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BULLETIN

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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,

Hello everyone!

I am very pleased to report that our Society board meeting in January was very enjoyable and productive. One of the areas we focused on was how the Society can offer more value to our members. In this spirit, I would like to use this space to offer a free clinical training resource to Society members: a list of transtheoretical "common" factor skills for Deliberate Practice training/supervision. These skills have been shown to be highly correlated to counselors' outcomes. Put simply: when a counselor is struggling with helping a client, it can often be helpful to use Deliberate Practice to focus on one or more of these skills in supervision.

These Deliberate Practice skills were developed for use in the Sentio California Marriage and Family Therapy (MFT) MA which is hybrid online/in-person. The Sentio program features an intensive skill-focused pedagogy with Deliberate Practice.

The list of Deliberate Practice skills can be found at this link.

Happy training!

Yours,

Tony Rousmaniere

Society for the Advancement of Psychotherapy

ELECTRONIC COMMUNICATION EDITOR'S COLUMN

Zoe Ross-Nash, PsyD

Hello Division 29 and members of SAP!

Spring is here and we are so thrilled to share exciting updates and accomplishments of the division. We had a successful Winter *Psychotherapy Bulletin* and eBulletin publication thanks to the incredible submissions from authors like you. Our *eBulletin* connects with about 6,000 subscribers; people from around the world read the articles featured on both our website and *Bulletin*. We had a theme of submissions surrounding clinical supervision this quarter, I hope you enjoy the articles from our experts!

I also wanted to congratulate the Electronic Publication team. In January when the *Bulletin* and the Website merged, I had no idea what to expect. While I had been part of the internet publication team for three years, Amy Ellis, our devoted Publications and Communications Chair, and I were creating something new to accommodate the needs of the growing division. I am so grateful for the flexibility, passion, understanding, and expertise the Electronic Publication team holds. I extend my appreciation to Lacy Sohn, Yashvi Aware, Sarah Bondy, and Deanna Young for all your work making this transition as successful as it has been. We have also welcomed TJ Slade as our new Website Designer and technology specialist.

To diversify the topics we publish, the Electronic Publication team has started a monthly initiative encouraging authors to submit articles on certain genres. For example, we requested articles about women in March for Women's History Month and will recruit articles about the LGBTQIA+ community for Pride Month in June. We invite people to submit all year long, we hoped these initiatives would inspire people to write! Be on the lookout the first of every month for a new topic.

As a reminder, articles are accepted on a rolling basis. All articles will be featured on the website the day it is ready for publication. Those articles will be disseminated quarterly through the *Bulletin* depending on the date of publication on the website. For inclusion in the Winter *Bulletin*, the deadline for publication is January 15th. For inclusion in the Spring *Bulletin*, the deadline is April 15th. For inclusion in the Summer *Bulletin*, the deadline is July 15th. For inclusion in the Fall *Bulletin*, the deadline is October 15th. Feel free to click here for more information about the submission and publication process.

The 400 free student membership initiative was also a success. Division 29 is committed to providing affordable resources to our students and we received thousands of applications! We are very fortunate to have such an active and dedicated student membership. Additionally, we offer different awards and grants for students and clinicians. Click here for more information!

We have great articles in this issue, ranging from how to know when to hospitalize a patient to how to enter retirement. No matter where you are in your training or career, SAP has a resource for you.

Best,

Zoe Ross-Nash

Trauma-Informed Supervision and Disclosure from Supervisees

Zoe Ross-Nash, PsyD

Supervision is an essential part of training for the growth of psychologists. Consequently, a strong supervisory relationship is fundamental for both trainee and client welfare. The function of supervision is multifaceted, ranging from personal growth to clinical and professional development (Bernard & Goodyear, 2019). A trainee's ability to feel safe in disclosing ethical dilemmas, blind spots, reactions, and gaps in training depends on their comfort with self-disclosure. Determining what is appropriate trainee self-disclosure is a difficult task as supervisors do not need to know personal details about their trainees. However, supervisors are responsible for the ethical treatment of the clients receiving services under their license. Therefore, disclosure may be necessary to better understand what the potential ethical concerns are for the trainee.

The Supervisory Relationship and Self-Disclosure in Students and Psychology Trainees

It has been documented that the better the supervisory relationship between supervisor and psychology trainee, the more likely it is that the trainee will self-disclose in supervision (Mehr & Daltry, 2022). The supervisory relationship can be developed in a myriad of ways, such as shared goals, trust or bond, and tasks (Gibson et al., 2019; Gunn & Pistole, 2012). This is achieved through developing goals and expectations at the start of the relationship, discussing a remediation process if these expectations are not met, and providing frequent feedback to the trainee (Kersting, 2005).

Other theorists posit there are five components to good supervisory relationships: 1) support, 2) trust, 3) respect, 4) time, and 5) investment (Campoli et al., 2016). Trauma-informed support, more specifically, can be offered through administrative tasks, educational didactics, and providing space for the student using both formal (i.e., scheduled time) and informal (i.e., impromptu conversation) approaches (Ross-Nash, 2021). Trust is reciprocal, meaning it requires both trust in the supervisor from the trainee, and trust from the supervisor to the trainee (Campoli et al., 2016). Relevant and appropriate self-disclosure, boundary setting, and providing or receiving feedback all lend to the trust that is necessary for a strong supervisory relationship. Respect can be shown from supervisors by evaluating notes thoroughly and through being punctual, consistent, and present in their supervisory role. Additionally, recognizing and articulating a trainee's strengths in conjunction with identifying growth points can demonstrate a supervisor's respect for the trainee's development. Navigating conflict with kindness, self-examination, and curiosity, rather than being defensive or superior can lend well to a respectful supervisory relationship (Nelson, 2008). Time is the fourth quality of a strong supervisory relationship. It can often feel like there is never enough time to cover all that is needed in the supervision hour, especially with newer trainees. Triaging client's safety and trainee's skillset to

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approach the presenting problem can help prioritize how to spend time in supervision (Campoli et al., 2016). The last concept shared by Campoli and colleagues (2016) is investment from the supervisor. A supervisee who feels cared for and whose growth feels important to the supervisor will likely feel safer to self-disclose in the relationship.

Self-Awareness About Self-Disclosure in Students and Psychology Trainees

Psychotherapy is an incredibly unique career; few other professions require such an intimate understanding and mastery of a sense of self. When on an airplane, for example, passengers do not wonder about the concerns of the pilot as long as the plane lands. With psychotherapy, however, the anxieties of a clinician could significantly impact the outcome of treatment.

Therapist self-awareness is an essential part of psychotherapy (Williams et al., 2008), and can often dictate the outcome of therapy. Therapist self-awareness impacts cultural competency, ethical behaviors, and the ability to recognize scope of practice and potential limitations. Insight into a therapist's strengths, weaknesses, biases, and even personal trauma history can help therapists navigate complex therapeutic interactions that may illicit counterproductive reactions. According to the American Counseling Association's 2005 Code of Ethics, fostering self-awareness in therapists can help provide more effective care for their patients and clients (Warren et al., 2010).

For trainees, it is especially critical to have frequent check-ins regarding emotional well-being given the combined stress of being a graduate student and a psychology trainee. For supervisors of clinicians-in-training, blind spots and personal boundaries are important to assess and explore to protect the interests of the trainee and the client. This can be a difficult balance to achieve given the importance of following ethical guidelines. Supervision requires an artful finesse, embodying teacher, therapist, role-model, disciplinarian, and expert, all while encouraging the student to remain non-defensive, confident, and curious (Gizynski, 1978).

Ethics Code for Self-Disclosure in Students and Psychology Trainees

The Ethical Principles of Psychologists and Code of Conduct states:

> Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others. (American Psychological Association, 2018, Section 7.04).

Due to the subjective nature of the second part of this ethics code, supervisor's thoughts regarding disclosure from trainees should not be taken lightly. Consultation, self-awareness, and clinical judgement are required to make such decisions. Instances where this code may be relevant is if a trainee has a similar mental health disorder as a client, potentially leading to negative clinical implications (i.e., working with eating disorder clients

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when a trainee has been observed to or disclosed engaging in their own eating disorder). Another time a supervisor may inquire about a trainee's personal experiences is if a trainee indicates or shares a belief or lack of competency about working with a client effectively (i.e., discloses internalized homophobia and working with a client of the LGBT+ community). At some point, the supervisor must reflect on what additional training is needed for the trainee, while also considering what is in the best interest of the client. Moreover, there is a need to better understand a supervisee's reaction in order to best support them and the client. Consequently, self-disclosure is sometimes necessary to make that decision due to the risk supervisors take when working with and supervising psychology trainees. Ideally, the supervisory relationship will be strong and such disclosure will feel safe to be shared. If remediation is necessary, a strong supervisory relationship will not feel punitive and instead, feel ethical and conscientious.

Trauma-Informed Supervision with Students and Psychology Trainees

Trauma-informed supervision considers the history, context, and background that each trainee brings into the supervisory space. Parallel processes can occur from supervisor to trainee, and then trainee to client. This demonstrates that the supervisor has an impact on the client, even though they may never meet (Martin et al., 2022). Creating an atmosphere of trust, collaboration, and autonomy will encourage the trainee to feel safe in sharing and self-disclosing. This will better inform and deepen the supervisor's case conceptualization and clinical recommendations for a client's treatment. It will also allow the supervisor to tailor their supervision to the trainee's individual needs, reactions, and beliefs to aid them in their growth as a future mental health professional.

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SUPERVISION

A Supervisor's Deliberate Practice Journey

MacKenzie Stuart, LMFT

This article is part of the "Deliberate Practice in Psychotherapy" Series. Each article in this series elaborates on the experiences of a psychotherapy supervisor or trainee engaging in Deliberate Practice (DP) supervision, following the Sentio Supervision Model, developed by the Sentio Marriage and Family Therapy MA program (www.sentio.org) and the Sentio Counseling Center (SCC; www.sentiocc.org). The SCC is committed to several evidence-based distinctive features for best supervisory practices, including: All therapy sessions are videotaped; all counselors use routine outcome monitoring every session with every client; all counselors have weekly individual supervision, group supervision, and DP skills training; all supervision sessions are videotaped; and every week, SCC supervisors meet to provide feedback to each other's videotaped DP supervision sessions.

For more on the Sentio DP Supervision Model, see the introductory article in this series. (https://societyforpsychotherapy.org/deliberate-practice-supervision-series-from-the-sentio-marriage-and-family-therapy-program/)

Call to adventure

In March 2023, Hanna Levenson, one of my colleagues at the Wright Institute, invited Alex Vaz and Tony Rousmaniere, the dynamic duo of Sentio Counseling Center (SCC), to do a 6-hour training on deliberate practice and the Sentio Supervision Model (SSM) for our community. They were looking for volunteers to be in the hot seat, and I've always been the kind of clinician who loves roleplays so I volunteered.

Using a supervision preparation form they provided as my guide, I reflected on a recent psychotherapy session where a client's behavior had caught me off guard and I artlessly stumbled over my words. I was going to see the client again the next week and, frankly, I was dreading it. The supervision form itself was valuable; it helped me figure out the exact moment that had thrown me off my game.

As a training group, we collectively identified the challenge the client presented in that moment, and the therapist deficit that left me ill-equipped to respond well. We came up with a learning goal for me, rooted in my clinical style. Then, Alex did a pitch perfect impression of the client behavior, and I practiced intervening more effectively about half a dozen times. After each behavioral rehearsal, the facilitators and participants gave me constructive feedback before I tried it again. With each behavioral rehearsal, I felt myself moving towards a more effective intervention. The exposure to Alex's pastiche of my client even flushed out my countertransference without my having to name it explicitly. Outside of my psychotherapeutic life, I'm an athlete, and the SSM feels like pre-game drills, complete with coaching.

So much of my consultation stops at conceptualization and gaining thought partnership around clinical intervention

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a decade into my career was a breath of fresh air. I felt supported and playful during the behavioral rehearsal. During that next session I had been dreading, my client repeated the behavior and I effortlessly responded with the skill I had practiced in the training. The client's demeanor shifted and we had our most productive session to date. I signed up for the Sentio Counseling Center's deliberate practice supervision residency the next day.

Belly of the whale

As a professor, I've recorded my lectures and watched my lecturing improve due to reviewing those recordings. Since I received my clinical training during the era when tape recorders had actual tape in them, I had never seen video of myself performing clinical or supervisory work. During our first "supervision of supervisors" meeting, I sweat through my shirt watching myself on video. Is that how I sound when I'm thinking out loud? How did I miss how lost my trainee was? Why am I sitting like a shrimp?

But within a handful of meetings, I began focusing on opportunities to do something differently and more skillfully. My heart wasn't pounding anymore. I began to look forward to seeing a recording of myself while making a mistake. The quality of the feedback from my colleagues and facilitators helped me laugh at myself, play with a new way of doing things, and improve clinically.

