an individual's personal experiences (gender and sexuality)—cultural influences and heteronormativity is challenged and encourages the embracement of a new normal.

Romantic Relationships

Romantic Love

When thinking about relationships, love is often considered. According to Fehr and Sprecher (2019), love consists of the attitudes that predisposes an individual to think, feel and act towards another person or loved one. Other researchers have noted their own take on what it means to love, and this includes definitions surrounding the mixture of lust and friendship. Needs driven by sexual and emotional desires, including passion, exhilaration and excitement all encompass what it means to experience romantic love (Karandashev, 2015). Falling in love is said to be a universal human response and behavior, and research conducted has further expanded on this concept (Fehr & Sprecher, 2019). For instance, when university students in Canada, who recently fell in love, reported their experience—the majority described "indicators of the other person's attraction to them," for example, the other person making prolonged eye contact (Fehr & Sprecher, 2019). Readiness for the experience was also an influencing variable among these university students (Fehr & Sprecher, 2019).

Romantic love has shown impacts on the brain, where reward circuits, dopamine levels and various hormones have responded in positive ways. Schwartz and Olds (2015) article have discussed the regions of the brains that show activity in response to love. The brain's reward circuit is primitive in its association to love and has contributed to physical and emotional responses. For example, it is connected to responses such as racing hearts, sweaty palms, feelings of passion and anxiety and flushed cheeks. The amygdala, the prefrontal cortex and the hippocampus are also huge components associated with the reward neural network. These areas reinforce behaviors that induce pleasure, for example, sex (Schwartz & Olds, 2015). Falling in love

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has initiated high levels of dopamine, which serves as a function in mood and pleasure, and research has indicated that its activation helps to enhance pleasurable experiences and euphoria. Chemicals at work include oxytocin (which have roles pregnancy, nursing and attachment) and are released during sex, and heightened skin to skin contact (Schwartz & Olds, 2015).

Understanding the pleasurable effects of romantic love, if one experiences heartbreak, then the effects can be damaging. Verhallen, et. al., (2021) study focused on experiences in a relationship breakup is associated with working memory alterations and whether it relates to the severity of depressive symptoms. The findings highlighted that a breakup can be accompanied by working memory alterations (work-load dependent; Verhallen, et. al., 2021). Other areas in the brain which have shown increased activity and alterations are the cerebellum, anterior temporal cortex, anterior temporal cortex, and prefrontal cortex, after researchers explored grieving women after a romantic relationship break up (Najib, 2004).

Cultural Influences

Culture plays an integral role in understanding how people interpret love and romantic relationships. Considering this statement from Dr. Victor Karandashev (2015) "A Cultural Perspective on Love:"

"Love is a universal emotion experienced by a majority of people, in various historical eras, and in all the world's cultures, but manifests itself in different ways because culture has been found to have an impact on people's conceptions of love and the way they feel and behave in romantic relationships (p. 3)."

This notion speaks to the differences in culture and how it informs ways in which adult intimate relationships are perceived. Further exploration of factors such as individualistic cultures versus collectivistic cultures is significant in its contribution to romantic love and relationships. Historical context and proximity (geographical location) also contribute to how an individual interprets romantic connections. Another aspect is religion and how its theology has impressed upon norms in romantic relationships. Each area will be further explored in their respective subheadings.

Individualistic versus Collectivistic Cultures

Dion & Dion (1993) article highlighted the differences in individualistic cultures and collectivistic cultures, and their study aims to look at how the influence of these cultures inform love and intimacy in marriage (romantic relationships). The researchers focused on individualistic countries, that is the United States and Canada, and collectivistic countries, that is China, India, and Japan (Dion & Dion, 1993). Their findings suggested that romantic love is more likely the basis of marriages in individualistic cultures than in collectivistic cultures (Dion & Dion, 1993). The research also indicated that satisfaction within marriage is associated with intimacy in marriage and this was often noticed in individualistic cultures. Some implications in the study focused on deciphering the rationality of love (Dion & Dion, 1993).

Considering the impacts of love and romantic relationships on the brain discussed previously, Dion & Dion's (1993) study may support these topics, along with suggesting that culture does have a major role in explaining how romantic relationships unfold. The research further discussed some implications, noting that in individualistic cultures, individuals are more likely to marry out of love—but are more likely to experience unhappiness in their marriage and

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romantic relationships (Dion & Dion, 1993). This is based on the rationale that people do not think logically when they fall in love (Dion & Dion, 1993). Meanwhile, individuals in collectivistic cultures, where individuals typically marry through arranged marriages, are more likely to be happy (Dion & Dion, 1993).

This notion of long-term marital satisfaction in arranged marriages was not supported by articles exploring this topic after the nineties. For instance, Olcay, et. al. 's (2019) article discussed how Turkish husbands and wives in arranged or self-selected marriages differed. This study reported results consistent with cultural influences that most align with individualistic cultures (Olcay et. al., 2019). That is, spouses in self-selected marriages reported more expression of love, in comparison to arranged marriages, and that wives in arranged marriages reported significant gaps in partnership than in self-selected marriages (Olcay et. al., 2019). With Turkey being a relatively collectivistic culture (Halub et. al., 2012), this information surrounding marital satisfaction challenges old norms, and begins to hold space for the development of new practices and perspectives, and further questions historical or inherited procedures.

Historical Context

The constant change in society has shifted prior definitions of love, connection, and romantic relationships, and depending on one's geographical location and the associated historical context, the definitions of love can either positively or negatively construct what it means to love. China's population, for example, has dealt with several shifts in their community and within the culture (Karandashev, 2015). Early Chinese history has evidence positive attitudes towards passion, love, and sexual desire, until Neo-Confucian's (rationalists who imposed and exercised strong influence on Chinese thoughts and perception) gained power. Attitudes toward love, romance were altered and subsequently became more repressive towards these topics. What was most important (during the ruling of the Neo-Confucians and influence of Neo-Confucianism) was procreation and there was little to no emphasis on sexual attraction between couples. There was the expectation of the women, during this time, to be faithful to their husbands, despite non-reciprocity (Karandashev, 2015).

The People's Republic of China during the late 1940s also imposed strict rules and controls on love. For instance, when the puritanical morals became firmly established within the society, this assumed denial of romantic love, and affirmed collective over individual needs—and one should place all their efforts and 'affection' towards the collective (Karandashev, 2015). Since the early 1990s, as increased influences of individualism and consumerism begin to dominate Chinese society, it is now the norm for Chinese youth to mimic beliefs and behaviors of the Western parts of the world (Blair & Madigan, 2016). Young Chinese women and men have expressed desire to date more frequently, and there has since been a progressive stance of love and romance (Blair & Madigan, 2016).

Religion

Religiosity is an important factor as it relates to an individual's understanding and interpretation of the world. Religion serves as both a protective and risk factor, depending on the population being assessed. There are several protective factors when looking into one's identity with their faith, and Petts' (2014) research have highlighted positive impacts among youth's psychological well-being in relation to family structure, parent-child relationship quality and religious atten-

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dance. Findings suggested that youths raised by married parents received greater social and financial support and were exposed to fewer disadvantages in society (Petts, 2014). The study also revealed that youth who attend religious services with parents were more likely to experience higher psychological well-being throughout adolescence. This has been said to provide and increase feelings of integration and social support. The youth's beliefs may not necessarily align with that of the practiced religious beliefs; however, there is a feeling of connectedness to their parents and the religious community, and this assists with better coping mechanisms when the youth is faced with stress (Petts, 2014).

Considering the positive effects of religion on one population (as mentioned above), on the other spectrum, there are individuals who struggle with coupling their outward expression (particularly sexual orientation) of them self with their spiritual beliefs. Youth or young people who often identify as of lesbian, gay, bisexual and transgender (LGBT+) do not have access to support within their faith communities and this impacts mental health, and contributes to interpersonal conflict (Subhi & Geelan, 2012). Researchers conducted a qualitative study of 20 participants, (including 10 males and 10 females) who identify with the Christian faith, and also identify as LGBT+, to further explore the conflict between religion and sexuality. Findings were consistent with conflict between faith and sexuality—and the negative effects that individuals experienced included depression, guilt and anxiety, suicidal ideation and alienation. The conflict is also said to increase if the individual comes from a close-knit family with strong religious backgrounds, which speaks to the influence of parent's religiosity regardless of age and life course (Subhi & Geelan, 2012).

Heteronormativity

Descriptions of how individuals operate in their respective cultures, is influenced by cultural perspectives: individualistic versus collectivistic, historical context and religion. These perspectives inform the pervasive construct known as heteronormativity. Heteronormativity is the understood as the pervasive norms of heterosexuality ("Heteronormativity," 2008). It is the default expression of sexuality and serves the gender binary (either male or female). With this norm, traditional gender roles and birth-based identity are expected, monogamy, and homophobia are reinforced and, whether overtly or subtly—race becomes a driving factor in the representation of heteronormativity. Understanding these topics will further explain how romantic relationships are influenced.

Gender Roles

Heteronormativity sets the standard for gender roles and there is the privilege for individuals who identify as heterosexual, as this is understood as the standard" and is the "natural" way of being (Kowalski & Scheitle, 2020). Considering how gender roles have affected sexual minority groups, research has shown that lesbian women and gay men are less likely to endorse traditional gender role attitudes, in the household, around their own families (private settings); however, gender roles in public settings (e.g. women in political office), it is seen where gay men opinions do not differ from the opinions of heterosexual individuals. Researchers discuss how this narrative may be influenced by the heteronormative patriarchal structure that still exists (Kowalski & Scheitle, 2020), and it imperative to understand how this may also influence romantic relationships.