Ultimate boon

It feels good to be in a parallel process with my supervisees. They know someone is reviewing my recordings the same way I review theirs. They know I've been assigned deliberate practice homework the same way I assign them homework. They see me make mistakes, lose my train of thought, or forget things. My experience with relational supervision taught me that those moments can cause ruptures or can impact the supervisee's trust in me as their supervisor. This can lead to a learning experience by engaging in process conversations about how we felt at the moment of my imperfection. The SSM asserts learning is a lifelong process and mistakes are an opportunity for play and experimentation. It flattens the ineffective parts of the power differential between supervisor and supervisee, while still honoring the differing levels of knowledge and experience in the room.

Video: Structuring supervision with a trainee through the Sentio Supervision Model

Click here for video:
https://youtu.be/_fecVJRjgDI?si=IO2zJIZi-BLx3ssX

I've supervised over 20 pre-licensed clinicians and taught hundreds of masters-level students. Common among them is a sincere desire to do the right thing in the therapy room, which can lead to an occasionally-incapacitating level of anxiety. The SSM is containing and supportive. Tony orients trainees to the model by showing a recording of him getting a client's name wrong and doing nothing about it. With a rakish smile, he dares them to show him a recording of them doing worse. The learner's mindset is showcased and welcomed at every level of the organization and is reinforced by the SSM itself. Supervisees leave supervision with a clear sense of what to do during future sessions and concrete skills to practice. This focus on skill acquisition also creates stronger, more competent clinicians. The trainees I supervise at SCC have been seeing clients for under a year, but their clinical acumen is on par with that of associates with years more experience.

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I now think of clinical skills acquisition in a materially different way. Gone are 20-minute back-and-forth roleplays where we imagine what a client might say or do. I am now stronger at breaking an intervention down into its component parts, describing them, and walking a supervisee through practicing them. This makes skills more digestible and makes it more likely a supervisee will be able to use them in the room with a client. Gone are the days of suggesting a supervisee use an intervention and hearing "I forgot" at the next supervision meeting. I am also increasingly able to tie a skill to a particular client challenge or therapist deficit. There are themes in challenges and deficits, and themes in the interventions used to address them. Those themes are thrown into sharp relief by learning goal creation, and responses to them honed by behavioral rehearsal.

Crossing of the return threshold

My enthusiasm for deliberate practice has suffused itself into all facets of my work, from the classroom to the clinic. At SCC, the SSM is held within a complete infrastructure package. I walked into a system covering everything from OQ®-Analyst feedback-informed treatment to automatic video recordings to weekly supervision of supervision meetings. Metaphor Therapy, the for-profit corporation where I serve as CEO, president, clinical supervisor, psychotherapist, administrative assistant, and janitor, doesn't have the same economy of scale as a 501(c)(3) nonprofit training organization, and some of this infrastructure is costly. While I love fidelity to a model, I know that perfect is the enemy of the good. In the year I've been delving into deliberate practice, I've slowly begun to build out my own infrastructure. I've led supervisees in exercises from the APA series of deliberate practice books. I've shifted from roleplays to deliberate practice drills in supervision and the classroom. Next month, I'm investing in a platform so I can focus supervision meetings on video recordings. At SCC, having the whole infrastructure package means I see trainee progress happen in leaps and bounds, and figuring out how to achieve similar results in my modestly-sized practice requires more experimentation.

Even though I am sold on the utility of deliberate practice and the SSM, I do still sometimes yearn for the less effective relational supervision of yore. As a professor, I am drawn to the most information-dense topics where content is king. My own education focused on case conceptualization rather than interventions. I love to ruminate over the *why* and *how* of a case with a colleague. I love to pontificate on psychoeducational trivia. And, if I'm being honest, I miss phoning it in sometimes. In relational supervision, I can let a supervisee run their mouth for the duration of our time together while nodding sagely and asking, "What's your impulse here? Go with that." However, within the SSM, case conceptualization and didactic content are privileges for when a supervisee has sufficiently mastered the skills necessary to serve their clients. At the beginning of a clinician's career, there are so many skills to learn and practice. There is no room to phone it in.

When I applied to graduate school, my undergraduate advisor wrote in his letter of recommendation that I had grown bored of the abstract nature of political theory and needed praxis to be satisfied in my career. Deliberate practice is a fantastic synthesis of the theoretical and the practical, the educational and the applied. It has reinvigorated my love for supervision and psychotherapy alike. I'm proud of the work I've done and am chuffed to be

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a part of Sentio Marriage and Family Therapy MA Program's teaching cohort for the 2024-25 academic year. The foundational structure of my classroom and practice have fundamentally changed as a result of my time with the Sentio Supervision Model, and I couldn't be more excited about it.

SUPERVISION

Deliberate Practice Supervision Series from the Sentio Marriage and Family Therapy Program

Alexandre Vaz, PhD
Tony Rousmaniere, PsyD

Welcome to our series on Deliberate Practice for the Psychotherapy *Bulletin*.

Our goal for this series in the *Bulletin* of the Society for the Advancement of Psychotherapy (American Psychological Association Division 29) is to inspire clinical supervisors, trainees and licensed professionals to integrate Deliberate Practice into their work. Each article in this series will present a trainee and supervisor's perspective in engaging in **Deliberate Practice supervision**, following the novel **Sentio Supervision Model**. Readers will learn about the potential benefits and challenges of integrating Deliberate Practice skill building into traditional clinical training; and will have access to videos showing real trainers and trainees engaging in Deliberate Practice activities.

In this introductory article we provide a brief overview of what Deliberate Practice is and why it matters for psychotherapists. We then present the **Sentio Supervision Model**, a 7-step Deliberate Practice supervision approach developed by the **Sentio Marriage and Family Therapy (MFT) program** that helps trainers integrate comprehensive skill building into clinical supervision.

What is Deliberate Practice?

Deliberate Practice is a series of research-based learning principles that studies have shown to predict the development of professional expertise across multiple fields (Ericsson, 2018, 2008). **In short, it is not enough to attend lectures or read about your field to become a master surgeon, basketball player, violinist and, yes, psychotherapist** (Vaz & Rousmaniere, 2021). Instead, trainees from these fields need both conceptual *and* active procedural-experiential skills training to achieve expertise. Deliberate Practice is an evidence-based training approach to facilitate this integration.

Here's how pioneering expertise researcher K. Anders Ericsson summarized the key Deliberate Practice principles:

> Analyzing a review of laboratory studies of learning and skill acquisition during the last century, we found that improvement of performance was uniformly observed when people were given tasks with well-defined goals, were provided with feedback, and had ample opportunities for repetition. These deliberate efforts to increase one's performance beyond its current level involve problem solving and finding better methods to perform the tasks. When a person engages in a practice activity (typically designed by teachers) with the primary goal of improving some aspect of performance, we called that activity deliberate practice. (Ericsson, 2003, p. 67)

In our own "translation" of these principles (Goldman et al., 2021; Vaz &

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Rousmaniere, 2022), we emphasize the major distinction between *conceptual* versus *procedural* learning in psychotherapy, and how both are necessary for clinical expertise. The table below provides a clear distinction between these two learning activities.

Table 1. Comparing routine performance, conceptual learning, and deliberate practice (used with permission from Vaz & Rousmaniere, 2022)

Activity	Definition	Examples
Routine performance	Performing work as usual	Providing therapy
Conceptual learning	Learning activities without repeated rehearsal/practice and feedback	Attending lectures Reading about psychotherapy theory, models, and research
Deliberate practice	Repetitive rehearsal of specific skills with ongoing corrective feedback	Repeated behavioral roleplaying of a specific clinical skill (e.g. empathic understanding)

Why does this matter for psychotherapists?

A growing number of prominent psychotherapy researchers and authors now suspect that **Deliberate Practice (DP) could be a missing "key ingredient" to foster clinical mastery** (Anderson & Perlman, 2020; Boswell et al., 2020; McLeod & McLeod, 2022; Miller et al., 2020; Norcross & Karpiak, 2017; Wampold et al., 2019). **Over 15 published studies from independent research teams around the world have shown that DP training outperforms our field's "training as usual" methods for clinical skills acquisition** (for reviews, see Nurse et al., 2024, and Mahon, 2023). Research on this is still in its infancy, so we expect to see rapid growth in the number and quality of studies in the near future. (For an up-to-date list of DP in psychotherapy papers, visit: https://sentio.org/dpresearch).

Despite the widespread enthusiasm and preliminary positive findings for the use of Deliberate Practice in psychotherapy training, most interested parties—supervisors, therapists and trainees—still struggle with how to actually implement DP in a rigorous and consistent fashion. In other words, **the field is sorely missing concrete and trainable guidelines to implement DP in various clinical settings.**

Sentio's Deliberate Practice Supervision Model

One team that has been making strides in developing DP guidelines and procedures is **Sentio**. The **Sentio Marriage and Family (MFT) MA program** is a 20-month hybrid online and in-person program that provides a fast-track to becoming licensed as a LMFT in California. The Sentio Marriage and Family Therapy program adopts a novel strategy for training therapists, employing small groups and maintaining a low ratio of students-to-faculty. This setup enables personalized and intensive mentorship right from the start. Importantly, **this program is the first to our knowledge that systematically integrates Deliberate Practice skill building into every course and class meeting**. This means that every week, Sentio trainees receive rigorous conceptual *and* procedural-experiential training, as both are essential to develop clinical competency.

As part of Sentio's mission to disseminate open-source resources on Deliberate Practice, its team has developed **the first step-by-step Deliberate Practice super-**

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vision model. The **Sentio Supervision Model (SSM)** is a 7-step approach that helps trainers integrate three supervision-enhancing methods into every supervision session: (1) the use of routine outcome monitoring, (2) the use of therapy recordings in supervision, (3) personalized Deliberate Practice skills training (Haggerty & Hilsenroth, 2011; Lambert et al., 2018). **We should note that this DP supervision approach can also be used if trainee's have no client outcome or therapy recordings available**—these are very helpful augments to DP supervision, but not necessary to carry out its main steps.

Below is a summary of the main steps in the Sentio Supervision Model:

SENTIO SUPERVISION MODEL (SSM)		
Steps	**Brief description**	**Example**
Step 1. Check Trainee's Outcome Data	If outcome data is available, focus the supervision on the client whose outcomes signal that they are the most distressed or at risk of clinical deterioration.	Mary and her supervisor notice that her client Joe is flagged by an outcome measure as being particularly at risk of deterioration. Because of this, they choose to focus on this client for supervision.
Step 2. Review Supervision Preparation Form	Trainees complete a Preparation Form prior to each supervision that elicits preliminary ideas from the trainee on what the focus of supervision could be.	Mary wrote in her preparation form that her client Joe tends to get angry at her when she asks about his feelings. She says she doesn't know how to address this.
Step 3. Identify a Client Challenge	At this stage, supervisor and supervisee collaborate to agree on a challenging and observable client behavior that needs to be more effectively addressed in session.	As Mary and her supervisor look at her therapy recording, they indeed notice that Joe is getting angry after being asked about his feelings. They agree to focus supervision, at least for now, on addressing this challenge.
Step 4. Identify a Therapist Deficit	After identifying a client challenge, the supervisor helps the trainee see what they are doing in session that is not working or keeping therapy stuck.	The supervisor noticed and reflected back to Mary that when her client Joe gets angry in session, she looks anxious and quickly changes the subject. The supervisor points out that this therapist behavior in session is part of what might be keeping therapy stuck.
Step 5. Identify a Learning Goal	The supervisor and trainee collaborate to identify a concrete clinical skill to more effectively address the identified client challenge.	Mary's supervisor proposes to address the identified client challenge by doing an alliance repair intervention. Specifically, Mary could point out that she notices her client's frustration and, instead of quickly changing the subject, she could nonjudgmentally invite the client to elaborate on his frustration.
Step 6. Behavioral Rehearsal	The supervisor guides the trainee to repeatedly practice the identified skill *in vivo*. For each round of rehearsal, the supervisor provides brief, actionable feedback to refine the trainee's intervention.	The supervisor asks Mary to imagine she is in front of her angry client right now and invites her to try intervening with the proposed alliance repair skill. With each of her attempts, the supervisor provides feedback on how to better her intervention.
Step 7. Assign Deliberate Practice Homework	The supervisor proposes a solitary practice homework, if possible using a video recording of the client challenge to repeatedly keep practicing the same skill that was practiced during supervision	Mary's supervisor ends the supervision session saying: "Use the therapy recording with Joe to repeat the same exercise we just did for at least 10-minutes until your next session with this client or our next supervision."

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For a video primer on Deliberate Practice supervision, see: https://youtu.be/i6673obvd-g?si=6G5udEmy9riEYecz

Conclusion

While Deliberate Practice might seem straightforward at first, we have found that it requires considerable effort and training on part of the supervisor to implement DP supervision effectively. Also, different clinical supervisors and trainees will, of course, have different needs that should be accommodated for within the broad structure of this supervision model.

In the next articles in this series, we will present supervisors' and trainees' experiences with Deliberate Practice supervision. You will hear from experienced supervisors about their transition from facilitating "supervision as usual" to DP supervision; and from trainees' experiences and challenges in engaging in DP supervision. These reports will be coupled by videos showcasing DP supervision in action.

We look forward to you joining us in the articles in this series.

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FEATURE

When Should My Suicidal Patient Go to the Hospital?

Samuel Knapp, EdD, ABPP

At one time, hospitalization was considered the standard of care when working with patients with suicidal thoughts or suicide attempts. However, almost all suicidal patients can now be treated effectively as outpatients. Several outpatient interventions can substantially reduce the risk of a suicide attempt (see, for example, reviews by Jobes & Chalker, 2019; Nuij et al., 2021). When, then, should psychotherapists recommend hospitalization for a suicidal patient?

I consider myself a hospitalization moderate. I have personally seen both the benefits of hospitalizations and the ways it has been misused, and I strive to keep current on the evolving research on suicide prevention. On the one hand, I have encountered patients with such a high risk of suicide that hospitalizations were necessary to save their lives. One young woman being treated by my agency was so intent on killing herself that if the police had arrived at her home five minutes later, she would have been dead. Nevertheless, such extreme cases are rare, and few patients with suicidal thoughts need to receive hospital care.

I have also seen the overuse of hospitalizations by undertrained and alarmist psychotherapists who did not have the training in evidence-supported interventions that can reduce the risk of suicide and initiate suicide prevention. Below are considerations for psychotherapists who need to decide when to recommend the hospitalization of a suicidal patient, including the standards to use, the contraindications, the importance of discharge planning, and special considerations with involuntary or pressured psychiatric hospitalizations.

When Is a Psychiatric Hospitalization or Hospital Care Indicated?

The decision to recommend a psychiatric hospitalization requires weighing the benefits of a hospitalization against its costs. Sometimes, hospitalizations may be necessary to save a patient's life or start them on the road to recovery and suicide prevention. Psychiatric hospitalizations for suicidal patients may be indicated if patients pose such an immediate threat to their safety that they need to be monitored closely or if they have unusual or comorbid medical issues that require close attention.

Most psychiatric units provide short-term care focused on stabilization (Simon, 2012). Stays can be extended if patients have comorbid issues or complications such as substance misuse or psychotic features. Patients or their families may have unrealistic expectations from a hospital stay, so psychotherapists should explain their goals for the hospitalization and ways that patients can maximize the benefits of their hospitalization.

Ideally, psychotherapists will recommend a hospitalization after a thorough evaluation that allows patients to tell their stories at their own pace, and the psychotherapist has consulted with family members and other treatment providers. They then need to determine if the usually effective outpatient interventions to reduce suicide risk, such as

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safety planning, lethal means counseling and psychotherapy, are sufficient to ensure patient safety. However, the conditions that give rise to the need for hospitalization may arise quickly, so sometimes psychotherapists have little time to reflect, involve family members, or consult with others.

Assessing Risk for Suicide and Suicide Prevention

Predictions of a suicide attempt are fraught with many uncertainties, and no formula can predict the likelihood of a suicide attempt with great accuracy. Psychotherapists can, nonetheless, make the best decisions if they follow an established format for assessing risk (e.g., Jobes [2023] or Bryan and Rudd [2018]).

Screening instruments, such as the Columbia Suicide Screening Scale or the Ask Suicide-Screening Questions, can assist psychotherapists in making these decisions. However, these instruments should never be used in isolation to determine the risk of suicide or the needed level of care. No suicide screening instrument is high in both specificity and sensitivity (Runeson et al., 2017), and no one screening instrument is noticeably better than any other (Gutierrez et al., 2021).

Some psychotherapists rely on levels of risk formulae to inform psychologists whether the services should be inpatient, intensive outpatient, or regular outpatient. These may help some psychotherapists to think through the information that they have. Nonetheless, psychotherapists should not overvalue these formulae. First, they are imprecise. They lack consistent definitions across studies, and no study has demonstrated that they can predict the short-term likelihood of suicide with any reasonable degree of accuracy (Berman & Silverman, 2013). Also, suicidal risk fluctuates over time and sometimes very rapidly. A patient who seems safe one day may appear highly suicidal the next. Finally, placing a patient at a level of risk may lead to confirmation bias, wherein the interpretation of new data is overly influenced by a level of risk previously established for a patient.

Psychotherapists should weigh the clinical benefits of hospitalization against the costs to the patient, including disruptions in their lives, the potential for exposure to harmful events in the hospital, and the social stigma involved. Even brief hospital stays mean patients cannot work, go to school, care for children, or participate in other important life activities, and may have financial burdens imposed on them.

A less obvious cost to patients is that they may have to invest much time to secure hospital admission. In the ideal situation, a patient is also being treated by a psychiatrist with privileges in a nearby hospital, and the psychiatrist can admit the patient quickly. Nevertheless, arranging a hospitalization can often be taxing on the psychotherapist and the patient. I have known patients who have waited hours in the hospital emergency department while case workers looked for a hospital bed, only to be sent home while the case worker tried again the next day.

Repeated hospitalizations may be clinically contraindicated for persons with chronic and severe personality disorders, and psychotherapists need to balance the patient's immediate safety with the long-term goals of treatment (Carmel et al., 2018). Psychotherapists need to consider, for example, if the hospitalization would reinforce inappropriate behavior by giving too much attention to suicidal thoughts at the expense of looking at other aspects of life and different ways to cope with difficulties.

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The hospitalization decision also needs to consider the quality of the services in the recommended hospital and the potential for harm occurring in the hospital. No two hospitals are alike. Many patients experienced good care in hospitals and reported that their experiences there set them on a recovery trajectory. Other patients reported a dehumanizing atmosphere and exposure to problematic and frightening behavior from other patients (Large et al., 2014). While traumatic events in a hospital may contribute to the suicide of some patients, it is difficult to determine how often this happens because those sent to the hospital may already have a high risk (Ward-Ciesleski & Rizvi, 2021).

Psychotherapists should generally respect patient preferences regarding hospitalization (see the section on involuntary psychiatric hospitalizations for limited exceptions). If psychotherapists need to consider a hospitalization, they should document their decision-making process, including information relied upon to make the decision, the pros and cons of hospitalization, and why the final decision was made. The level of detail should be sufficient for an outsider to understand why the psychotherapists acted the way they did.

Discharge

Because of the short stays for most psychiatric hospitalizations, discharge planning should start soon after the patients are admitted. Ideally, there will be a smooth transition between inpatient and outpatient services, but this does not always occur. The risk of death by suicide is exceptionally high in the first months following discharge from a psychiatric hospital (Chung et al., 2017). Among VA patients, 40% of those who died from suicide within the first week died on the day of discharge (Riblet et al., 2017).

Psychotherapists should inform hospital staff on admission whether they intend to continue seeing the patients after discharge so the staff can make appropriate discharge recommendations. Some hospitals permit psychotherapists to visit or have phone contact with their patients while receiving hospital care, although this needs to be coordinated with the hospital.

Special Considerations with Pressured or Involuntary Psychiatric Hospitalizations

Involuntary or pressured psychiatric hospitalizations should be the last resort and used only when the danger to the patient is great and imminent and the psychotherapist can identify no other way to diffuse the danger. In addition to all of the contraindications for a hospital stay in general, involuntary psychiatric hospitalizations involve additional stigma associated with it, the loss of autonomy for patients, and may have secondary consequences such as the inability to own firearms in many states legally.

Pressure can occur not only through a formal involuntary psychiatric process but by threatening an involuntary hospitalization (and loss of ability to own firearms, loss of freedom to discharge oneself, and so on). Perceived coercion is linked to poorer outcomes. Those who report being pressured into hospitalization have small but significantly higher rates of subsequent suicide attempts than those who do not report such pressure, even when other factors were held constant (Jordan & McNiel, 2020).

If psychotherapists determine that an involuntary psychiatric hospitalization is needed, they should ensure that the statutory conditions have been met. Also, they should involve patients in the

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decision as much as possible, although a few patients, such as those in acute psychotic states, may not be able to participate in a meaningful way. Psychotherapists must be transparent about why they recommend the hospitalization and what services they want the hospital to provide. I have secured the cooperation of many suicidal patients by listening carefully to their concerns, explaining why I was recommending the hospitalization, involving them in the decision, and respecting their wishes as much as possible. For example, by carefully listening to one patient, I learned that she was refusing to go to the recommended hospital because her husband had died there, and it appeared that she had PTSD-like symptoms from that experience. Nonetheless, she willingly agreed to go to another hospital.

Practice Pointers

- Outpatient interventions can usually aid in suicide prevention to keep patients safe, although psychiatric hospitalization may be needed in rare situations.
- The decision for inpatient treatment should be based on a thorough patient assessment, including the immediate risk of harm, the benefits and risks of hospitalization, and the patient's preferences.
- Psychotherapists should not overvalue levels of risk formulae or suicide screening instruments when making recommendations about hospitalizations.
- Hospitalizations may be clinically contraindicated for some patients with a chronic risk of suicide.
- The quality of care in hospitals varies widely. Some patients report harmful experiences in hospitals, while others report benefits.
- Psychotherapists should document why hospitalization was or was not recommended, including the pros and cons of the decision and why the final decision was made.
- Because the risk of suicide following a discharge is very high, psychotherapists should communicate clearly with the hospital their desired involvement in treatment following release and, if appropriate, be closely involved in the discharge planning.
- Involuntary or pressured psychiatric hospitalizations should be the last resort when the threat of a suicide attempt is imminent, alternative ways to secure the patient's safety are not feasible, and efforts to obtain the patient's consent have failed.

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Society for the Advancement of Psychotherapy

FEATURE

Pornography and Sexual Dysfunction: Is There Any Relationship?

Stewart Cooper, PhD, ABPP

Psychotherapists working with couples or individuals involved in intimate relationships often receive questions or need to respond to issues related to the use of pornography. These can emerge as a primary or secondary focus of treatment. One specific area where substantial misinformation exists is in the connection between the use of pornography and sexual response/dysfunction during partnered sex. It is important for psychotherapists to base their assessments and interventions on an accurate understanding of the existing empirical data.

The open access article, *Pornography and Sexual Dysfunction: Is There Any Relationship?* authored by David Rowland, PhD, and Stewart Cooper, PhD, provides a rich summary of the research findings in this particular area of scholarship.

Rowland and Cooper (2024) had four goals in their narrative review: 1) Identify and review methodological issues that affect confidence in the extant literature; 2) Briefly summarize recent review papers on the topic; 3) Encapsulate and update the literature, examining the issue in two groups: the general population and specific subpopulations of problematic pornography users; and 4) Provide an evaluation and discussion of the state of research on this topic.

Their article is divided into several sections, starting with an introduction that not only clearly defines the issue but also identifies and defines the two variables of interest, sexual response/dysfunction and pornography use. The paper then presented the review methodology employed to identify high quality research articles published post 2016. This was followed by a synthesis of those articles within the two populations of interest: the general population and specific problematic pornographic users.

Rowland and Cooper (2024) drew several conclusions from their review. They demonstrated that claims of a strong impact of Frequency of Pornography Use (FPU) and/or Problematic Pornography Use (PPU) on sexual functioning during partnered sex are unfounded both by the findings of studies and/or by misinterpretations of them. Additionally, they found significant diversity of outcomes of pornography use, including how they currently play out differently for women and men and for problematic and non-problematic users. Importantly, Rowland and Cooper (2024) concluded that a relatively small percentage of men—perhaps younger, sexually inexperienced, and/or residing in sexually restrictive environments—might (even in the absence of pornography use) struggle with sexual performance during partnered sex, and this situation may be exacerbated by excessive or problematic pornography use. Equally important, they further noted that studies based on community samples do not support the notion that pornography use is widely and strongly associated with impaired sexual functioning during partnered sex.

Rowland and Cooper (2024) sought to advance the field via specific sugges-

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tions. They expressed the hope that a proximal outcome of this review would be the advancement of research in this field, achieved via two pathways. First is the inclusion of more relevant covariates directly associated with PPU and also with the particular sexual dysfunctions being assessed. It was their premise that these covariates may be accounting for much of any observed correlation between pornography use and the development of problematic outcomes. Second is the development of more intricate and detailed models that supplant concepts such as PPU and compulsive use with their component pieces, enabling retention or discarding of common and/or specific elements of PPU/addiction.

As a final note, Rowland and Cooper (2024) highlight that while pornography has been a part of human culture over the millennia, the development of technology has had a profound impact on the nature, amount, and availability of cybersexual activity, from viewing pornographic material to online sexual activities, both in-person and with robotic partners. They challenge thought leaders in this field to envision the future of human sexuality in an environment where such (once unimaginable) disruptive interfaces are likely to affect the nature and definition of sexuality in future generations.

The full open access article can be downloaded from:
https://link.springer.com/article/10.1007/s11930-023-00380-z?utm_source=rct_congratemailt&utm_medium=email&utm_campaign=oa_20240202&utm_content=10.1007/s11930-023-00380-z

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FEATURE

The Doctor is Out: Reflections on the End of a Practice

Leslie Connor, PhD

When my husband retired 4 years ago, he hung up the phone and was done. In the blink of an eye, his company laptop was ready to ship off and his home office was on its way to becoming our guest bedroom again. A new, exciting, responsibility-free horizon met him almost immediately. So he was a bit surprised each time he asked me how my path to retirement was going. (He's been married to a psychologist long enough to know to ask that question.) My answer: these last months of practice have been hard and unlike anything else I've ever done professionally.