Monogamy

Jacquot's (2009) description of monogamy notes "… is characterized by two adults

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sexually committed solely to one another for a prolonged period of time or for life" (p. 577). Rothschild's (2018) article discussed the examination of monogamy as a social institution, and how the concept was constructed as a part of mono-normativity. The article held Freud accountable in his early writing versus his later work, noting that Freud had considered monogamy as "an oppressive sexual norm, a neurosis for both men and women" (p. 34). Freud then retracted his statement, identifying that the modern world could not have existed without monogamy, and that social functions and culture relies on monogamy (Rothschild, 2018). The article further explored the normalization and naturalization of monogamy as the healthy and moral way of functioning and, most importantly, the only way to maintain a romantic relationship (Rothschild, 2018).

"White" Heterosexuality

Deliovksy's (2009) article discussed the desires and power of European (White) women and men engaging to establish and maintain their existence. This is seen at the reproductive level, where historically, sexuality was regulated for the reproduction of whiteness, as White people and "bodies" were needed for domination (Deliovsky, 2009). This continues to inform the norms of romantic relationships, and what the general public is exposed to. The privilege of whiteness also tends to dominate other groups, as seen in child-rearing choices of white lesbians (Ryan & Moras, 2017). These individuals would choose white donors, subsequently making choices about the race of their potential children. Though there were no overt conversations in the qualitative analysis (i.e. not explicitly saying, 'I want a white child'), there were preferences in terms of skin color, eye and hair color, and ethnicity.

Deconstructing Cultural Views and Heteronormativity

Identity and Same-Sex Relationships

In 2020, authors at the University of California's School of Law outlined the estimated number LGBT+ adults in the United States (U.S.). They found that 4.5% of the U.S. adult population identified as LGBT+, that is 11,343,000 people in total (Conron & Goldberg, 2020). The Centers for Disease Control and Prevention (2019) noted that there are 980,000 same-sex households in the United States. These households (couples) are more likely to be unmarried and have a smaller share of children, in comparison to opposite-sex couples (U.S. Census Bureau, 2021). It is also typical for same-sex couples to have both people employed. With the increase in diversity of household types, it is imperative to understand how same-sex couples navigate their romantic relationships in a predominantly white, patriarchal, and heteronormative informed society.

Establishing New Norms in Romantic Relationships

Lamont's (2017) discusses how queer relationships (LGBTQ+ identified couples) have challenged the notions and norms of conventional relationship practices. The research focused on how these individuals navigate culturally dominant gendered dating and courtship practices (Lamont, 2017). The findings noted that queer individuals actively rejected heterosexual norms and worked to create new norms and egalitarian ways of establishing their own romantic relationships. It was important for the respondents to acknowledge flexibility and non-gendered care work in their committed relationships, and essentially setting and asserting the tone in their own lives (Lamont, 2017).

Another study focused on the demo-

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graphic characteristics (gender identity, gender expression and sexuality) of individuals who are willing to, or have considered to, date transgender individuals (Blair & Hoskin, 2019). These demographics included cisgender men, cisgender women, trans men, trans women and gender queer individuals. Cisgender refers to an individual's gender identity matching their assigned sex at birth; transgender refers to one's gender identity and expression not aligning with their assigned sex at birth, and; gender queer explains individuals who do not conform to gender distinctions (Blair & Hoskin, 2019). Researchers found across the sample that, mostly heterosexual men and women, indicated no consideration to date trans people, and that individuals identifying as bisexual, queer, trans or non-binary were most likely to date a trans person (Blair & Hoskin, 2019). This reiterates the community creating their own narratives of romantic relationships despite majority ruling.

Though there is research acknowledging the onset of deconstructing hetero-norms, two-spiritedness has historically held space in the Native American community as a respected and traditional identity. Through disruptions for power and conquest, these communities were oppressed and eventually 'eradicated.' Two-spirit people in Native American communities celebrated people, whether male, female or intersex ("Two-Spirit," 2015). Within these communities, employed and specialized work roles did not discriminate by gender—for instance, men and women would work as healers, which is considered a male role, and females could also participate in hunting and warfare, eventually becoming leaders or chiefs ("Two-Spirit," 2015). Considering romantic relationships, two-spirit people formed sexual and emotional relationships with non-two-spirit individuals. Love was associated with luck in these communities and one's ability to bestow luck onto others.

Complexities in Other Communities

Heteronormativity has raised complexities in other communities and their own romantic relationships. Leiser's (2018) article highlighted the impacts of the media on the perceptions of the bondage and discipline, dominance and submission, sadism and masochism (BDSM) and kink communities. Due to (often not accurately depicted) popularization, there is an influx in the BDSM community that has shifted the dynamic of this once queer-influenced space. These inaccurate descriptions of sexual practices are problematic, as it demonstrates harmful ways of operating in the community, and perpetuates discriminatory actions against individuals who actively and intently express themselves in these communities. With the 'normalization' of incorrect and harmful sexual practices, it in turn causes additional stigma to the queer and leather communities and their perceptions on relationships (Leiser, 2018).

Non-monogamous romantic relationships are also impacted as they are often not considered in conversations outside of the hetero-norms. Ling, et. al. (2022) article discussed non-monogamy as a consensual relationship "characterized by the understanding that one or more individuals in a romantic relationship may also have other sexual and/or romantic partners" (p. 1075-1076). With this, non-monogamous relationships do not benefit from opportunities that are afforded to monogamous partners. For instance, marriage is limited to monogamous relationships, and "plural" marriages are prohibited and often still criminalized (in the United States; Ling, et. al., 2022).

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Conclusion

Cultural influences and heteronormativity have influenced many nations and have subsequently influenced romantic relationships. Considering how people interpret love based on the individualism and or collectivism of their culture, their historical context and their own religion and relationship with a Higher Power, speaks to the diverse nature of how romantic relationships are interpreted and understood. On the quest for power, it is understood how heteronormativity was used as a catalyst for segregating other communities, and still informs some of the ways in which the world operates today. It is important to understand the positive impacts of love on the brain. Different communities have begun their own work to reclaim their communities, identities and (traditional) norms. This then creates a sense of unity and belongingness within these communities, and especially in their romantic relationships, as opposed to feelings of restrictions due to conforming to what is considered 'normalcy.'

Citation

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Society for the Advancement of Psychotherapy

FEATURE

The Historical Mental Health Effects of Viral Infections: Implications for COVID-19

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Coronavirus disease 2019 (COVID-19) and the response efforts created an omnipresent effect of COVID-19 to individuals in the United States and globally in 2020. This literature review was written in 2021, one year after the outbreak, and recent studies have reported that the COVID-19 pandemic was an event that elicited behavioral, emotional, and psychological turmoil and can be considered as a traumatic event (Ettman et al., 2020). Individuals living through community-wide disasters, such as viral infections, have an immediate risk to their mental and physical health as well as their social relationships (Norris et al., 2002). Therefore, one's mental health is sensitive to traumatic events as well as the social and economic consequences (Ettman et al., 2020). This literature review will examine the behavioral, emotional, and psychological turmoil such as increased anxiety, depression, substance use, posttraumatic stress symptoms and how it has been connected to previous viral illnesses and the implications from the COVID-19 pandemic.

Viral Infections

Viral infections and their mental health effects have been well documented as early as the 20th century. In the 20th century, there have been three major viral outbreaks: 'Spanish flu' in 1918, 'Asian flu' in 1957, and 'Hong Kong flu' in 1968 (Douglas et al., 2009). The 'Spanish flu,' a H1N1 virus, is a noteworthy virus of the 20th century. The 'Spanish flu' spread was catastrophic as it spread across the globe resulting in 500 million individuals becoming infected and approximately 50 million deaths. However, the purpose of the literature review will examine more recent, well documented, and studied viral outbreaks.

A more recent viral infection, COVID-19, stemmed from the Corona Virus family in late 2019. COVID-19 was first reported in the Wuhan, China; shortly thereafter, on January 7, 2020, the novel Corona Virus was genetically sequenced and found to be linked to the respiratory disease (World Health Organization, 2020)

Implications of COVID-19

The COVID-19 outbreak in 2020 caused many countries around the globe to initiate health response efforts to decrease the transmission of the virus which effected individuals' physical and mental health. The response efforts vary in their swiftness to initiate precautionary health measures for their citizens which included banning travel, avoiding mass gathering, and even banning or limiting the amount of outdoor exercise (Frank & Grady, 2020). In the United States, 42 states were placed in a stay-at-home or shelter-in-place advisories which affected approximately 316 million individuals or 96% of the population. Due to these advisories, individuals have experienced disruption to their daily routine, physical and social isolation, food insecurity, and unemployment and financial stress (Ettman et al., 2020). Individuals also experienced disruption in social engagement such as avoiding crowded places and limiting their use of public transportation to reduce transmission of

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the virus (Usher et al., 2020). The viral symptoms created unique global challenges due to the increase susceptibility compared to other viral infections and their high mortality rate (World Health Organization, 2018). In response to the rapid and lethal spread of the virus, many countries created policies to enter into a "lockdown" to prevent the COVID-19 spread (Frank & Grady, 2020).

Quarantine vs Isolation

It is important to note that the individuals experiencing COVID-19 cannot be accurately described as undergoing quarantine or isolation because of the unyielding nature of the virus and the various response to the virus on a national level. Social isolation, whether quarantine or isolation, creates a negative, unpleasant experience. The unpleasant experience of social isolation is often exacerbated if they are diagnosed with a contagious disease (Brooks et al., 2020). Individuals are separated from their families and loved ones while experiencing a loss of freedom as well as an uncertainty of the duration of their current state (Brooks et al., 2020). The negative effects may also include post-traumatic stress symptoms, stress, boredom, fear, frustration, inadequacy, and financial loss (Esterwood & Saeed, 2020). Children during quarantine and isolation reported experiencing isolation, social exclusion, and fear from other children due to school closures, and disruption to their daily routine (Esterwood & Saeed, 2020).

Viral Illnesses Impacting Diversity Issues

Viral illnesses and their effects on mental health are not evenly distributed across the population. Individuals who have lower incomes and less accumulated wealth are more likely to experience mental illness; particularly, those who are unemployed and experiencing financial hardship (Ettman et al., 2020). Historically, racial and ethnic minorities experience a disproportionate burden of death and illness during public health emergencies such as the 2009 H1N1 virus and the Zika virus (Center for Disease Control and Prevention, 2021). COVID-19, among other viral infections, negatively affect vulnerable groups like racial and ethnic minorities but also younger adults, health care workers, caregivers or caretakers, as well as those individuals' receiving treatment for a pre-existing psychiatric condition (Stephenson, 2021). According to the CDC, approximately 75% of individuals between 18 to 24 and 50% of individuals between the ages of 25 to 44 reported at least one mental or behavioral health symptom due to COVID-19 (Stephenson, 2021). In regard to racial groups being affected by viral infections, 52% of Hispanics reported they were negatively impacted by COVID-19 (Stephenson, 2021). Additionally, 21% of Hispanic and 19% of Black individuals had seriously considered suicide within the past 30 days (Stephenson, 2021). Although the rates for mental health issues do not significantly differ among the general population, there are ethnic and racial disparities for mental health services that result in Black and Hispanic individuals having decreased access to mental health and substance use treatment (Double Jeopardy, n.d). Some racial and ethnic minorities live in densely populated areas such as low income areas, public housing, or multigenerational homes making it more difficult to social distance or self-isolate (Double Jeopardy, n.d). Also, social racial and ethnic disparities create inadequate assess to clean water and plumbing, as well as jobs that do not offer the paid time off or the option to work from home (Center for Disease Control and Prevention, 2021). These factors contribute the inability to comply with the

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COVID-19 mandates to help reduce the risk of spreading the transmission of the virus (Center for Disease Control and Prevention, 2021).

The decreased access to mental health services compounded with the additional stressors of COVID-19 results in racial minorities, Black and Hispanics, to have at higher vulnerability of experiencing mental health issues such as anxiety and mood disorders due to COVID-19 (Double Jeopardy, n.d). The higher vulnerability experienced by racial and ethnic minorities affects their ability to anticipate, confront, repair and recover from the effects from a viral illness (Center for Disease Control and Prevention, 2021).

Overview of Anxiety and Mood Disorders

Anxiety and mood disorders are common mental health conditions in the general population around the world (Coughlin, 2012). Mood disorders are expected to be the second leading cause of global disease by 2030 (Okusaga et al., 2011). Anxiety and mood disorders is a broad category that encompasses Generalized Anxiety Disorder (GAD), Post-Traumatic Stress Disorder (PTSD), Acute Anxiety Disorder, Panic Disorder, Major Depressive Disorder (MDD), Bipolar Disorder, and other mood disorders (Coughlin, 2012). The scope of the literature review will also include suicide to understand the severity and toll one's mental illness imposes on an individual. Also, the risk of attempting suicide is significantly higher in individuals with a mood disorder diagnosis (Okusage et al., 2011).

Anxiety and Response to Viral Infections

Anxiety, also with other associated behaviors and emotions, was a commonly seen diagnosis in reaction to previous pandemics. Individuals in England, Scotland, and Wales engaged in significant behavioral changes as a precautionary measure after the H1N1 Swine flu (Rubin et al., 2009). The significant behavioral changes included increased hand washing and surface cleaning in over 38% of the individuals in the study (Rubin et al., 2009). In 5% of individuals, there was avoidance behavior such as avoiding large crowds or using public transportation (Rubin et al., 2009). The changes in the behavior was correlated with high levels of anxiety in the individuals becoming infected with the virus (Rubin et al., 2009).

Jeong et al. (2016)'s study examined individuals that were isolated for two weeks because they had been in contact with patients infected with MERS. Jeong et al. (2016)'s study examined the prevalence of anxiety symptoms, as well as anger, from being infected with MERS during the isolation period and four to six months after the isolation period. The results indicated 47% of individuals experienced anxiety symptoms during the isolation period and 19.4% of the individuals continued to experience anxiety four to six months after the isolation (Jeong et al., 2016). An additional study examined 1700 individuals in 2105 during the MERS Korean outbreak (Sergeant et al., 2020). Individuals with a pre-morbid mental health disorder had an increase in the likelihood of developing persistent anxiety post exposure (Sergeant et al., 2020). This study indicated the lasting effects of anxiety and how it can be experienced after one is infected with a viral illness.

Aside from an increased prevalence of anxiety in individuals infected with a virus, care takers also experience similar psychological outcomes. Care takers, also frequently referred to as caregivers, are defined as individuals that are a family member or friend, healthcare worker, or a nontraditional healer who is treating the

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sick (Van Bortel et al., 2016). Elizarrarás-Rivas et al. (2010)'s study examined the psychological response of family members of patients hospitalized for H1N1 in Mexico. The majority of family members in the study reported sub-threshold levels of stress and depression however, the levels of anxiety were much higher. Approximately 75% of family members reported levels of anxiety and 15% reported high levels of anxiety for their family member that was infected with H1N1 virus (Elizarrarás-Rivas et al., 2010). Elizarrarás-Rivas et al. (2010)'s results also determined that older age, higher level of education, and the female gender were variables that are more strongly associated with higher reports of anxiety (Elizarrarás-Rivas et al., 2010).

Anxiety was also seen in caretakers during the Ebola Virus. During the Ebola Virus, care takers began to feel significant fear, anxiety, as well as helplessness that they may be exposed to the virus and succumb to their own death (Van Bortel et al., 2016). Additionally, care takers began experiencing the psychological effects such as anxiety, frustration, and grief in their responsibilities to care of the individual, particularly if the individual was a family member (Van Bortel et al., 2016). The caretakers' frustration stemmed from the guilt of being unable to look after or save their patients (Van Bortel et al., 2016). The frustration and guilt was coupled with working long hours, overwhelmed with caring for multiple individuals, limited safety equipment, and the high mortality rate of the Ebola Virus (Van Bortel et al., 2016). The increased level of anxiety effected not only care takers on an individual level but also on a community level. At a community level, there are psychological consequences such as disruption and uncertainty of the future as the community members shift into new roles that were previously occupied of those who had passed away.

Depression and Response to Viral Infections

Depression was another commonly seen diagnosis in previous viral infections as an implication for one's mental health. Park et al. (2020)'s study conducted a 12 month investigation of long term mental health outcomes of related risk factors in individuals that were exposed to MERS in Korea. PTSD and Depression were the main outcomes measured the Park et al. (2020)'s study. Park et al. (2020)'s study found in the post-infection phase with MERS, individuals reported a 27% depression rate after 12 months This rate of depression was more comparable than individuals infected with SARS in Hong Kong with a depression diagnosis rate of 13.3% (Mak et al., 2010).

Bah et al. (2020)'s study examined the prevalence and predictive factors of anxiety, depression, and PTSD among individuals that have been infected with the Ebola Virus. Bah et al. (2020)'s results concluded close to half of the individuals that were infected with the virus showed the possibility of meeting the criteria for depression. This is consistent with other studies that examined individuals in Sierra Leone and found a 35% rate of depression four months after receiving care of the Ebola Virus (Bah et al., 2020). The literature also supports Keita et al. (2017) results that examined long term depression rates in individuals infected with the Ebola Virus. Keita et al. (2017) concluded individuals that were infected with Ebola Virus in Guinea, for a period of around 8 months, had a 15% rate of presenting with depressive symptoms. Furthermore, the depressive symptoms created negative consequences such as individuals having difficulty reintegrating in society (Keita et al., 2017). Previous literature has also indicated that females have higher rates of

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depression than males (Keita et al., 2017). However, the depressive symptoms identified in the individuals did not appear to present a particular pattern or how an individual responded to the treatment in this study (Keita et al., 2017).

Post-Traumatic Stress Disorder and Response to Viral Infections

Wu et al. (2008)'s study examined 549 hospital employees from a hospital in Beijing during the 2003 SARS outbreak. The initially study sought to examine the alcohol abuse and dependence symptoms among the hospital employees that had been exposed to the SARS outbreak (Wu et al., 2008). However, the study also assessed the participants exposure to the outbreak, symptoms of post-traumatic stress and depression. Wu et al. (2008) found that post-traumatic symptoms were significantly associated with hospital employees that have been exposed to the SARS outbreak and were associated with alcohol abuse/dependence symptoms 3 years after the outbreak. Therefore, the SARS outbreak indirectly impacted the hospital employees drinking behavior but also created post-traumatic stress symptoms. Wu et al. (2008) results indicated that additional health conditions and risk factors can manifest creating complexity in a psychiatric diagnosis. For hospital employees in China, the effect of being quarantined in a hospital due to SARS was seen as a predictor for post-stress symptoms even up to three years after being exposed to the virus (Brooks et al., 2020).