The feeling many people have about their retirement, something along the lines of: "Yippee Ki-Yay!" will come, but I wanted to share what is rarely talked about with regard to ending a private practice: saying goodbye is some of the most moving work you will do.

For me, the process began 12 months prior, when I told clients that I would be retiring in a year. One astute client said, "Well, that gives me enough time to be happy for you without worrying what the ending will look like just yet." Nearly everyone asked if I would suggest a new therapist (I would) and asked me to refer them to someone just like me (I couldn't).

I spent months reacquainting myself with colleagues so that I could be sure not to recommend someone who was planning to retire in short order. Before this, meeting for lunch or coffee was something I never made time for, especially during the pandemic. So it was delightful to connect and reconnect with other practitioners who were also eager to hear how my retirement experience was unfolding. After all, there is no manual on thoughtful and caring goodbyes. Just as each clinician's practice is unique, so is the ending they write.

I looked online for guidance and advice on retiring and/or closing a private practice. There's no shortage of material on finishing well from an ethical and professional perspective (e.g., informing referral sources, securely storing files, and purchasing extended malpractice insurance, to name a few) but very little about the softer side of retirement. I found one article from a new practitioner who said goodbye to a client after *8 months* of work together. As sympathetic as I was to the rookie experience, where every "first" is special, I was looking at goodbyes after 5, 10, 15, even 20+ years.

Shortly after my initial announcement, my clients were eager to return to our ongoing work. Only occasionally did anyone revisit the seismic change that was about to happen. So I made it my job to periodically refer to my timeline, as well as to what to expect. Denial is a powerful thing that serves to protect us, but not prepare us.

One young woman, with whom I expected to meet until I retired, abruptly announced one day, 5 months early, that she was ready to stop therapy. There was nothing natural in her timing, which made me curious. I posed a question to her: "When you were dating, did you break up with people before they

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broke up with you?" "Oh yes," she answered quickly, and then it was clear. She was struggling with anticipatory loss and decided to cut things off before the pain grew more intense. We ended that day.

Most other folks wanted to get as much done as possible before we said goodbye, and I felt the same. With each remaining appointment, I wanted to provide not only my best counsel, but also enough to last for many years to come. My sense of responsibility for each person's well-being kicked into high gear, not surprising to those who know me. It was like the summer before you send your teen off to college. Can they fend for themselves? Are they ready? Will their clothes all shrink in the dormitory dryer? I not only wanted to finish well by making each goodbye a personal one (a book, a poem, a symbolic transitional object), I also wanted them to be able to draw on our insights long after we ended. When colleagues asked me how things were going, I'd typically say two things: finding my way is both daunting and a bit lonely.

I quickly realized I was building a tall order for myself. My hope was that each client could leave with the ability to articulate what our progress together had been, that they would be able to identify the themes within the work and the complexities in finding a path forward, while also knowing when to ask for help. I knew it would be slightly less painful that way. But just like a parent of a teen, I was reminded that not all birds soar when they leave the nest.

Many clients were right there with me, holding onto our time together, seizing the remaining opportunities, knowing this was not forever. It had never been forever, but now there was a countdown. Two months before closing my practice, I scheduled all final appointments so each person knew how many sessions remained and exactly when our work would be ending. The countdown was quantifiable now.

I looked high and low for poems to give as parting gifts, knowing that poems, like music and metaphors, express emotion for which we often can't find words. While a thousand pithy quotes turned up, the poem search grew frustrating. Was I looking for one perfect poem, a unique one for each client (if that's your goal, I suggest you start today), or a set of poems that would apply to almost everyone? I stopped looking and rethought my plan.

I've always been drawn to writing, so I settled on the idea that I would write each client an individualized card. My initial goal of writing one card per day for 35 days quickly transformed into late night card writing sessions on the weekends before the final goodbyes. In retrospect, I don't think that my heart had the words I needed to say goodbye until the time was ripe.

In *Psychotherapy and Process*, Bugental writes: "Finally there comes the time of relinquishment. We have grown together a good working relationship; now we must let go of it. This is not a light matter, but it is not a tragic one either." He adds, "The ending needs the authenticity we have sought all along."

As the last 2 weeks of practice approached, I prepared for the final goodbyes. I was now fully in the moments when you try to express all final thoughts, offer a hug or warm handshake, and then wish them well. Oh, it's a doozy of an experience. Would we ever see each other again? If we did, would the time be right to greet, hug, or

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get a quick update? Or would we have to quietly smile at one another to protect the privacy of the relationship? And if we did talk, would it feel all too brief compared to the weeks, months, and years of trust-building, risk-taking, laughter, and tears?

Hour after hour, my heart was in my throat as I talked with each person for a final time. I wanted to reflect their strengths, talents, determination, beauty, and goodness back to them. I wanted to remind them of the themes in our work that would carry forward, with a touch of realism about how old patterns can return when we least expect them. I also wanted to make room for their expressions of appreciation and warmth. There were many tears, words of appreciation, a spontaneous "I love you, Dr. Connor" or two, and even a beautiful prayer from a seminarian client.

While still their psychologist, I had come to care about each person, human to human.

How life-giving this work is! After all, where else is truth so singularly the focus? And where else are you given the gift of seeing beyond the tangible to the essential core of the soul, where a story about family traditions or vacation disasters or irrational arguments becomes the basis for seeing love, shame, hurt, vulnerability, and resilience?

In a time when, thanks to social media, we don't have to let go of any human being we've met along the way, this was one time where the goodbyes had to be firm. But it felt so strange to many folks, and a bit to me as well.

It really was goodbye to people who have been part of my professional life, and to the special role that we get to have in others' lives. I knew I could and would talk honestly and intimately with my loved ones, but never quite in the way that this career has allowed me to. I feel lucky to have had hours and hours of meaningful conversation over the last 32 years of practice; some tough, some inspiring, some both.

I read Mitch Albom's *Tuesdays with Morrie* earlier this year for the first time. Towards the end of his remarkable life, Morrie tells Mitch that "death ends a life, not a relationship." I feel the same way about retirement, which for me grew into a sacred and tender experience. Saying goodbye with each client offered a steppingstone to my next chapter. And I am grateful to have experienced it.

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Society for the Advancement of Psychotherapy

FEATURE

Moving Towards Understanding and Undoing the Stigma of Borderline Personality Disorder: Harm of Stigma with Borderline Personality Disorder

Carla Capone, MS
Olivia Romano, MS

"Manipulative," "attention seekers," and "drama queens" are a few damaging ways clients with borderline personality disorder (BPD) are often described; these individuals are among the most stigmatized within a clinical population (Allan, 2018; Deans & Meocevic, 2006; National Alliance on Mental Health, 2017). BPD is a disorder centered around pervasive patterns of instability in the context of emotion regulation, interpersonal relationships, self-image, and impulse control (American Psychiatric Association, 2013). Stigma towards psychological disorders creates added difficulty for those who have a diagnosed condition, attributing to greater apprehension about seeking treatment and exacerbating feelings of hopelessness. Stigma specifically related to BPD often becomes a self-fulfilling prophecy on behalf of the clinician. Preconceived negative views towards clients become reinforced at the emergence of challenging symptoms (i.e., maladaptive attempts to self-soothe, intense vacillations of mood), creating hostility towards the individual as opposed to conceptualizing such as symptoms not yet successfully treated (Aviram et al., 2006).

Although clients with BPD hold a significant prevalence within the clinical population (~20% of inpatient population, ~11% of outpatient; Chapman, 2023), they are often the subject of negative attitudes and/or judgements from mental health professionals, resulting in—often due to clinician's own fear or anxiety—a reluctancy to treat. Antagonistic feelings towards those with BPD are often the result of common suicidal tendencies, including perceived around the clock availability from the therapist, as well as strong, negative countertransference feelings, such as anger, embarrassment, and helplessness (Bodner et al., 2011). However, both fears of overwhelming burden from and hostility towards those with BPD are often an indication of treatment failure or clinician inexperience (Gunderson & Palmer, 2012). In fact, those with more severe symptomology have even been shown to have a greater potential for symptom improvement, particularly a decrease in maladaptive behaviors, challenging the longstanding idea that those with BPD cannot progress in therapeutic treatment (Barnicot et al., 2012).

Current Treatments and Gaps in Research for Borderline Personality Disorder

Once considered an untreatable mental disorder, BPD is now successfully improved with several empirically supported approaches of various theoretical orientations, such as those derived from cognitive, psychodynamic, psychoanalytic, and common factor theories. For example, dialectical behavior therapy, transference-focused psychotherapy, mentalization-based treatment, schema-

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focused therapy, structured-clinical management, and general psychiatric management have all been shown to improve BPD symptomatology. Favorable outcomes have also been shown from stepped and dismantled manualized therapies (Choi-Kain et al., 2017). Though available and promising, many clinicians working in community settings do not have the resources necessary to administer comprehensive manualized treatments (e.g., specialized trainings, supervision, etc.), or even the knowledge of their existence—making known ways to competently treat clients with BPD profoundly lacking or inaccessible. These disconnects between research and practice may exacerbate clinicians' apprehension or fear of treating those with BPD, maintaining biased stigma even further.

Along with being a treatable disorder, BPD also has a high rate of remittance of ~25% within a year, ~50% within 2 years, and up to 93% over a 10-year period. Once those with BPD have successfully remitted, they show very low rates of reoccurrence or relapse of around 6% (Gunderson et al., 2011; Gunderson & Palmer, 2012; Zanarini et al., 2005; Zanarini et al., 2010). While clients with BPD present in various way that can be complicated, the majority of those in treatment do not require constant availability of clinicians and are actively seeking to relieve their painful emotional worlds. As therapists often experience those with BPD as "resisting treatment," such wariness or felt hostility is better understood as a symptom of the disorder, or an example of transference, and not a personal attack on the therapist (Gunderson & Palmer, 2012).

Research studying personality disorders is often overlooked and underfunded. Randomized control trials (RCTs) examining successful treatments for BPD are overwhelmingly scarce, making up only 7% of all psychotherapy process RCTs, despite having up to a 20% prevalence in clinical populations. Comparatively, RCTs focusing on depression and/or anxiety, for example, make up 83% of trials yet hold a global prevalence of 55%. Though one of the costliest disorders to health care systems, as those with BPD utilize several services like psychiatric hospitalization, individual and group therapy, day treatments, and recovery house residences, BPD remains notably under researched (S. McMain, personal communication, July 6, 2022; Soeteman et al., 2008).

Fostering Alliance with Borderline Personality Disorder Clients

As with most clinical cases, therapeutic alliance serves as a top predicator of successful treatment outcomes for those with BPD and should be thought of as an integral focal point of any treatment regardless of orientation (Barnicot et al., 2012). Ways of building therapeutic alliance can include providing psychoeducation about the disorder, taking client's emotional reactions of events/interpersonal struggles seriously, and creating goals together. In fact, even just the disclosure of a BPD diagnosis to a client can contribute to a stronger alliance, as doing so can increase collaboration between the dyad, lessen feelings of aloneness, and further understanding of the disorder, helping to manage a client's expectations of emotional experiences (Bateman & Fonagy, 2016; Gunderson & Palmer, 2012; Lequesne & Hersh, 2004). Though clinicians often describe challenging feelings of countertransference while working with BPD, research has shown that a client's own burnout from treatments is a top predictor of clinician burnout. This, again, suggests that thoughtful and successful treatment early on, including

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working towards a strong alliance, are essential when treating these individuals (Linehan, 2000).

Summary of Shame and Stigma of Borderline Personality Disorder

BPD is a disorder that constitutes a large portion of a clinical population. Contrary to popular myths, studies indicate that BPD has a better prognosis than other serious mental illnesses (Lieb et al., 2004). Though symptoms of BPD typically consist throughout the lifespan, they can largely decrease with time and treatment. Research has shown that the prognosis of BPD is characterized by high rates of remission and low rates of relapse, with fostering a strong therapeutic alliance and providing psychoeducation being key aspects of any treatment. Though the prevalence of BPD is notable, trials studying effective treatment of such are lacking.

Mitigating stigma by having open discussions about BPD can help reduce misconceptions and encourage clinicians to be more compassionate toward these individuals. An essential part of reducing clinicians' difficult countertransference feelings toward those with BPD is recognizing behaviors that engender such feelings as symptoms of the disorder, and not personal attacks to the therapist. Increasing awareness that BPD is a treatable mental health concern can lessen stigma and judgment of these individuals, decrease therapists' apprehension and anxiety toward treatment, and cultivate, as Marsha Linehan says, "a life worth living" for those with BPD.

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FEATURE

How Self-Determination Theory Can Inform Interventions for Suicidal Patients

Samuel Knapp, Ed.D., ABPP

Consider this example: A psychologist sought consultation because her patient was not responding adequately to treatment. The consultant asked her three questions: Have you built a connection with your patient? Does your patient feel a sense of control and engagement in psychotherapy? Is your patient building the skills to handle their emotions and life difficulties?