Wu et al. (2008)'s results was consistent with Mak et al. (2010)'s study conducted in Hong Kong. Mak et al. (2010) results indicated that 47.8%, almost half, of the participants in the study that had contracted SARS had experienced PTSD. Also, 25.6% of the participants continued to experience PTSD after 30 months post-exposure. As previously mentioned, Park et al. (2020)'s study examined the MERS outbreak in 2015 in Korea. The prevalence of PTSD in the participants 12 months after being infected with MERS was 42.9% (Park et al., 2020). The increased rate of PTSD was also seen with a decrease quality of life with the individuals. The PTSD prevalence was documented as comparable to 41.7% of individuals developed PTSD after being exposed to SARS in a hospital in Singapore (Park et al., 2020). The individuals that contracted SARS had a higher rate of PTSD than patients with Human Immunodeficiency Virus (HIV), individuals in an intensive care unit, or individuals that were in a human made disaster that were diagnosed with PTSD (Park et al. 2020). Park et al. (2020) attributed that high anxiety levels, the stigma of receiving the virus, and having a family member pass away from MERS were predictors for the diagnosis of PTSD. However, Park et al. (2020) noted that the individuals that were diagnosed with PTSD had a higher score for negative coping strategies as well compared to individuals that were not diagnosed with PTSD. The feeling of anger arising in individuals who were have experienced trauma, such as a viral outbreak, is an important factor in the development of PTSD (Jeong et al., 2016). This suggests that useful coping strategies may be helpful and should be included in the treatment intervention.

Implications for the Current Pandemic

The current literature results are consistent with the new studies on COVID-19 and mental health. The mental health impact of viral infections is compounded with stressors such as lack of finances and stigma of receiving the virus (Ettman et al., 2020). An overview of the results in China involving mental health and COVID-19 have found students and gender as significant factors

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for experiencing negative health effects from the pandemic. Similarly, the initial studies conducted in America found factors involving gender, income, education experienced high levels of stress, anxiety, and depression from the pandemic. Additionally, initial studies conducted in America found health care workers face a higher risk of developing PTSD and suicidal ideations during COVID-19.

Conclusion

The increased prevalence of mental and behavioral health conditions associated with COVID-19 highlights the impact of the pandemic and the treatment of these conditions. The pandemic requires communication and collaboration from a multidisciplinary mental health care approach to adequately manage the increase in psychological disorders and the psychological impact from COVID-19 (Esterwood & Saeed, 2020). The multidisciplinary mental health care approach in the United States, and other countries, provides the opportunity, such as community base interventions and telepyshcology, for supportive care and prevention focused interventions from evidenced based treatments (Esterwood & Saeed, 2020). This will also allow individuals to bridge the connection of mental health services for racial and ethnical minorities or community areas with limited mental health services (Double jeopardy, n.d.). Alas, it can be concluded that viral infections, along with COVID-19, affect the mental health in individuals and their communities. Therefore, it is imperative to provide individuals and certain population groups that may be more high risk of experiencing mental health related disorder with the appropriate psychological interventions and strategies. The appropriate interventions and strategies can help ensure the perseveration of the general population mental health for COVID-19 and the next viral infection.

Citation

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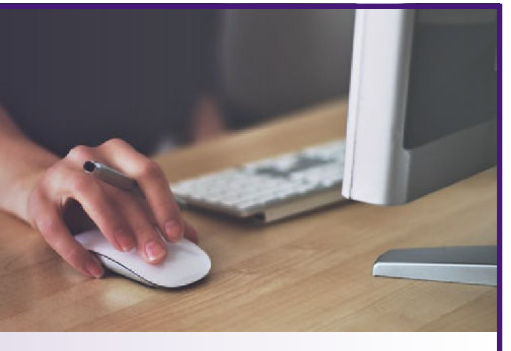

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ETHICS

Personal Psychotherapy as an Essential Self-Care Strategy

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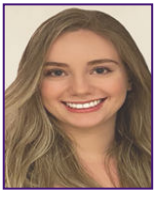

Numerous authors have emphasized the importance of the ongoing practice of self-care for psychotherapists (e.g. Baker, 2003; Barnett et al., 2007; Norcross & VandenBos, 2018; Wise & Reuman, 2019). Support for this focus on self-care by all psychotherapists is found in the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (Ethics Code, APA, 2017), first in the aspirational General Principle A: Beneficence and Nonmaleficence which guides psychologists to "be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work" and then in the enforceable Ethical Standard 2: Competence. Standard 2.06: Personal Problems and Conflicts requires psychologists to monitor their functioning and effectiveness, and to "refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner." Additionally, "When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties." The goal of Standard 2.06 is to ensure that limitations in one's professional functioning that result from personal problems and conflicts do not lead to harm to one's clients.

Self-Care, Ethics, and Psychotherapist Competence

While the practice and profession of psychotherapy can be greatly rewarding, it may also be stressful, demanding, and both physically and emotionally exhausting for the psychotherapist. As Barnett and Homany (2022) describe, work-related issues, demands, and challenges as well as stressors in the psychotherapist's personal life, and personality characteristics and blind spots for the psychotherapist can each contribute to the development of problems with professional competence. Work as a psychotherapist may lead to the development of burnout and vicarious traumatization, and psychotherapists can experience mental health disorders just as all individuals may. While the graduate education and training each psychotherapist receives provide an important foundation for their clinical competence through the acquisition and development of essential knowledge and skills, it in no way immunizes psychotherapists against the ill effects of any of these stressors, demands, challenges, and difficulties. In fact, the challenges and stressors associated with being a psychotherapist along with predispositions psychotherapists bring to this role may actually increase the likelihood of these difficulties developing (O'Connor, 2001).

A direct connection between self-care and the maintenance of one's clinical competence and effectiveness has been

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widely acknowledged (e.g., Wise et al., 2012). The effects of burnout and vicarious traumatization can negatively impact the psychotherapist's ability to access and effectively apply their knowledge, skills, judgment, and decision-making for the benefit of their clients (Barnett et al., 2007). Further, how one responds to and copes with these difficulties has a direct impact on one's functioning and clinical effectiveness as well. Some psychotherapists eschew helpful self-care activities, instead engaging in avoidance or denial, perhaps due to what Wise and Reuman (2019) identify as a "myth of invincibility" in which psychotherapists "believe they are immune from the issues that their clients face" (p. 131). Others may rely on maladaptive coping strategies such as self-medication with various substances or by attempting to address difficulties by working more hours, not scheduling breaks in their day, sleeping less, and by skipping meals. Consequently, this impacts competence and ethics, infringing on the ability to flourish.

Ways to Improve Ethics through Self-Care

Effective self-care should address the physical, emotional/psychological, relational, and spiritual/religious aspects of the psychotherapist's life (Ziede & Norcross, 2020). Further, it should acknowledge personal histories and dispositions of each psychotherapist, the unique challenges and stressors in their personal life, the ongoing demands and effects of being a psychotherapist, and the interaction of each of these (Pipes et al., 2005). The effective practice of self-care involves the ongoing integration of what Coster and Schwebel (1997) and Stevanovic and Rupert (2004) term positive career sustaining behaviors. Commonly employed career sustaining behaviors these authors identified include self-awareness and the use of positive self-talk, working to maintain a balance between one's professional and personal lives, a focus on the relationships in one's personal life, taking breaks from work to include vacations, engaging in enjoyable leisure time activities, consulting with colleagues, engaging in relaxation, and participating in personal psychotherapy.

While many psychotherapists may engage in solitary or independent self-care activities, it is widely accepted that there are multiple limitations to this approach. A tendency to isolate oneself and not include others in the development and implementation of one's self-care plan can be both of limited effectiveness and a risk factor for the development of problems with professional competence (Barnett & Homany, 2022). Due to limitations in accurate self-assessment along with personal biases and blind spots, to engage in effective self-care and wellness promotion activities psychotherapists must include others in these efforts (Johnson et al., 2012). Wise and Reuman (2019) emphasize the essential role reflective practice plays in each psychotherapist's competence, to include "understanding one's own history, needs and motivations, strengths and weaknesses, worldview, and life purpose" (p. 131). Each of the above are important reasons for including others in these efforts, to include participating in one's own psychotherapy.

Personal Psychotherapy as a Self-Care Strategy

Psychotherapy for the psychotherapist may be an important self-care activity, assisting the clinician to better cope with ongoing challenges, demands, stressors, and conflicts in their personal and professional lives, to include their own and clients' mental health issues (Consoli et al., 2021). As Pearlman and Saakvitne

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(1995) state, it is "a place in which to process the impact and effect of our therapeutic work on ourselves, to take all of our needs, our wishes, our fears, all of our feelings and thoughts" (p. 394). They also describe how personal psychotherapy provides benefits far beyond oneself, impacting relationships with others in one's life to include those with clients.

Personal psychotherapy for psychotherapists provides support and assistance when the psychotherapist experiences loss, confronts life transitions and challenges, and ethical concerns, like when grappling with mental health struggles. It also assists the psychotherapist to work through their own issues, blind spots, and unresolved conflicts that may impact their effectiveness as a psychotherapist (and as a person). Norcross and Guy (2013) cite strong evidence that personal psychotherapy "is an emotionally vital and professionally nourishing experience central to self-care" (p. 752).

It is found that approximately 80% of psychotherapists across professions have participated in personal psychotherapy (Rønnestad et al., 2016). A recent survey of members of the Society for the Advancement of Psychotherapy found 82% of respondents reported having participated in personal psychotherapy at least once (Norcross et al., 2023). Yet, some psychotherapists do not participate in personal psychotherapy. Potential reasons for not participating in personal psychotherapy may include shame, preconceived notions about one's identity as a care giver and not being one who seeks care for themselves, denial or minimization of difficulties and not believing psychotherapy to be needed, perceived lack of time and financial resources, and concerns about confidentiality and potential multiple relationships with other psychotherapists in one's community (Baker, 2003; Hersh, 2022; Norcross & Guy, 2013).

For those who do participate in personal psychotherapy, Ziede and Norcross (2022) found psychotherapists report motivations to include the pursuit of personal growth and to address personal problems. These authors also elucidate the many potential benefits of personal psychotherapy for psychotherapists. These include:

- Improved emotional and mental functioning and increased potential to flourish.
- A better understanding of personal issues and dynamics.
- Enhanced coping skills and better management of the challenges associated with being a psychotherapist.
- Helping the clinician to better understand the role of being a client, thus assisting them in their work with their clients.
- Benefiting from the modeling of psychotherapist expertise by their psychotherapist.