The consultant derived these three questions from self-determination theory (SDT), which identifies three basic needs or intrinsic motivators of human behavior which are:

connectedness to others, *autonomy*, and *mastery*. Connectedness or relatedness to others "involves the need to feel connected with and significant to others" (Ryan et al., 2011, p. 230). This involves both a sense of being cared for by others and a sense that one can contribute to the well-being of others. Autonomy "describes actions that are self-endorsed and volitional rather than controlled or compelled" (Ryan et al., 2011, p. 230). It does not refer to being isolated or separate from others but instead indicates having a sense of control over one's choices. Mastery or competence "concerns the psychological need to experience confidence in one's capacity to affect outcomes" (Ryan et al., 2011, p. 230). It is a belief that one can take actions that are likely to reach one's goals. Internal motivation for treatment improves when patients believe the treatment will meet their needs.

One can see the importance of self-determination in the World Health Organization's (2022) definition of mental health, which includes developing connections, making decisions, and coping with life stressors. Patients feel better when these intrinsic needs are met and worse when these needs are thwarted.

Psychotherapists can consider these needs or motivators when working with any patient, although they appear especially important for suicidal patients. Psychotherapists can use these three questions to monitor their patients' engagement in psychotherapy in addition to understanding their suicidal patients and helping them identify treatment goals.

Suicidal patients often experience frustration with these three intrinsic drives. Admittedly, suicidal thoughts and behaviors arise from the complex interaction of genetic, life history, psychological, and environmental factors, and there may not be one pathway to a suicide attempt for all people. Nonetheless, certain beliefs increase the risk that a person will have suicidal thoughts or attempt suicide, such as *perceived burdensomeness* (a sense that others would be better off if they were dead), *thwarted belongingness* (a feeling that one does not belong or is not accepted by a valued social group), or *entrapment* (a sense that their pain is unbearable and they have no options available to end intolerable life situations). Furthermore, suicidal patients often ruminate or feel intrusive, repetitive, and negative thoughts they cannot control.

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As found in the research by Tucker and Wingate (2014), the basic needs identified by SDT appear linked to the beliefs and experiences that could lead a person to consider suicide. For example, perceived burdensomeness and thwarted belongingness may represent a frustration of the need for connectedness; internal entrapment may represent the perception of a lack of autonomy or choices in one's life; and rumination appears to represent a lack of mastery over one's emotions (emotional self-regulation). Conversely, those with their intrinsic needs met may be more likely to believe their life is worth living. One effective intervention with suicidal patients is to help them identify their reasons for living, many of which appear to be linked to meeting their intrinsic needs.

Specific Steps Using Self-Determination Theory

Just as the causes of suicidal ideation are complex and multifaceted, interventions can also be multidimensional and personalized. The effective treatment of suicidal patients often requires psychotherapists to make many decisions regarding the optimal intervention for their patients. Nonetheless, regardless of their theoretical orientations or the location where they deliver services, psychotherapists can incorporate insights from SDT to inform their approach in making these decisions.

Can I Help My Patient to Connect with Others?

Loneliness, the perceived discrepancy between perceived and desired social connections, is associated with various psychological and physical limitations. Loneliness has an impact on health comparable to the effects of smoking, high cholesterol, and lack of physical activity. Relationship quality is related to all-cause mortality and morbidity (Holt-Lunstad et al., 2017). In contrast, strong social networks are associated with well-being (Murthy, 2023). Social relationships provide emotional comfort when people are distressed, material assistance when needed, information or advice on handling life difficulties and distractions, and opportunities for joint relaxation and entertainment.

Persons with suicidal thoughts often feel a lack of connectedness to others. They may experience perceived burdensomeness or thwarted belongingness (Tucker & Wingate, 2014). Furthermore, relationship losses often precede suicide attempts. In contrast, maintaining a solid social network is a protective factor against suicide and is linked to good mental health (Stone et al., 2018).

Effective psychotherapists build relationships with their patients and help them feel comfortable and secure in psychotherapy. They approach their patients with a compassionate and curious mind without judgment and validate their experiences (understanding how they came to have suicidal thoughts without endorsing suicide as a goal; Schechter & Goldblatt, 2011). A good relationship early on in psychotherapy is associated with fewer subsequent suicidal thoughts and attempts (Huggett et al., 2022).

In addition to building a good treatment relationship, psychotherapists frequently help their suicidal patients build or repair relationships with others. Loneliness may have different causes, and the interventions need to vary accordingly. For example, some patients may misinterpret or overreact to minor social offenses and need cognitive therapy to address dysfunctional interpretations of social interactions. Some may need relationship counseling to mend or strengthen relationships with others. Still, others may need opportunities to engage in social activities like social clubs or churches (Mann et al., 2017).

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Can I Promote My Patient's Autonomy?
People like to have choices in their lives. Nevertheless, when patients feel entrapment, they perceive they have no options left to them and can do nothing to end their unbearable pain except to kill themselves. In addition, one significant factor that keeps people from seeking treatment for suicidal thoughts is the fear that their autonomy will be taken away if they reveal their suicidal thoughts. They may fear that they will be forced to go into a hospital against their will or that their psychotherapists will disclose confidential information about them without their consent (Hom et al., 2017). Even if they enter psychotherapy, these fears may keep them from revealing their suicidal thoughts thoroughly.

Although respecting autonomy is important when treating all patients, it becomes especially important when treating suicidal patients. Psychotherapists can respect patient autonomy by listening carefully to their patients, explaining the nature and anticipated course of treatment clearly to them, collaborating with them throughout treatment as much as clinically indicated, and soliciting their feedback concerning their progress and perceptions of the psychotherapy process (Joiner et al., 2009; Knapp, 2024). This may involve, for example, adapting treatment according to the patient's characteristics, needs, and preferences. Treatments that incorporate patient preferences tend to result in better outcomes than treatments that do not (McAleavy et al., 2018; Norcross & Cooper, 2021).

The informed consent process, for example, can respect patient autonomy if it is used to ensure that patients understand what treatment will involve, what is expected of them, and how they expect their psychotherapist to act. Also, good psychotherapists see the informed consent process as part of treatment by conveying faith in the patient that they have the power and agency to effect positive change. As Jobes (2023) tells his patients, "The answers to your struggles exist within you—we will find these answers together as treatment partners" (p. 64). Psychotherapists should also be entirely transparent about what they are doing and why. For example, before starting a new activity, they may engage in mini-informed consent sessions to explain the purpose and rationale of the activity (Bryan & Rudd, 2018).

Additionally, psychotherapists can respect patient autonomy by involving patients in as many treatment decisions as clinically possible. For example, psychotherapists can include patients in every step of developing a safety plan, including identifying their reasons for living, the options for distracting them from their suicidal thoughts, and whom to contact if they are feeling depressed. As O'Connor (2021) has stated, "A safety plan is someone else's plan, it is not your plan" (p. 198).

Finally, psychotherapists can ask patients about their perceptions of their treatment progress and the acceptability of the psychotherapy processes. For example, Bryan and Rudd (2018) suggest that psychotherapists ask their patients to rate their perception that they would follow the plan on a 10-point scale when developing crisis plans. Even though patients were involved in the plan's development, it gave them a second opportunity to consider its overall value and ways to improve it.

Can I Improve My Patient's Sense of Mastery or Competence?

Although the exact nature of the suicidal experience will vary from patient to patient, some thoughts and feelings commonly occur among patients with

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suicidal thoughts (Rogers et al., 2023). These include, but are not limited to, hyperarousal behaviors, such as insomnia, nightmares, or agitation, or self-disapproving emotions, such as self-disgust or shame. These intense negative emotions often lead to entrapment or a pervasive belief that one can do nothing to end their unbearable pain. Nonetheless, gaining a sense of control over one's emotions may help reduce the patient's sense of entrapment. Of course, no one can have control over all of life's circumstances. They cannot control whether a factory stays open or closes, whether they or their loved one has a severe health concern or other factors related to their well-being. However, entrapment often limits their ability to identify what they can control. Psychotherapists can help their patients gain a sense of agency to influence events under their control and moderate their reactions to circumstances beyond their control.

Treatments may include cognitive reappraisals of these events, self-compassion-focused meditations, mindfulness training, psychoeducation on sleep hygiene, relaxation training, or medications to reduce emotional arousal or depression. Patients will develop more confidence in managing their emotions as their emotional arousal declines. Although patients may still have stressful life events, they are not seen as catastrophic. And while patients may continue to have unpleasant feelings, they can begin to see them as transitory or tolerable.

Practice Implications When Utilizing Self-Determination Theory

Suicide becomes less likely when patients learn to meet their needs. Psychotherapists can use the insights from SDT to help their patients formulate treatment goals, identify effective interventions, and rethink psychotherapy if patients appear stuck and are not making adequate progress. Specifically, psychotherapists can:

- Connect with their patients in psychotherapy and help them create or maintain connections where they feel cared for by others and can reciprocate care for others.
- Respect patient decision-making throughout psychotherapy and help patients identify and implement their options and choices.
- Help patients develop the ability to monitor and regulate their emotions and thoughts and gain some mastery of these skills.

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Society for the Advancement of Psychotherapy

FEATURE

The Myth of the Psychologist: Changing Emotional States is a Process Not an Outcome

Francis L. Stevens, PhD

The Omniscience Psychologist

As a psychologist, I typically get one of two responses when I meet someone new and they inquire about my profession. The first is a quick clamor response, as if by speaking I can plunge deeply into their psyche and see parts of themselves they prefer to stay hidden. The second response is a personal story, so I can give them some special insight that's going to resolve whatever personal concern they may have. I often try and deflect this by making the joke that I'm not a good enough psychologist to see, understand, or fix whatever concerns they might have. All this perpetuates the myth of psychologists having some special insight that can detect and fix problems. The problem here is this diminishes what psychotherapy really is, an experiential process of change. Change occurs through experience; you change behavior by doing an alternative behavior, thinking with improved thinking, and emotion with a new emotional experience (Greenberg, 2023). For many individuals who come to psychotherapy because they feel horrible, there is no psychological insight to undo this; only the hard work of emotional change.

Emotional Change in Psychotherapy

Right now, emotional change is an abstract notion. How does one even begin to change their emotions? This is something I and many others have been working on and affective neuroscience offers some promising solutions (Lane & Nadel, 2020). The first step is for psychotherapy to move past seeing emotions as an output phenomenon. Negative emotions don't occur because someone doesn't have the intuition to understand how their parents' behavior affected them or because they lack the rational thinking skills to modulate the uncomfortable emotional state. Although these interventions may have value in psychotherapy, they don't result in emotional change (Stevens, 2023). So, what does emotional change look like in practice?

First Steps Towards Emotional Change

1. Practice emotional awareness. This can be done through practicing mindfulness, journaling about your feelings, or just talking about your experience with a friend. Try to see emotions as information from your body. Be less judgmental and more curious about your emotions.
2. Validate your feelings. Whatever you feel is what it is. You can't change these feelings: they're real even if they don't make any sense to you. Why am I angry in this situation? You may not know why, but your anger is real. You can accept it without acting upon it. Remember, you can't change your feelings; you can only change how you respond to what you are feeling.
3. Practice self-compassion. Many of my patients get tangled up because they are mean to their feelings. This informs your body that you should suppress these feelings. Not only is it harder to work with feelings that you ignore, but that critical voice leaves

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you with the uncomfortable feeling of guilt for having feelings.

These are the first steps for responding to our emotions. They probably won't fix any major psychological disorder, but these initial skills are necessary to practice and build before moving on. What these first steps do is stop us from fighting with ourselves and move us towards accepting our emotional experience. Then, more advanced techniques can be implemented to transform the emotion itself. For therapists interested in the neuroscience and theory behind emotional change, as well as getting started on the more advanced stuff, read *Affective Neuroscience in Psychotherapy: A Clinician's Guide for Working with Emotion*.

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FEATURE

Coming back home: A journey to reconnection with self

Simran Deep Singh, MS

It was one of those mornings after a long wedding weekend. I was happy and excited to meet my therapist and tell her about the fun and exciting events that took place. At that point of my life, waking up happy was a rare experience for me.

This was just a month into the start of my therapy. I was learning what it's like to be vulnerable and trust another person. Before therapy, I was uncomfortable being perceived or seen by people. I began to understand how to open myself emotionally while embracing myself in the holding of another. It was a scary and confusing experience. It helped me understand why it is important for people training to be a therapist to be in their own therapy.

I don't remember a lot of details, except that I was in a cheerful mood, with *mehendi* on my hands. I had a vibrant, joyful face and a lot of nice feelings. I sat waiting for the familiar warm presence of my therapist.

When we started talking, I told her about how my weekend was. I had been back to my father's hometown, which is in Himachal Pradesh. It is up in the mountains and very far away from all the city noise and crowd. I was reading a book on my way to the place and then on the way back to my home. I was reading *Come as you Are* by Emily Nagoski, and that too, was a very heart opening experience.

I told her about all the things we did; weddings have always excited me. It was a small-town wedding. I told her about the nice clothes and jewellery I wore, the not-so-nice food, the family politics, and conflicts. I told her about how whenever I am in that place, I feel very alienated because I feel like an outsider. In these trips, I bond so much more with my sister. Hence, I had spent a lot of time connecting with her too.

At the time, and initially, I had started my therapy to build a better relationship with my face and body. I used to hate it, I used to loathe it. I used to flinch if I ever saw my face in the mirror. There was rarely a day where I didn't hate my physical appearance as much and found it worth looking.

My therapist had asked me to tell her what features of my face I didn't like. I had told her, "it's the crooked cupid bow of my lips, the gap in my teeth, the slight squint in my eyes, the acne prone skin, the skin scarred with acne marks, the baby hair". It was hard for me to find even one thing that I didn't find ugly about my face.

I remember crying when I first verbalized all these things. Prior to that, it was all in my head, essentially a pool of nonverbal thoughts and feelings about my face.

In this session, I had very excitedly told my therapist about wearing a *patiyala suit* in one of the wedding ceremonies. It had a plain, mauve colored *kurti,* and green colored floral printed *patiyala salwar* and *chunni*. It was a pretty simple suit, and I had paired it up with a *jhumki,* and nothing else. No makeup, nothing. Not that I recall now.

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My sister and I had been clicking photos of ourselves and the clear blue sky, and the mountains and the clouds. One picture of mine had me sitting down on a small staircase that led to the terrace, with the wind making my hair covering some parts of my face. I was smiling.

It is a beautiful picture. I think it is one of the most beautiful pictures I have ever seen. After I saw it for the first time, I could not believe it was me. It didn't feel like the person in that picture and I were the same individuals, that we share the same body, or that I could ever look this beautiful.

Naturally, I talked about all of this to my therapist. I told her that I felt really beautiful in that photo and I couldn't believe that was me. I shared I have never felt this beautiful in my life. It was a very new and unfamiliar feeling.

My therapist attentively and patiently listened to me talk about experiencing myself in such an unusual manner. After I was done, she told me that she is curious about the entire experience I had.

I asked her why, wondering if I was not clear about what I was experiencing? Finding myself beautiful for the first time?

She told me, as much as that is what this is, the person from a couple of sessions who talked about all the flaws in her face is also the same person. I felt confused.

She went on to explain that the person who talked about the flaws and who hated her face, the person in the photo, and the person in front of her right now talking about finding herself beautiful, are all the same individuals.

It made me confused even more, as to how this observation is relevant. She went on to say that this means that objectively my face doesn't have any problems. It is not "ugly."

It was just this. These simple words, an observation or a statement. It moved something, shook something deep inside me.

As simple as this sounds, it was a shock for me to hear someone say that objectively there is nothing wrong with my face.

She didn't even say I was beautiful or that I was not ugly. She just said that objectively my face is just as someone else's would be.

In some ways, there was a deep spiritual movement that happened inside me when I heard that. I went dumbstruck. I couldn't say anything to that for some time. I don't remember what happened after this though. I don't remember the rest of our conversation, or how I reacted.

I just remember that it was healing for a person I had just met to tell me, explain it to me, from my own words, observations and statements, and in a very as-a-matter-of-the-fact manner that "Simran, there is nothing objectively wrong with you."

It was kind. It was loving, accepting, even if it was just an observation. I felt as if someone just changed the entire way I experience my world and myself.

The aftermath of that session is very blurry. Still to this date, I carry these words with me.

Gradually, over a period of two years, my confidence for my body and my face evolved in so many beautiful ways.

Of course, I do slip in these cycles briefly of starting to hate and fixating myself on these flaws, but now I have been able to find a lot of grounding and holding in that one interaction I had with my therapist.

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That was my finest hour of therapy. An interaction, a form of love and acceptance, that perhaps I will always hold so close to my heart. An interaction that transformed my relationship with myself.

Perhaps, this was the starting point of the end of my dissociative experiences. To know that the body I am in, is not objectively flawed. I began to live in my body after knowing this.

As a human, it changed my understanding of what it is to be seen. It bettered and deepened my belief of how relationships also can be. It does not take a grand gesture to impact someone. Through holding the space and accepting them with their flaws and imperfections, growth is made. Growth is also made through recognizing their strengths and dreams. The idea that a person can love someone without requesting change of them was profound to me.

It also helped me as a clinician because prior to that I had a novice understanding of how therapy works. I used to imagine it as a "teacher-student" type dynamic. That clients will sit on the couch and share their problems, then the therapist would respond on what they think would help. Through that simple exchange I believed all problems would resolve. In this one interaction, I understood it was just the very surface of therapy.

One does not have to fix one's problem. A client and their therapist just has to aid them to feel self-reliant enough to either accept that the problem, or give the client the resources to solve the problem by their own selves.

The love I felt in this one finest hour, was not even the finest hour of my own clinical work, however it laid the template for me to be a relational human and be, just be, in the world.

ETHICS

Personal Psychotherapy as a Self-Care Strategy for Psychotherapists-in-Training

Alana N. Levine, BS
Jeffrey E. Barnett, PsyD, ABPP

Numerous authors have highlighted the many challenges and stressors experienced by graduate students in clinical and counseling psychology throughout their training (e.g., Harder, 2024; Prakash et al., 2023; Sosoo & Wise, 2021) and that "given the multiple demands and expectations for students in professional psychology programs" some level of stress is an inevitable part of this training (Colman et al., 2016, p. 194).

Challenges, Demands, and Stressors for Graduate Trainees

For some, this may involve transitioning to a new city and academic environment, all while leaving existing support systems to cultivate new personal and professional relationships. In addition to these social and environmental changes, trainees must manage financial burdens associated with pursuing their education. As a result, many students may need to maintain employment during their training, resulting in additional time constraints, or may be obligated to take out substantial loans. These pressures, coupled with academic and clinical demands and expectations, can create a very challenging and stress filled experience for graduate trainees. El-Ghoroury et al. (2012) found that graduate students report numerous stressors "that interfered with their optimal functioning" (p. 122). These include academic requirements to include both rigor and quantity, financial limitations and anxiety associated with increasing debt, and ongoing challenges with maintaining some semblance of balance in their lives between academic/work obligations and personal life/self-care.

Additional stressors experienced by graduate trainees include managing ongoing evaluation and feedback from supervisors, professors, and peers, as well as meeting supervision and research obligations (Harder, 2024). Shen-Miller et al. (2011) also describe program dynamics to be a potentially contributory factor to the stress trainees experience. These may include a "perceived need among trainees to uphold images of perfection" (p. 114), feeling that they are constantly being evaluated, lack of programmatic support, and what Barnett and Cooper (2009) describe as a lack of a culture of self-care within one's graduate program. Many graduate students are reported to experience difficulty effectively coping with these challenges and stressors (Shen-Miller et al., 2011) and with all of the above in mind, it should not be surprising that graduate training is typically found to be the most stressful time period across the career span of psychologists (Schwartz-Mette, 2009).

As a result of these myriad considerations, trainees are especially vulnerable to stress, distress, and burnout, which may result in trainee mental health difficulties. While distress is a common experience in response to ongoing stres-

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sors in one's environment, failure to adequately attend to and manage distress may result in the development of symptoms of burnout (Baker, 2003). Burnout manifests as a psychological syndrome stemming from chronic interpersonal stressors in the workplace, which leads to diminished well-being and compromised professional performance (Maslach & Leiter, 2016). Burnout results in various consequences, both personal and professional, including the possibility of physical deterioration, insomnia, interpersonal conflicts, reduced work efficacy, and escalated substance use as a maladaptive coping strategy (Stevanovic & Rupert, 2004).

Clinical Competence for Graduate Trainees: An Ethical Obligation

Due to the nature and significance of their work, graduate trainees must address their personal mental health needs. This tenet is outlined in the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (Ethics Code, APA, 2017), in which students attend to the possible impact of their "physical and mental health on their ability to help those with whom they work" (Principle A, Beneficence and Nonmaleficence) and the need to attend to "personal problems that may interfere with their performing work-related duties adequately" (Standard 2.06, Personal Problems and Conflicts). This ethical responsibility helps to ensure the maintenance of clinical competence, which is defined as the knowledge, skills, attitudes and values, judgment and decision-making, and the ability to access and apply them effectively for the benefit of the client (Elman & Forrest, 2007). Given that graduate students are providing professional services to clients, such as psychological evaluation and treatment interventions, they must maintain their competence. Consequently, they must engage in the ongoing use of effective self-care strategies to mitigate against the potentially negative effects various stressors and their impact may have on one's effective functioning (Coleman et al., 2016).

Personal Psychotherapy as a Self-Care Strategy and Its Benefits for Graduate Trainees

Personal psychotherapy serves as a potentially beneficial self-care method for graduate students to decrease instances of burnout and increase their competence (Orlinsky et al., 2011). Among its vast benefits, psychotherapy can offer graduate students an invaluable outlet to process the extensive demands and responsibilities of their training. In a supportive, non-judgmental, confidential therapeutic space, trainees may feel especially comfortable to openly discuss their experiences. Research shows that personal psychotherapy increases an individual's self-awareness and ability to moderate their emotions effectively, skills that are essential to being a capable and effective trainee and future psychotherapist (Baker, 2003). Moreover, personal psychotherapy can provide graduate students with firsthand knowledge of what clients experience, which has many advantages. For example, psychotherapy can serve as an exceptionally beneficial training tool, enhancing a trainee's capacity for empathy and the ability to understand the client's perspective (Jite-Ogbuchi, 2017). Thus, personal psychotherapy can enrich the development of both personal and professional competence of a psychotherapist in training.

Numerous studies highlight the promising outcomes of psychotherapy. A review of relevant studies can be found in the American Psychological Association's statement on the recognition

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of psychotherapy effectiveness (APA, 2013). Bennett-Levy (2019) delved into pivotal practices, such as personal psychotherapy and self-reflection, that contribute to the cultivation of effective psychotherapists. Among the array of benefits, these practices have been shown to enhance interpersonal and personal qualities, refine and advance therapists' technical skills, and foster improvements in well-being and enhanced conceptual skills—all of which are profoundly valuable to the work of a psychotherapist (Ziede & Norcross, 2022). These findings demonstrate the multifaceted advantages of integrating psychotherapy into the self-care practices of psychotherapists-in-training.

Recommendations for Alternative Self-Care Practices for Graduate Trainees

Acknowledging the potential barriers to accessing ongoing personal psychotherapy, including financial and time constraints, confidentiality concerns, and stigma surrounding mental health services, it becomes evident that graduate students may benefit from alternative practices. One such intervention is the Mood Lifter for Graduate Students (ML-GS), a novel biopsychological approach where students participate in weekly, peer-led psychoeducation meetings. Research has shown this low-cost alternative offers significant reductions in students' depression, anxiety, and perceived stress ratings following this protocol, with results maintained at 1-month follow-up visits, underscoring the effectiveness of ML-GS as a suitable treatment for graduate students. Such an intervention should be seen as a valuable addition to other self-care practices engaged in by graduate students. It should not be seen as a replacement for other effective ongoing self-care practices such as spending quality time with friends and family, participating in physical activities, and leisure pursuits that can further support overall well-being (Stevanovic & Rupert, 2004).

Removing Obstacles of Self-Care for Graduate Trainees

As part of promoting a culture of self-care, graduate programs (through their administrators, faculty, and supervisors) can take concrete steps to support the use of personal psychotherapy by trainees and to reduce or remove barriers and obstacles that many trainees may experience.

- **Reducing Stigma**. Educators and trainers may reduce stigma, as well as potential feelings of embarrassment and shame, through ongoing discussions about the role and importance of personal psychotherapy for trainees and practicing professionals alike. These discussions may occur in clinical supervision and in relevant courses such as ethics and psychotherapy courses.
- **Valuing Personal Psychotherapy**. Through open discussion and appropriate self-disclosure, supervisors and faculty members may help normalize personal psychotherapy as a common, appropriate, valuable, and even essential practice for psychotherapists and psychotherapists-in-training.
- **Reducing Financial Barriers**. Training programs should acknowledge financial barriers and constraints faced by students and offer access to reduced fee or free psychotherapy services. One method for doing this is to have past graduates of a program offer these services to current students with the understanding that these current student clients will 'pay it forward' by providing such services to future students in the

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program once they are licensed professionals. Graduate programs may also enlist practicing professionals in the local community to provide reduced fee psychotherapy to students and provide students with a list of these professionals, keeping this list updated each year.

Laying the Foundation for A Career as a Psychotherapist

Embarking on a career as a psychotherapist can be deeply fulfilling, yet it also presents significant demands and challenges beginning at the training phase. Therefore, it is crucial to proactively explore and adopt effective interventions to address potential adverse outcomes faced by trainees. While significant evidence exists to support the use of ongoing self-care activities in general (e.g., Colman et al., 2016), the use of personal psychotherapy as an important self-care activity should not be overlooked by graduate trainees. Beyond being an important strategy for meeting the ethical obligation to maintain one's competence, it is essential that future psychotherapists see personal psychotherapy as care for oneself both personally and professionally. It is also hoped that attention to this important issue in graduate school will contribute to the establishment and development of the attitudes, values, and practices associated with of one's professional identity as a psychotherapist.