Interestingly, the views of psychotherapy clients are very positive about psychotherapists participating in personal psychotherapy. Most current and former psychotherapy clients surveyed by Ivey and Phillips (2016) viewed psychotherapists' participation in their own psychotherapy to be very positive, with 75% of those surveyed desiring their psychotherapist to have done so. Respondents reported that psychotherapists who participated in personal psychotherapy were "more empathic, trustworthy and self-aware psychotherapists" (p. 101). They also viewed personal psychotherapy to be an important self-care activity and an important form of experiential learning for psychotherapists.

How to Flourish through Self-Care

It is hoped that all psychotherapists will engage in the ongoing practice of self-

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care to fulfill their ethics responsibilities of maintaining competence and providing effective treatment. This is essential for addressing the effects of being a psychotherapist as well as with the many stressors and challenges in each psychotherapist's personal life. Further, it is hoped that psychotherapists will not limit themselves by focusing on minimal standards and expectations, but also to aspire to achieve the most effective functioning possible, what Wise and Reuman (2019) describe as thriving and flourishing. In addition to basic self-care strategies such as a healthy diet, adequate rest, regular exercise, managing one's workload and client mix, attending to the relationships in one's life; engaging in relaxing, enjoyable, and rejuvenating activities; among other positive career sustaining behaviors, it is hoped that all psychotherapists will value the role of personal psychotherapy at different points in their careers and lives, engaging in it to achieve the many personal and professional benefits it offers. Psychotherapists will hopefully see this as an essential aspect of their ongoing efforts to maintain their clinical competence, ethics, and effectiveness and to support their efforts to provide the best treatment possible to their clients and to thrive and flourish both professionally and personally.

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A Call to Action: Decolonizing Clinical Practice

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Theories and processes of psychology have largely been influenced by North American and European psychologists whose Western-oriented paradigms have not promoted inclusivity or recognized the strengths of ethnically diverse cultures. Western paradigms promote power, hierarchical order, and structural privilege to the detriment of the well-being and mental health of racially and ethnically diverse cultures (Goodman et al., 2014; Goodman & Gorski, 2015). This can occur through the use of visible and concealed practices aimed at socializing marginalized communities and aligning them with dominant cultural standards and experiences (Singh et al., 2020). More recently, current training practices in psychology embrace more openness and seek to provide culturally competent and culturally responsive treatments for marginalized populations seeking mental health services and also call for the decolonization of psychology. The perspective of critically questioning and disrupting inequities in institutional systems and structures is conceptualized as the practice of decolonization (Hernandez-Wolfe, 2011).

Psychology as a profession is recognizing the importance of addressing the needs of individuals with marginalized identities and individuals from diverse backgrounds. The field of counseling psychology has become a leader in shifting toward a transformative approach to decolonize all aspects of the profession. Literature has been published on methods of decolonizing clinical practice for well-established therapists (Goodman et al., 2014). Yet, there is a dearth of literature on effective strategies for students and early career therapists to effectively engage in decolonizing clinical practice. Decolonizing clinical practice places emphasis on challenging existing knowledge, engaging in critical dialogues, and sharing knowledge across the discipline to transform therapy practice (Sharma & Kivell, 2023). When examining clinical practice through a decolonial lens, it becomes imperative to dismantle educational practices that reproduce conditions of oppression by challenging hegemony, deconstructing imperialist ideologies, and developing space for diverse clients and communities (Goodman et al., 2014). Training programs should examine their curricula offerings and provide students opportunities to develop critical consciousness around issues of social justice.

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The conditions of oppression reproduced by colonized clinical practices have largely contributed to the neglect and pathologizing of perspectives and experiences relevant to BIPOC and marginalized individuals and communities. Decolonization is an active resistance against the forces of colonialism that addresses the negative implications of eurocentrism and deficit-based approaches (Fellner, 2018). Furthermore, it deconstructs colonial ways by restoring community-based indigenous perspectives that are culturally relevant to individuals of racial and ethnic backgrounds (Fellner, 2018). Rather than maintaining a sole focus on culture and identity, a decolonized view shifts its attention to the power hierarchy where inequalities are embedded in systems and structures granting few privileges at the detriment of many (Goodman & Gorski, 2015).

When examining systemic inequities, psychology's history is riddled with patterns of neglect, abuse, and a failure to address mental healthcare disparities among BIPOC populations. These disparities include poorer psychotherapy outcomes and higher rates of premature termination in marginalized client populations (Wilcox, 2023). Despite this pervasive history of disparity, numerous scholars expose minimal progress in the improvement of psychotherapy and mental health outcomes for BIPOC individuals and communities (Wilcox, 2023). Supporting this claim, a recent study conducted with queer and/or trans Black people, Indigenous people, and other People of Color (QTBIPOC) (Arora et al., 2022) suggested optimal therapy experiences are contingent on the intentional dismantling of systemic oppression in therapy. Results also suggest that therapy has potential to be ineffective or even harmful for QTBIPOC individuals when systems of oppression are not adequately dismantled in the therapy room (Arora et al., 2022). This further highlights the necessity of decolonized therapeutic work that centers non-western healing practices (Arora et al., 2022). While the findings previously mentioned are specific to QTBIPOC populations, similar findings have been found with studies examining African American, Indigenous and Latine populations and the negative effects associated with experiencing ineffective psychotherapy (Sharma & Kivell, 2023;Vazquez, 2022). Subsequently, studies have indicated better mental health care outcomes among marginalized groups when culturally relevant and indigenous healing practices are implemented in client treatment plans (Sharma & Kivell, 2023;Vazquez, 2022).

While there are studies that demonstrate a pressing need for decolonial clinical practices, there is less literature that addresses how to decolonize clinical practice, especially for students and beginning therapists. Continued attention in this area is warranted in order to continue dismantling systems of oppression to improve the mental health needs for individuals from diverse backgrounds and marginalized identities. More inclusive and effective therapeutic spaces can be created by incorporating diverse perspectives and challenging Western pedagogies and praxis.

Recommendations for Psychology Trainees and New Therapists

1. Approach clinical practice with a commitment to decolonization, recognizing the impact of historical and cultural factors on mental health.
2. Seek professional development and continuing education opportunities to

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expand knowledge in anti-racism and liberation psychology approaches
3. Incorporate an advocacy and social justice perspective when working with clients
4. Build a network of mentors who prioritize cultural competence and cultural humility to help create a supportive community for ongoing dialogue and learning
5. Redefine diagnosis, treatment, and assessment from a decolonized and liberation-focused approach. An essential component of decolonizing psychology is breaking down systems that focus solely on cultural differences and do not pay attention to the dismantling of systematic privileges (Goodman & Gorski, 2015).
6. Develop a culturally responsive clinical practice that engages cultural humility and a deep understanding of the interaction between therapist and clients' privileged and marginalized identities (Comas-Díaz, 2012).
7. Understand the influence and role of cultural capital (Yosso, 2005) which includes utilizing cultural strengths to avoid focusing on negative aspects of culture and build on the positive ones. Practicing cultural capital in sessions may allow the practitioner to help empower the client (Yosso, 2005). For example, if family or community is essential to the client, encouraging the client to bring in individuals may help with the healing process. Another example is if the client values spirituality or religion, encouraging the client to discuss religion or spirituality in sessions. Research shows that discussing religion or spirituality in sessions creates a more comforting atmosphere, allowing clients to build rapport (Terepka & Hatfield, 2020). Lastly, if the client values food sharing within their culture, allowing the sharing of food within sessions could also increase the comfortability and rapport in sessions (Warren, 2009)
8. Understand the consequences of racism on mental and physical health outcomes (Iradukunda & Canty, 2023).
9. Supplement colonized knowledge of psychology through models such as The Black History Knowledge (BHK) model (Chapman-Hilliard & Adams-Bass, 2016). This model provides a framework for utilizing history to inform practice. Understanding the history of oppression and colonization in psychology can better inform students in practice (Chapman-Hilliard & Adams-Bass, 2016). Models such as the BHK model can be effective in decolonizing psychology by increasing understanding of the history behind intelligence tests and personality assessments. Many tests and assessments were created with one group in mind. Making this group the standard by which behaviors, intelligence, personality, and knowledge of other groups is measured can be detrimental. It is important to understand the impact this may have on clients.

Recommendations for Training Programs to Support Psychology Trainees and Students

1. Supervision and mentorship are essential in training student therapists. A goal of supervision should be to help students shift perspectives and make social justice and advocacy central to their professional functioning (Goodman et al., 2014).
2. Addressing decolonization in training programs is accomplished by incorporating multicultural and social justice perspectives throughout the curriculum, and hiring and retaining faculty (Goodman et al.,

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2014). It is essential to increase diversity in hiring faculty and ensure that incoming faculty value and promote the decolonization of clinical practice (Goodman et al., 2014; Cartwright et al., 2021).

3. Incorporating community engagement opportunities throughout the curriculum of training programs (Iradukunda & Canty, 2023; Goodman et al., 2014). These opportunities assist trainees and students in engaging with the community prior to internship and practicum experiences. For example, Henderson et al., (2019) noted that counseling education curriculum should include a community psychology course focusing on projects that create partnerships in the community to help uncover community needs and assist with building relationships. Community psychology courses or other experiential learning courses can help students engage in leadership roles, expand their understanding of community needs, and gain practical skills in the field early in the curriculum. Students and trainees often do not engage with the community until their final years of training (Goodman et al., 2014).
4. Recognizing the impact of social determinants on mental health outcomes is vital to making meaningful changes in clinical practice. Acknowledging and advocating the need for change in social and governmental systems may help empower clients (Alegría et al., 2018). For example, utilizing empathy with clients who may suffer from social determinants rather than holding them accountable for systemic imbalances can be effective.
5. Theoretical frameworks, such as the Psychology of Radical Healing (PRH) and The Keeping Radical Healing in Mind Therapeutic Approach (Adames et al., 2023), as well as approaches such as Comas-Diaz's (2016) Racial Trauma Recovery approach should be included in training programs to help trainees and students gain a better understanding of how to engage and support healing in the BIPOC community.