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Society for the Advancement of Psychotherapy

WASHINGTON SCENE

"YO, BIG SHAQ, THE ONE AND ONLY"

Pat DeLeon, PhD, MPH, JD
Former APA President

The Vibrant Public Policy Process: The public policy/legislative process is anything but static. It continues to evolve, reflecting subtle societal changes that many of our colleagues do not appreciate. Former APA President Ron Fox used to remind those of us interested in prescriptive authority (RxP) that visionary Ohio academic leaders were nursing's critical RxP catalyst. With significant foundation support, they successfully lobbied for RxP authority for their advanced graduate students, under faculty supervision. Upon graduation, those cohorts asked the Ohio legislature: "If I could provide needed clinical services as a student, why can't I continue to serve my patients now that I have graduated?" This past month I again had the pleasure of attending the AACN (American Association of Colleges of Nursing) Dean's Annual Conference where one of the invited speakers discussed her vision for the role of physicians. She was immediately met with considerable "push back" by the audience who spontaneously objected to AMA's systematic efforts to restrict nursing's clinical practice and called for the enactment of national scope of practice legislation, modeled after that adopted, again notwithstanding considerable medical opposition, by the Department of Veterans Affairs (VA). With the current leadership of academic nursing seemingly focusing upon what are essentially clinical practice issues, perhaps significant change is in the winds.

New Mexico: On March 6, 2002, New Mexico's landmark RxP legislation was signed by their Governor, becoming the first state (other than Indiana and Guam) to enact this authority. On February 29, 2024, their current Governor signed SB. 127 significantly updating New Mexico's precedent setting legislation. Leslie Dozzo, President of the State Psychologist Association (SPA) of New Mexico and a prescribing psychologist: "In over twenty years of practice in New Mexico, prescribing psychologists have been providing safe and effective services primary to rural and underserved communities and populations across the state. A recent survey of members found most responders provide roughly 95% of their services to Medicaid recipients or to the indigent. Our new legislation states: 'psychotropic medication' means a controlled substance or dangerous drug that may not be dispensed or administered without a prescription but is limited to only those agents related to the diagnosis and treatment or management of mental, nervous, emotional, behavioral, substance use or cognitive disorders, including the management of or protection from side effects that are a direct result from the use of those agents, whose use is consistent with the standards of practice for clinical psychopharmacology.' This is a significant improvement over the language that previously defined our practice. Instead of specifying which agents we can prescribe, this broadens the scope of our practice to that of 'clinical psychopharmacology' which more closely resembles the practice of other psychiatric pro-

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viders. The legislation further broadens our scope of practice in that it now allows us to treat ADE's (side effects) of psychotropic medications, which is much closer to the standards of psychiatric practice, albeit in consultation with the patient's health care professional.

"The bill also adds prescribing psychologists with at least four years of experience as independent-level prescribers to the list of 'supervising clinicians' for a psychologists who is undergoing RxP training. The change of the supervisor terminology from 'prescribing physician' to 'prescribing clinician' opens the door to prescribing psychologists (with 4 years' experience), who are now included in the term of 'prescribing clinician', to supervise psychologists during practica. This will need to be clarified in rule promulgation.

"Regarding the membership of the Board of Psychological Examiners, the bill now guarantees that of the five psychologist members, two shall be prescribing psychologists, an important change in the make-up of the board. It also recognizes our organization as eligible to nominate prescribing psychologists to fill those seats. Finally, the bill states: 'A psychologist with a conditional prescription certificate may prescribe and administer psychotropic medication injections under the supervision of a supervising clinician and upon completion of board-approved training. A prescribing psychologist may prescribe and administer psychotropic medication injections upon completion of board-approved training.' Prior to this, we have been able to prescribe injectable psychiatric medications, however we were unable to administer them."

Evolving National Trends: During a recent membership briefing, Victor Dzau, President of the National Academy of Medicine (NAM), discussed the impressive NAM Strategic Plan Implementation progress. Within their Goals for Science, Critical Issues, Transformation, Equity, and Readiness were critical policy issues including emerging technology, misinformation, climate change, artificial intelligence, workforce concerns, and two which should be of particular interest to psychology and nursing; i.e., their Culture of Health and Women's Health initiatives. For over two decades, the Institute of Medicine (now NAM) has conducted a series of studies on health disparities, beginning with its 2003 report on *Unequal Treatment: Confronting Racial Bias and Ethnic Disparities in Health Care*. It is estimated that the economic burden of racial and ethnic health disparities in 2018 was $75.1 billion in excess medical care costs and $286.9 billion arising from excess premature deaths. Policy experts continue to report that the United States ranks last compared to other high-income countries in how health systems perform on measures of quality, access, efficiency, equity, outcomes, and life expectancy. This is despite health care expenditures that are twice that of the next closest nation.

Social determinants of health (SDOH) are the conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Across the lifespan these environments influence one's health and how one navigates the health care system. It is the unequal distribution of health-promoting and health-damaging resources in those environments, along with a myriad of historical and current societal forces, that contribute to unequal health and health care outcomes across racial and ethnic populations.

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NAM's most recent report notes that our nation has made progress in advancing health care equity; however, racial and ethnic inequity remains a fundamental issue. These inequities in health care are complex and driven by key societal forces such as racism and oppression, social determinants of health, social norms and values, and laws and public policies. A diverse health and science workforce, representative of the communities it serves, is essential to health care equity. Yet, our nation has made little progress addressing this goal. Emerging approaches to achieving health care equity show promise and are poised for increased investment, implementation, and expansion so that progress is translated into long term improvement in outcomes. Continued research and evaluation, as well as accountability, is essential to advancing health and health care equity. Unfortunately, public awareness of health disparities is still low, with less than 50% of the general public recognizing that health disparities exist.

Women's Health: In his State of the Union address, President Biden laid out his vision for transforming women's health research and improving women's lives all across America. The Uniformed Services University (USU) is most fortunate that Lynette Hamlin of the Graduate School of Nursing is actively involved. "The President and First Lady announced more than twenty new actions and commitments by federal agencies. I am honored to have been asked to lead two of these actions. The Department of Defense (DOD) and Department of Veterans Affairs (VA) are launching a new Women's Health Research collaborative to explore opportunities that further promote joint efforts to advance women's health research and improve evidence-based care for Service members and Veterans. I am the DOD co-chair for this Collaborative. USU established a dedicated Director of Military Women's Health Research Program, a role that is responsible for identifying research gaps, fostering collaboration, and coordinating and aligning a unified approach to address the evolving needs of Active Duty Service Women, for which I am serving as the inaugural Director of the MWHRP."

The President's March 18, 2024 Executive Order expressly noted: "My Administration is committed to getting women the answers they need about their health. For far too long, scientific and biomedical research excluded women and undervalued the study of women's health. The resulting research gaps mean that we know far too little about women's health across women's lifespans, and those gaps are even more prominent for women of color, older women, and women with disabilities….

"It is time, once again, to pioneer the next generation of discoveries in women's health. My Administration seeks to fundamentally change how we approach and fund women's health research in the United States. That is why I established the first-ever White House Initiative on Women's Health Research—which is within the Office of the First Lady and includes a wide array of executive departments and agencies and White House offices—to accelerate research that will provide the tools we need to prevent, diagnose, and treat conditions that affect women uniquely, disproportionately, or differently.

"Together with the First Lady's tireless efforts, the Initiative is already galvanizing the Federal Government to advance women's health, including through investments in innovation and improved coordination within and across agencies. We are also mobilizing

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leaders across a wide range of sectors, including industry, philanthropy, and the medical and research communities to improve women's health.

"It is the policy of my Administration to advance women's health research, close health disparities, and ensure that the gains we make in research laboratories are translated into real-world clinical benefits for women. It is also the policy of my Administration to ensure that women have access to high-quality, evidence-based health care and to improve health outcomes for women across their lifespans and throughout the country."

Accompanying the President's announcement, the White House highlighted several of these new initiatives including: "Expand Fellowship Training in Women's Health Research. CDC… is expanding training in women's health research and public health surveillance to OBGYNs, nurses and advanced practice nurses… (and) will invite early career clinicians to train in public health and policy to become future leaders in women's health research. (And) Connect Research to Real-World Outcomes to Improve Women's Mental and Behavioral Health. The Substance Abuse and Mental Health Services Administration (SAMHSA) is supporting a range of health care providers to address the unique needs of women with or at risk for mental health and substance use disorders."

Licensure Mobility: Alex Siegel, Director of Professional Affairs, Association of State and Provincial Psychology Boards (ASPPB): "The Psychological Interjurisdictional Compact (PSYPACT), endorsed by APA, which allows for increased access of care and continuity of care for providing psychological services across state lines, continues to add new jurisdictions. Currently, there are 39 jurisdictions which enacted legislation to adopt PSYPACT and are currently part of the PSYPACT Commission and 2 states which passed legislation (VT and SD) and will become active participants on July 1, 2024 bringing the total at that time to 41 jurisdictions. There is active legislation in Massachusetts (SB. 1980), New York (SB. 6883), California (AB. 2051), and Mississippi (SB. 2157). There are only 10 jurisdictions out of 55 not part of PSYPACT nor have legislation (AK, GU, IA, HI, LA, MT, NM, OR, PR and VI) As of 3/31/24 there were 11,408 Authority to Practice Interjurisdictional Telepsychology (APIT) holders which allow psychologists to interjurisdictional practice into another compact jurisdiction and 675 Temporary Authorization to Practice (TAP) holders which authorizes those psychologists to temporarily physically go into another compact jurisdiction."

Senior Psychologists Keep On Truckin': Former APA President Ron Levant: As I wrote in Rod Baker and Pat's excellent volume, *Retirement experiences of psychologists*, I retired from my job but not my profession. As Ron Fox used to remind us, we are part of the educated elite (less than 2% of the U.S. population have a doctoral degree), and it is therefore our affirmative duty to utilize our expertise to address society's most pressing problems. I spent many decades of my life developing my expertise in the psychology of men and masculinities. Now, in retirement, freed from my daily professional and clinical duties, I have been active in sharing this knowledge with regard to the problems associated with masculinity in general and with regard to gun violence in particular. On that point, most (more than 90%) acts of gun violence are committed by boys and men, yet most (more than 90%) males do not commit acts of gun violence. This year I am bring out two books, one is my

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memoir: Levant, R. F. with Bowman, A. (2024), *The problem with men: Insights on overcoming a traumatic childhood from a world-renowned psychologist*. Virginia Beach, VA.: Koehler books. In press. And the other is a clinical handbook: Levant, R. F., & Pryor, S. (Eds.) (2024). *Assessing and treating emotionally inexpressive men*. New York: Routledge. In press. I am also working on a third volume: Hoffman, E., Wolfe, G., & Levant, R. F. (Eds.) (2025). *Oxford Handbook of Masculinities and Mental Health*. In preparation. I am also giving interviews to the press, appearing in podcasts, and writing OpEds."

"Yo, in the sauna. Man's not hot (Never hot). Yeah, skidika-pap-pap" (Man's Not Hot, Big Shaq)."

Aloha,

Pat DeLeon, former APA President – Division 29 – April, 2024

JOIN US IN CONGRATULATING OUR 2024 SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY AWARD WINNERS!

Society for the Advancement of Psychotherapy Distinguished Psychologist Award

J. Christopher Muran, PhD

Dr. Muran is Dean and Professor at the Gordon F. Derner School of Psychology, Adelphi University, where he served as training director for the doctoral program in clinical psychology (2009-2021). He completed postdoctoral training in cognitive therapy (University of Toronto) and psychoanalysis (New York University). He is a fellow of the American Psychological Association (Divisions 12 and 29) and on its Advisory Steering Committee for the Development of Clinical Practice Guidelines. He is past president of the international Society for Psychotherapy Research, past editor of its journal Psychotherapy Research, and recipient of its Distinguished Career Award. He is also recipient of the Alfred M. Wellner Lifetime Achievement Award for Research Excellence from the National Register. He currently serves on the editorial boards for the Journal of Consulting & Clinical Psychology and Clinical Psychology: Science & Practice. Since 1990, Dr. Muran has been Principal Investigator of the Psychotherapy Research Program at Beth Israel Medical Center (now Mount Sinai Beth Israel), which has been funded by grant awards from the National Institute of Mental Health. He was Chief Psychologist at Beth Israel for 15 years (1994-2009) and is on faculty at Icahn School of Medicine at Mount Sinai. He was also appointed to the faculty of New York University Postdoctoral Program in 2021 and held the Horst Kächele Chair (visiting professorship) at International Psychoanalytic University/Berlin in 2022. Dr. Muran has published over 175 papers and 10 books, including Therapist Performance under Pressure: Negotiating Emotion, Difference & Rupture (2020; with Catherine Eubanks), Practice-Oriented Research (2016; with Louis Castonguay), The Therapeutic Alliance: An Evidence-Based Guide to Practice (2010; with Jacques Barber), Dialogues on Difference: Diversity Studies of the Therapeutic Relationship (2007), Self-Relations in the Psychotherapy Process (2001), and Negotiating the Therapeutic Alliance: A Relational Treatment Guide (2000; with Jeremy Safran).