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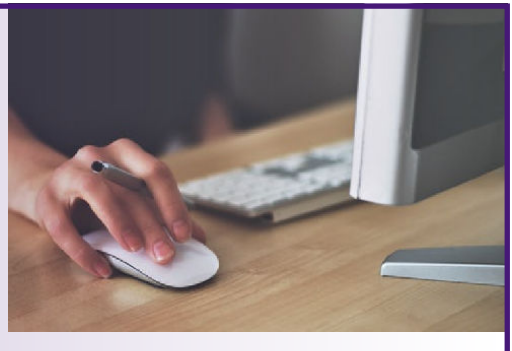
Society for the Advancement of Psychotherapy



Society for the Advancement of Psychotherapy

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WASHINGTON SCENE

"Please don't take him just because you can"

Pat DeLeon, PhD
Former APA President

"I WAS REMINISCING JUST THE OTHER DAY. WHILE HAVING COFFEE ALL ALONE"

The Evolving Importance Of Licensure Mobility: At the end of 2023, Alex Siegel, Director of Professional Affairs, Association of State and Provincial Psychology Boards, reported that there were 40 jurisdictions (39 effective), out of a total of 55 states and territories, which had adopted and were part of the PSYPACT Commission. The Psychological Interjurisdictional Compact (PSYPACT) allows for increased access of care and continuity of care for providing psychological services across state lines. Successful applicants are awarded Authority to Practice Interjurisdictional Telepsychology (APIT) and temporary Authorization to Practice (TAP) credentials. The APIT authorizes psychologists to practice interjurisdictional from their home state into the receiving state (where the patient is located). The TAP credential authorizes psychologists to temporarily physically provide face-to-face psychological services in the distant PSYPACT state. Alex has further noted that an increasing number of the health professions have embraced a compact approach, similar to psychology's.

During the previous Congress, licensure mobility received attention from several Congressional committees. For example, the U.S. House of Representatives included report language in the Fiscal Year 2024 Department of Health and Human Services Appropriations legislation for the Bureau of Health Workforce: "Interstate Licensure. The Committee recognizes that almost 100 million Americans live in a primary care health professional shortage area and over 156 million—almost half of the U.S. population—live in a mental health care health professional shortage area. While efforts continue to support the recruitment and retention of the health care workforce, optimizing the existing workforce is critical. The Interstate Medical Licensure Compact, created under the Licensure Portability Grant Program, is a voluntary, expedited pathway to licensure for qualified healthcare professionals, including psychologists, to practice in multiple states…. The Committee encourages HRSA to expand public awareness of these compacts to encourage provider participation."

On December 22, 2023, President Joe Biden signed H.R. 2670, the National Defense Authorization Act for Fiscal Year 2024, into public law for the 63rd consecutive year. Included in the legislative conference report was language addressing the portability of professional licenses of servicemembers and their spouses. "Portability of professional licenses of servicemembers and their spouses: The House bill contained a provision (sec. 640) that would require the Secretary of Defense, acting through the Defense State Liaison Office, to consult with licensing authorities of States to increase awareness of section 705A of the Servicemembers Civil Relief Act

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(Public Law 117-333) not later than September 30, 2024. The Senate amendment contained no similar provision. The House recedes. The conferees note that the Department of Justice is working on implementing the requirements of section 705A of the Servicemembers Civil Relief Act, and the Department of Defense continues to raise awareness of this statutory provision among servicemembers and their spouses."

In reviewing the provisions of the Servicemembers Civil Relief Act (SCRA), the Congressional Research Service (CRS) reported in June, 2023: "Portability of professional licenses of servicemembers and their spouses—Section 705A (50 U.S.C. Section 4025a). Added in 2023, this section provides for the recognition of professional licenses and certificates (not including law licenses) issued by other jurisdictions to servicemembers or spouses of servicemembers who have relocated to a new jurisdiction pursuant to military orders, providing the license remains in good standing with the issuing authority and any other issuing authority that has issued a similar license to the licensee. The licensee must meet standards of practice for the relevant profession in the new jurisdiction, including fulfilling any continuing education requirements, and is subject to the relevant disciplinary authority there. The licensee must have actively used the license during the two years preceding relocation to the new jurisdiction. If the licensee is able to practice in multiple jurisdictions through an interstate licensure compact, the provisions of that compact apply."

CRS further pointed out that the U.S. Attorney General is authorized to commence a civil action in U.S. district court for violations of the underlying statute. In essence— "In any case in which a servicemember or the spouse of a servicemember has a covered license and such servicemember or spouse relocates his or her residency because of military orders for military service to a location that is not in the jurisdiction of the licensing authority that issued the covered license, such covered license shall be considered valid at a similar scope of practice and in the discipline applied for in the jurisdiction of such new residency for the duration of such military orders…."

To put this development in perspective, in November, 2023, the web site *Military.com* reported: "A federal judge has ruled that the state of Texas violated a new provision of the Servicemembers Civil Relief Act in refusing to recognize an Air Force wife's out-of-state school counselor credentials—a rejection that prevented her from getting a permanent job in the state. As the first-ever decision on a law that required states to recognize occupational licenses issued elsewhere, the case has widespread implications for the estimated 255,000 active-duty military spouses who require professional credentials to work in education, medicine, real estate, the beauty industry and more." Professional licensure had once been considered the primary, if not exclusive, responsibility of the individual states. However, the federal government, both administratively and legislatively, would appear to have become increasingly concerned with its impact upon its employees and the nation. With the ever-increasing sophistication of telehealth technology, we would hope that the remaining 15 jurisdictions would seriously consider enacting PSYPACT this coming legislative year.

Personal Reflections Of A Dedicated Visionary: This past November, our nation and particularly the mental health community lost a compassionate and

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visionary leader, the former First Lady Rosalynn Carter. She was a passionate champion of mental health, caregiving, and women's rights. She served as a member of the Governor's Commission to Improve Services to the Mentally and Emotionally Handicapped when her husband was Governor of Georgia. And, she was the active honorary chair of his President's landmark Commission on Mental Health, helping to bring about the passage of the Mental Health Systems Act of 1980.

Rod Baker, VA psychology historian extraordinaire: "I've always seen her as one of the few public officials who took talking about mental health out of the closet. During her remarks before the American Psychiatric Association in May of 1979, she noted: 'Since I have been working in this field, I have been told time and time again that the subject (of mental health) is boring, that the public doesn't care about or indeed is even repelled by those who suffer from mental and emotional disorders, and that the press doesn't find mental health a 'sexy' or important national issue. I do not believe we have the luxury of giving in to these views.'"

Former APA President Frank Farley initiated a moving "Broom Closet" discussion among our former Presidential colleagues on their personal experiences with the former First Lady: "We have lost an amazing person who dedicated much of her life to concern for mental health—Rosalynn Carter, former First Lady, who died November 19 at age 98. I met Rosalynn when she invited me to participate with her in a special event on mental health issues at The Carter Center in Atlanta. It was a thrill to participate at that fine Center, created by President Jimmy Carter and First Lady Rosalynn, that has contributed so much to a range of public matters. Rosalynn had as her #1 issue the STIGMA of mental illness. No First Lady has contributed more to raising awareness of the problems of mental health. She was a gracious, giving person. (I note her founding of her Institute for Caregivers, and more). BOTH Jimmy and Rosalynn were amazing, including their 77 year marriage!

"A few years before the foregoing event I had spent much of a day with Jimmy at the White House when he invited me to join him in celebrating his creation of the U.S. Department of Education as a Cabinet Level Department. The nation had never had an Education seat on the President's Cabinet so Jimmy rightfully created it!! It was important to have education represented on the Cabinet, seated along with Defense, Labor, Commerce, etc. I was then President of the American Educational Research Association, the world's largest society of scholars in education, and he wanted me to represent at the White House celebration the nation's scholars and researchers in the field of education, teaching and learning. He had a large cubist-style poster in the White House in celebration of the event, titled 'Learning Never Ends'. He and I at one point were chatting while looking at the poster and I said as a hard-working professor 'Mr. President. It's gotta end sometime!' He laughed and said as a hard-working world leader 'I know what you mean!' At the end of the day-long celebration as I was about to leave the White House he brought me that poster! I still have it. All the best, Frank."

Nadine Kaslow: "It has truly been an honor and a privilege to serve on Mrs. Carter's Mental Health Task Force since 2000. For me, Mrs. Carter was a role model par excellence as a mental health advocate. During the past 2 plus decades,

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I have developed a special bond with the Carter family. It meant a lot to me that Amy Carter wore my pearls today, a small reflection of my deep connection to the family.

"Today, I attended Mrs. Carter's funeral, which was sad, inspiring, funny, poignant, and powerful. I never expected to be moved to tears in a group singing America the Beautiful, but somehow being in the same room with three Presidents and five First Ladies along with our Governor, two Senators, multiple Congress people, and former Surgeon Generals with Mrs. Carter's beautiful coffin prominently displayed can do just that. We heard so much about Mrs. Carter as a steadfast and tireless mental health leader and champion, one honored by multiple APA Presidents including Carol and Tony as examples. I know many of you had relationships with President and Mrs. Carter over the years and for each of you whose paths they crossed, I offer my heartfelt condolences.

"But I hope that we can all take a moment to celebrate a long life incredibly well lived. And more importantly, I hope that each of us and APA more generally will dedicate ourselves to ongoing mental health activism and humanitarian efforts. I know that for me doing so is one small way to honor her amazing legacy. With gratitude to Mrs. Carter, Nadine."

Dorothy Cantor: "Well said, Nadine. I had the privilege of serving for many years on the Board of the Rosalynn Carter Institute for Caregivers, as did Ray Fowler, at Georgia Southwestern in America's GA (which is as far from NY as you can get!) Mrs. Carter never missed a meeting and the depth of her concern for caregivers was palpable. She will always be an inspiration for me. Dorothy."

And, Susan McDaniel: "I was invited to one of Mrs. Carter's Family Caregiving seminars at the Carter Center with 9 colleagues from across the country. (Each seminar had a focus and was turned into a book.) Each of the 10 of us gave a talk. Mrs. Carter sat through all of them for the first day, along with her Secret Service, and was warm, knowledgeable, and interested in the content. At a reception that first day, she spoke to each of us independently for a fair amount of time. Mysteriously, the next morning she wasn't present. She had been so involved the day before that it was peculiar. Around 10 AM during our presentations, there was a knock on the door. We opened it and a staff person from the Carter Center said, to our utter shock collectively: 'We just learned last night that President Carter won the Nobel Peace Prize. The family is going to have a celebration, and would like to invite you to it.' So there we were—President and Mrs. Carter, their children, their grandchildren, two Carter Center staff, and the 10 of us. It was truly amazing. We had champagne and delicious food. I spoke to President Carter for what seemed like 30 min; I don't know how long it actually was. He was warm, accessible, and real. A peak experience all around…. Thank you to Mrs. Carter for her work fighting mental health stigma, advocating for family caregivers, and for serving with her husband as a role model of service leaders for all of us. Susan."

Tony Puente presented her with an APA Presidential Citation at the Carter Center in 2017 when he was able to spend time with her: "It was her humble, simple spirit that made the greatest impression. Carol Goodheart served on Mrs. Carter's cancer expert panel focused on the impact on caregivers, which resulted in a book. "Our group thoroughly en-

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joyed the project and enjoyed our time with her and former President Jimmy Carter in Atlanta. During my APA Presidency in 2010, she came in person to our convention to receive the APA Presidential Citation for her remarkable advocacy at the Opening Session. It now hangs in the Presidential Library and Museum. She graciously stayed after the session to sign her latest book for attendees."

An Intriguing Opportunity Two Decades Ago: February 23, 2003, Dean Given: "Prescribing in California—Our new Executive Director, CF, was approached by the California Medical Association's chief lobbyist ST about prescribing. He told her that if CPA was willing to discuss 'collaborative prescribing', CMA may be able to support this. I talked to a friend who is a past president of CMA about this. He said something like 'If ST were to tell CMA leadership that psychologist prescribing seems inevitable and CMA would do well to cut a deal and focus on more pressing matters, like getting physician reimbursement out of the toilet, the leadership would probably agree. We trust ST to make the calls for us about the political environment. We usually try to circle the wagons on prescribing but there certainly are some leaks and it does seem that elsewhere in the country states are rolling over.'

"I talked to some of our CPA leadership about this. Of course, the definition of 'collaborative' is crucial. There is concern for many that we ought not to put our advocacy energies toward prescribing at this point. However, if the possibility of such a bill were to reap a deal with CMA, all I spoke with would support this. Among our concerns about pursuing this further is that we do not wish to undermine the success of APA and other states in obtaining prescribing rights for psychologists. This is all at an informal discussion level at this stage and I would like to know your thoughts…." "But I don't wanna dance. If I'm not dancing with you" (Holy Ground, Taylor Swift).

Aloha,
Pat DeLeon, former APA President – Division 29 – January, 2024

Society for the Advancement of Psychotherapy

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2024 CHARLES J. GELSO PSYCHOTHERAPY RESEARCH GRANTS

Brief Statement about the Grant Program
The Charles J. Gelso, Ph.D., Psychotherapy Research Grants, offered annually by the Society for the Advancement of Psychotherapy to graduate students, predoctoral interns, postdoctoral fellows, and psychologists (including early career psychologists), provide three $5,000 grants toward the advancement of research on psychotherapy process and/or psychotherapy outcome.

Eligibility
All graduate students, predoctoral interns, postdoctoral fellows, and doctoral-level researchers with a promising or successful record of publication are eligible for the grant. The research committee reserves the right not to award a grant if there are insufficient submissions or submissions do not meet the criteria stated.

Submission Deadline: May 1, 2024

Request for Proposals
Charles J. Gelso, Ph.D. Grant

Description
This program awards grants for research projects in the area of psychotherapy process and/or outcome.

Program Goals
- Advance understanding of psychotherapy process and/or psychotherapy outcome through support of empirical research
- Encourage talented graduate students towards careers in psychotherapy research
- Support psychologists engaged in quality psychotherapy research

Funding Specifics
- Three (3) annual grants of $5,000 each are paid in one lump sum to the individual researcher, to the researcher's university grants and contracts office, or to an incorporated company. Individuals who receive the funds may incur tax liabilities (see IRS webpage on Grants to Individuals: https://www.irs.gov/charities-non-profits/private-foundations/grants-to-individuals).
- A researcher can win only one of these grants (see Additional Information section below).
- Funds must be transferred to the researcher, university grants and contracts office, or to an incorporated company by December 15 of the year in which the grant award notification is made.

Eligibility Requirements
- Demonstrated or burgeoning competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The same project/lab may not receive funding two years in a row
- Applicant must be a member of the Society for the Advancement of Psychotherapy (Division 29 of APA). Join the Society at http://societyforpsychotherapy.org/

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Evaluation Criteria

- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

Requirements Components for All Proposals

- Description of the proposed project to include title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1-inch margins, no smaller than 11-point font)
- CV of the principal investigator that focuses on research activities (not to exceed 2 single-spaced pages)
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal
- Timeline for execution (priority given to projects that can be completed within two years)
- Full budget and justification that clearly indicates how the grant funds would be spent. The budget should be no longer than 1 page. Indirect costs may not be included in the budget.
- A statement as to whether the grant funds will be used to initiate a new project or to supplement current funding. The research may be at any stage, but justification must be provided for the current request of grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.).
- **Graduate students, predoctoral interns, and postdoctoral fellows should refer the next section for additional materials that are required.**

Additional Required Components for Graduate Students, Predoctoral Interns, and Postdoctoral Fellows

- Graduate students, pre-doctoral interns, and postdoctoral fellows should also submit the CV of the mentor who will supervise the work.
- Graduate students and pre-doctoral interns must also submit 2 letters of recommendation, one from the mentor who will be providing guidance during the completion of the project and this letter must indicate the nature of the mentoring relationship.
- Postdoctoral fellows must submit 1 letter of recommendation from the mentor who will be providing guidance during the completion of the project and this letter should indicate the nature of the mentoring relationship.

Additional Information

- After the project is complete, a full accounting of the project's income and expenses must be submitted within six months of completion
- Grant funds that are not spent on the project within two years must be returned
- When the resulting research is published, the grant must be acknowledged
- All individuals who directly receive funds from the Society for the Advance-

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ment of Psychotherapy will be required to complete an IRS W-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31)

Submission Process and Deadline

- All materials must be submitted electronically.
- All applicants must complete the grant application form, in MSWord or other text format.
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file.
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email).
- All required materials for proposal should be submitted to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received; please resubmit.
- Deadline: May 1, 2024

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Science and Scholarship Domain Representative (Dr. Patricia T. Spangler at patricia.spangler.ctr@usuhs.edu), or Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net.

Society for the Advancement of Psychotherapy

2024 NORINE JOHNSON PSYCHOTHERAPY RESEARCH GRANT FOR EARLY CAREER PSYCHOLOGISTS

Brief Statement about the Grant:
The Norine Johnson, Ph.D., Psychotherapy Research Grant, offered annually by the Society for the Advancement of Psychotherapy to Early Career Psychologists (within 10 years post earning the doctoral degree), provides $20,000 toward the advancement of research on psychotherapy. All aspects of psychotherapy research can be supported, including the psychotherapy relationship, psychotherapy process, or psychotherapy outcomes.

Eligibility
Early Career (within 10 years post earning the doctoral degree) Doctoral-level researchers with a successful record of publication are eligible for the grant.

Submission Deadline: May 1, 2024

Request for Proposals
Norine Johnson, Ph.D., Psychotherapy Research Grant for Early Career Psychologists

Description
This program awards grants to early career psychologists (ECPs) for research on psychotherapy. All aspects of psychotherapy research can be supported, including the psychotherapy relationship, psychotherapy process, or psychotherapy outcomes.

Program Goals
- Advance understanding of psychotherapy (psychotherapy relationship, process, and/or outcomes) through support of empirical research
- Encourage early career researchers with a successful record of publication to undertake research in these areas

Funding Specifics
- One annual grant of $20,000 to be paid in one lump sum to the researcher, to the researcher's university grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities (see Additional Information section below).
- Funds must be transferred to the researcher, university grants and contracts office, or to an incorporated company by December 15 of the year in which the grant award notification is made.

Eligibility Requirements
- Early Career (within 10 years post earning the doctoral degree), Doctoral-level researchers
- Demonstrated competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The selection committee may elect to award the grant to the same individual or research team up to two consecutive years

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- The selection committee may choose not to award the grant in years when no suitable nominations are received
- Researcher must be a member of the Society for the Advancement of Psychotherapy. Join the society at http://societyforpsychotherapy.org/

Evaluation Criteria

- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

Requirements Components for All Proposals

- Description of the proposed project to include title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal.
- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)

Additional Information

- After the project is completed, a full accounting of the project's income and expenses must be submitted within six months of completion
- Grant recipients are expected to write a brief article related to their project for Division 29's *Psychotherapy Bulletin* within 2 years of receiving funding.
- Grant funds that are not spent on the project within two years of receipt must be returned
- When the resulting research is published, the grant must be acknowledged by footnote in the publication
- All individuals directly receiving funds from the Society for the Advancement of Psychotherapy will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31). (For further information, see IRS webpage on Grants to Individuals: https://www.irs.gov/charities-non-profits/private-foundations/grants-to-individuals).

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Submission Process and Deadline

- All materials must be submitted electronically at the same time
- All applicants must complete the grant application form, in MSWord or other text format
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received. Please resubmit.
- Deadline: May 1, 2024

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Science and Scholarship Domain Representative (Dr. Patricia T. Spangler at patricia.spangler.ctr@usuhs.edu), or Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net.

2024 SPECIAL GRANT: SCIENCE AND SCHOLARSHIP GRANT FOR MID- AND LATE-CAREER PSYCHOTHERAPY RESEARCHERS

Brief Statement about the Grant:
This Science and Scholarship Grant for Mid- and Late-Career Psychotherapy Researchers is offered only for 2024 by the Society for the Advancement of Psychotherapy. This grant will provide $20,000 toward the advancement of research on psychotherapy. All aspects of psychotherapy research can be supported, including the psychotherapy relationship, process, outcomes, training, and supervision.

Eligibility
Doctoral-level researchers who are more than 10 years post completion of the doctoral degree and who have a successful record of publication are eligible for the grant.

Submission Deadline: May 1, 2024

Request for Proposals
2024 SPECIAL GRANT:
Science and Scholarship Grant for Science and Scholarship Grant for Mid- and Late-Career Psychotherapy Researchers

Description
This one-time only grant will provide funding to mid-career and late-career psychotherapy researchers. All areas/topics of psychotherapy research can be supported, including the psychotherapy relationship, process, outcomes, training, and supervision.

Program Goals
- Advance understanding of psychotherapy through support of empirical research on psychotherapy
- Encourage and support mid- and late-career psychotherapy researchers who are qualified to conduct psychotherapy research to undertake research in these areas

Funding Specifics
- A one-time grant of $20,000 to be paid in one lump sum to the researcher, to the researcher's university grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities (see Additional Information section below).
- Funds must be transferred to the researcher, university grants and contracts office, or to an incorporated company by December 15, 2024.

Eligibility Requirements
- Doctoral-level researchers who are more than 10 years beyond completion o f their doctoral degree
- Demonstrated competence in the topic of proposed work
- IRB approval must be received from the principal investigator's institution

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before funding can be awarded if human participants are involved.
- The selection committee may choose not to award the grant if no suitable nominations are received
- Applicants must be a member of the Society for the Advancement of Psychotherapy. Join the society at http://societyforpsychotherapy.org/

Evaluation Criteria
- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

Requirements Components for All Proposals
- Description of the proposed project to include title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1-inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal.
- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)

Additional Information
- After the project is completed, a full accounting of the project's income and expenses must be submitted within six months of completion
- Grant recipients are expected to write a brief article related to their project for Division 29's *Psychotherapy Bulletin* within 2 years of receiving funding.
- Grant funds that are not spent on the project within two years of receipt must be returned
- When the resulting research is published, the grant must be acknowledged by footnote in the publication.
- All individuals directly receiving funds from the Society for the Advancement of Psychotherapy will be required to complete an IRS W-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31). (For further information, see IRS webpage on Grants to Individuals: https://www.irs.gov/charities-non-profits/private-foundations/grants-to-individuals).

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Submission Process and Deadline

- All materials must be submitted electronically at the same time
- All applicants must complete the grant application form in MSWord or other text format
- CV(s) may be submitted in text or PDF format. If submitting more than one CV, then all CVs must be compiled into one electronic document/file
- Proposal and budget must be submitted in one file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received. Please resubmit.
- **Deadline:** May 1, 2024

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Science and Scholarship Domain Representative (Dr. Patricia T. Spangler at patricia.spangler.ctr@usuhs.edu), or Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net.

Society for the Advancement of Psychotherapy

2024 SPECIAL GRANT: SCIENCE AND SCHOLARSHIP GRANT FOR QUALITATIVE RESEARCH IN PSYCHOTHERAPY

Brief Statement about the Grant:
This Science and Scholarship Grant for Qualitative Research in Psychotherapy is offered only for 2024 by the Society for the Advancement of Psychotherapy. This grant will provide $20,000 toward the advancement of qualitative research on psychotherapy. All aspects of psychotherapy research can be supported, including the psychotherapy relationship, process, outcomes, training, and supervision.

Eligibility
Doctoral-level researchers with a successful record of publication are eligible for the grant.

Submission Deadline: May 1, 2024

Request for Proposals
2024 SPECIAL GRANT: Science and Scholarship Grant for Qualitative Research in Psychotherapy

Description
This one-time only grant will provide funding to qualitative research on psychotherapy. All areas/topics of psychotherapy research can be supported, including the psychotherapy relationship, process, outcomes, training, and supervision. Proposed research design may be mixed method, but grant funds must be applied to implementation of qualitative methods. Generative/natural language artificial intelligence (AI) programs may be used but are not required.

Program Goals
- Advance understanding of psychotherapy through support of qualitative research methods
- Encourage psychotherapy researchers to use, develop, and optimize qualitative methods to explore topics in psychotherapy research

Funding Specifics
- A one-time grant of $20,000 to be paid in one lump sum to the researcher, to the researcher's university grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities (see Additional Information section below).
- Funds must be transferred to the researcher, university grants and contracts office, or to an incorporated company by December 15, 2024.

Eligibility Requirements
- Doctoral-level researchers
- Demonstrated competence in the topic of proposed work, but may be a novice in the proposed qualitative research method
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved.
- The selection committee may choose not to award the grant if no suitable nominations are received

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- Applicants must be a member of the Society for the Advancement of Psychotherapy. Join the society at http://societyforpsychotherapy.org/

Evaluation Criteria

- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

Requirements Components for All Proposals

- Description of the proposed project to include title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1-inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal.
- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)

Additional Information

- After the project is completed, a full accounting of the project's income and expenses must be submitted within six months of completion
- Grant recipients are expected to write a brief article related to their project for Division 29's *Psychotherapy Bulletin* within 2 years of receiving funding.
- Grant funds that are not spent on the project within two years of receipt must be returned
- When the resulting research is published, the grant must be acknowledged by footnote in the publication.
- All individuals directly receiving funds from the Society for the Advancement of Psychotherapy will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31). (For further information, see IRS webpage on Grants to Individuals: https://www.irs.gov/charities-non-profits/private-foundations/grants-to-individuals).

Submission Process and Deadline

- All materials must be submitted electronically at the same time
- All applicants must complete the grant application form, in MSWord or other text format

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- CV(s) may be submitted in text or PDF format. If submitting more than one CV, then all CVs must be compiled into one electronic document/file
- Proposal and budget must be submitted in one file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received. Please resubmit.
- Deadline: May 1, 2024

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Science and Scholarship Domain Representative (Dr. Patricia T. Spangler at patricia.spangler.ctr@usuhs.edu), or Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net.

Society for the Advancement of Psychotherapy

Find the Society for the Advancement of Psychotherapy at www.societyforpsychotherapy.org

SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY –APA Division 29

Enter Our Annual Student Award Competitions!

The Society for the Advancement of Psychotherapy student award competitions include four awards for the best papers submitted on specific topics and two standard awards:

- Donald K. Freedheim Student Development Paper Award: Best paper on psychotherapy theory, practice, or research
- Lillian Comas-Diaz Diversity Paper Award: Best paper on issues of diversity in psychotherapy
- Mathilda B. Canter Education and Training Paper Award: Best paper on education, supervision, or training of psychotherapists
- Jeffrey E. Barnett Psychotherapy Research Paper Award: Best paper addressing psychotherapist factors that may impact treatment effectiveness and outcomes
- Practice Award: Awarded to candidate who best demonstrates commitment to the practice of psychotherapy and exemplary achievement in clinical work
- Teaching/Mentorship Award: Awarded to candidate who best demonstrates commitment to teaching and mentorship in the context of psychotherapy and related fields

What are the benefits to you?

- Cash prize of $500 for the winner of each contest. Certificate and check presented at the Society's Awards Ceremony at APA Convention.
- Enhance your curriculum vitae and gain national recognition.
- Abstract will be published in the *Psychotherapy Bulletin,* the official publication of SfAP/Division 29.

What are the requirements?

- All applicants must be members of the Society for the Advancement of Psychotherapy. Join at www.societyforpsychotherapy.org
- Papers, clinical practice, and teaching/mentorship must be based on work conducted by the applicant no more than two years post-graduate degree.
- See detailed award descriptions and requirements at https://societyforpsychotherapy.org/members/student-portal/awards/

Submissions should be emailed to:

Krizia Wearing, Chair, Student Development Committee, Society for the Advancement of Psychotherapy, at wearingk@chc.edu

Deadline is April 1, 2024

Society For The Advancement Of Psychotherapy

THE ONLY APA DIVISION SOLELY DEDICATED TO ADVANCING PSYCHOTHERAPY

MEMBERSHIP APPLICATION

Society for the Advancement of Psychotherapy

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

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

Name _____ Degree _____

Address _____

City _____ State _____ ZIP_____

Phone _____ FAX _____

Email _____

If APA member, please provide membership #

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

Card # _____ Exp Date _____/_____

Signature _____

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

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

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

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PSYCHOTHERAPY BULLETIN

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

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

Society for the Advancement of Psychotherapy (29)
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www.societyforpsychotherapy.org

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

www.societyforpsychotherapy.org

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

We'd love to hear from you!