Award Winners, continued on page 52

Society for the Advancement of Psychotherapy/American Psychological Foundation Early Career Award 2024 Co-winners

Alice E. Coyne, PhD

Dr. Alice Coyne is an Assistant Professor of Psychology at American University. Dr. Coyne completed her PhD at the University of Massachusetts Amherst and completed her postdoctoral training at Case Western Reserve University. Broadly speaking, Dr. Coyne's research program aims to identify and develop ways to capitalize on patient, therapist, and dyadic characteristics and processes that can enhance the effectiveness of mental health care (MHC). More specifically, she studies personalized pathways to therapeutic change through answering the broad questions of *how*, *for whom and in what contexts*, and *when delivered by whom* does psychotherapy work? Across these interrelated foci, Dr. Coyne draws on diverse research designs and methods, including longitudinal process-outcome research, experimental comparative effectiveness trials, meta-analyses, community-based research (with diverse MHC stakeholders), and qualitative studies. She has conducted this work in the context of various treatments (e.g., cognitive behavioral therapy, interpersonal psychotherapy, and prolonged exposure), for a broad range of conditions (e.g., depression, generalized anxiety disorder, and posttraumatic stress disorder). Across these treatment-patient contexts, Dr. Coyne is keenly interested in bridging the science-practice gap by increasing the effectiveness and precision of therapeutic interventions, including when delivered in routine practice settings that can reach historically underserved and marginalized populations.

Maggi Price, PhD

Dr. Maggi A. Price, a licensed psychologist and Assistant Professor at Boston College's School of Social Work, has distinguished herself in the field of mental health research. With a robust academic and clinical foundation from Boston College, Harvard University, and Yale School of Medicine, Dr. Price dedicates her work to diminishing mental health disparities, especially among marginalized youth such as transgender individuals and youth of Color. Her research is twofold, focusing on both understanding mental health inequities through data analysis and developing interventions to foster mental health equity. This includes examining structural stigma and enhancing support systems for affected communities. Recognized for her impactful work, Dr. Price has received numerous awards and fellowships from prestigious organizations like the National Institute of Mental Health and the American Psychological Association. More information on Dr. Price's work can be found at her Affirm Lab's website: www.affirmlab.org.

Joshua Swift, PhD

I am extremely honored to be considered for the president position for the Society for the Advancement of Psychotherapy. For the past 55 years, the Society has been a driving force in shaping what our field looks like today. If elected, my presidential initiative would focus on both preservation and expansion.

In terms of preservation, I would place a priority on supporting our journal in disseminating high quality scientific content with direct clinical application, and supporting the Society's grants in funding such research. I would also continue to support the momentum of our recent presidents in offering diverse practice and training articles and videos through the website, webinars, social media, and other electronic communication.

In terms of expansion, I would encourage growth of our outreach to and collaboration with other national and international professional organizations. I would also focus on sharing our knowledge and expertise with the general public—such as through advertisements, articles, or videos to help people as they consider psychotherapy, engage in psychotherapy, or independently seek to improve their overall well-being.

I am a professor of psychology at Idaho State University and a licensed psychologist. In the Society I have served as a consulting editor for the journal, a contributor to the bulletin and website, a member of the Training and Education Committee, chair for the Science and Scholarship Committee, and most recently Treasurer. This Society has been a professional home for me and I would be pleased to now serve in the presidential role. ■

Barbara L. Vivino, PhD

I am honored to be nominated for President of the Society for the Advancement of Psychotherapy (SAP). As a long term (6 year) member of the Board, I have witnessed both its triumphs and challenges, and I am deeply committed to ensuring its well-being. If elected, a key initiative will be to work closely with the Board to increase the visibility of our important Division. I have been continually impressed by the quality of the members our Division and their contributions to the field of psychotherapy. At the same time, I have been surprised at how few of my psychologist/psychotherapist colleagues know of the excellent work we are doing to promote psychotherapy. Increasing visibility through enhanced social media presence and offering quality continuing education opportunities will support the continued efforts of the Board to increase membership and value for members.

Throughout my career, I have consistently demonstrated a dedication to service, integrity, and effective leadership. I believe in the power of collaboration and inclusivity and aspire to represent the diverse voices and needs of our division. I first came to serve on the SAP Board as the Chair of the Professional Practice Committee, eventually moving into the position of Domain Representative.

President-elect, continued on page 54

I have had broad and extensive experience as psychologist, professor, researcher, and psychotherapist. I am currently in private practice in Berkeley, California, strongly committed to both research and practice, passionate about representing the voice of professional practitioners and scholars and committed to serving on the Board of SAP. In addition to serving the SAP Board, my leadership skills have been enhanced as Director of Clinical Training at the California Institute of Integral Studies, where I had first-hand knowledge of the needs and complexities of psychotherapists in training. As a leader I understand the importance of listening to and engaging with the people I represent. I pledge to be accessible, transparent, and accountable to you, and I welcome your input and feedback.

During my two-term tenure as the Professional Practice Domain Representative and prior to that as the Committee Chair, the committee has grown from a 2-person committee struggling to discover the needs of private practitioners to an active and diverse 9-person committee engaged and providing resources. We developed and completed video content for the website. Some examples include: *Race in Psychotherapy, Setting fees in Psychotherapy, Psychotherapists Self Care, How to Reach Underrepresented Groups, Interstate Practice* and the first ever on demand CE course, *Climate Psychology* . In addition, we conducted a nationwide survey for private practitioners. As a member of the D29 Board, I served on Awards Committees, Nominations Committees, Program Committees and By-Law Change Committee.

As president I would carry on and support the initiatives that were started by previous boards in addition to implementing the new initiative of increasing the division's overall visibility to the psychotherapeutic community.

I have learned to deeply appreciate and embrace the mission of SAP and it's a diverse and vital community as well as its culture of positivity, collaboration, and support and am eager to continuing working to enact positive change.

Thank you for considering me as your candidate. I humbly ask for your vote and the opportunity to continue my service to SAP as President. ■

Ken Critchfield, PhD

Hello fellow SfAP members! I am a practitioner and Fellow of the Society. I am also an Associate Professor and Director of the Clinical PsyD Program at Ferkauf Graduate School of Psychology of Yeshiva University. Across my career I have worked closely with Lorna Smith Benjamin (another Society fellow) to teach, develop, and test a method of treatment called Interpersonal Reconstructive Therapy (IRT) as used with adult clients having severe and complex clinical presentations. I first became a member of Division 29 about fifteen years ago, and in 2010 became chair of the Education and Training committee. My involvement has continued since then in various ways, including as chair of the Continuing Education committee since 2019. Serving now as Treasurer for Division 29 would mean being able to continue supporting the essential infrastructure needs of a Society that I consider as one of my core professional homes. I have prior experience as a Treasurer for the Society for Exploration of Psychotherapy Integration (SEPI) and believe this experience, plus my prior involvement at SfAP board meetings is excellent preparation for the role. If elected, I aim to work with other board members and leadership to ensure that SfAP continues to offer the best possible sort of professional home for all of us: a space that actively supports diverse and stimulating intellectual and scientific debate; supportive, collegial relationships; as well as support, nurturance, and resources for diverse professional identities and career paths. I ask for your vote. ■

Gerald P. Koocher, PhD, LP, ABPP

The opportunity to serve as treasurer of the Society for the Advancement of Psychotherapy would be a welcome extension of my commitment to grow and promote our division as a home for psychotherapy practice, research, and training. I was honored to serve as president of the division in 1993, and have continued with committee service over the years. I have previously served as treasurer of three other divisions, the Massachusetts Psychological Association, and two five year terms as APA treasurer. I have a strong working knowledge of budget and investment operations and professional association management.

My goal as treasurer would be to work closely with our management firm and executive committee to assure sound operational practices and secure future operations. This becomes increasingly important as dues become a decreasing percentage of our annual income due to an ageing membership base. My priorities would include improving membership recruitment and engagement of early career psychotherapists, as well as considering improved prospects for growth of our financial resources.

I respectfully ask for your #1 vote. ■

CANDIDATE STATEMENTS
Candidates for Domain Representative For Membership

Firouz Ardalan, PhD

I am honored by the nomination for the Membership Domain Representative position of APA Division 29. My journey with the Membership committee began in 2021 as a student representative, and it has been a privilege to contribute to our division's growth since then. Over the years, I've focused on enhancing membership retention and expanding our base through innovative strategies.

Throughout my tenure on the committee, I've actively engaged in initiatives aimed at boosting student membership and facilitating access to Continuing Education (CE) credits. This hands-on experience has equipped me with a comprehensive understanding of our committee's dynamics, fostered strong collaborative relationships, and honed my ability to effectively advocate.

Recognizing that a robust membership base is the cornerstone of Division 29's longevity and impact, I am committed to advancing our shared objectives. I am enthusiastic about the opportunity to promote our division's outstanding resources and offerings, thereby igniting greater interest and engagement among our members.I look forward to the opportunity to serve our division in this capacity and contribute to its continued success. Thank you for considering my candidacy. ■

Jairo Fuertes, PhD

Dear colleagues, it would be a privilege to serve Division 29 as the Membership Domain Representative. I have served D29 in the past as the Diversity Domain Rep and as Chair of the Education and Training Committee. As a psychotherapy researcher and clinician, D29 is my academic home, it is a place where I feel that I belong. And this is because of the outstanding and caring individuals that the division has attracted and retained. The people make D29 a home, and if elected, I would endeavor to continue to make the division a new home for other psychotherapists, including graduate students, new professionals, and other clinicians. I would especially like to make D29 "a larger tent" by deliberately seeking more members of diverse communities in the world of psychotherapy, to make D29 a division that more completely represents and resembles our incredible profession. Gracias! ■

CANDIDATE STATEMENTS
Candidates for Domain Representative For Education and Training

Eric Sauer, PhD

I am running for Domain Representative for the Education and Training Committee (E & T) starting in 2025. I am a longstanding member of SfAP and I previously served as our E & T Committee Chair (2018-2020). I am a career-long educator, psychotherapist, and psychotherapy researcher and I hope to bring these long-standing passions into this SfAP leadership role. I have served in a number of leadership roles in other APA divisions/affiliations, including President of the Association or Psychology Training Clinics.

For more than 20 years, I have served as a professor of counseling psychology at Western Michigan University (WMU). In this faculty role, I have all of the traditional duties including providing professional service, research, and teaching/training. My longstanding research passion has been advancing our understanding of how client and therapist factors (especially attachment) impact psychotherapy process (e.g., working alliance) and outcome. In my time at WMU, I have also served as our department training clinic director. In this role, I oversee our clinic that provides low-cost services to the community, generates research, and provides clinical training to advanced counseling/psychology students.

Outside of these university roles, I also work in private practice and understand the psychotherapy process from this lens as well. Through varied roles, I have come to understand important ways that client, therapist, and relationship factors directly/indirectly contribute to process and outcome of psychotherapy. My goal as domain representative will be to work with this committee to find novel ways to promote and enhance psychotherapy education and training. ■

Erica Marshall-Lee

It is an honor to submit my candidate statement for Domain Representative for Education and Training. I am an Associate Professor at Emory University School of Medicine and board certified clinical psychologist. I have a long standing commitment to providing recovery-oriented and culturally responsive services to individuals experiencing severe and persistent mental health disorders (SPMD). As a faculty member for the past twenty two years, my passion and dedication for serving individuals with SPMD and training learners in recovery oriented, collaborative, strengths focused care using a social justice informed framework is apparent in my scholastic, clinical, and service activities. I am active in teaching, supervising, and mentoring trainees in the psychiatry residency and psychology training programs. I hold key education leadership positions as Associate Director for Advocacy and Diversity in the Emory University School of Medicine Postdoctoral Residency Program in Health Service Psychology and the Emory Psychiatry at Grady Psychology Practicum

Domain Representative for Education & Training, continued on page 58

Program Director. I see myself as a teacher to consumers of mental health services as well as learners in psychology, psychiatry, and other behavioral health professions. I am committed to the mission of the Society for the Advancement of Psychotherapy related to all aspects of education and training in theory, research, and practice. In particular, increasing the accessibility of psychotherapy services to the public, especially underserved communities, as well as increasing education and training opportunities in specialty domains within our profession such as serious and persistent mental health concerns. Thank you for considering me for this important role. ■

CANDIDATE STATEMENTS
Candidate for Domain Representative For Diversity

Changming Duan, PhD

I feel truly humbled to be nominated to run for election for **Member-at-Large: Diversity** of Division 29—Society for the Advancement of Psychotherapy (SAP). SAP is an outstanding community that has not only provided me and its members a welcoming professional home, judicious intellectual guidance, and strong collegial support, but also played a significant leadership within APA in addressing various cutting edge domestic and international issues that define psychology and psychotherapy practice in the 21st century. I am inspired by our society's leadership in promoting advancement of psychotherapy from diverse cultural and social perspectives and want to contribute to its mission through service as well as culturally responsive research and practice.

I obtained my Ph.D. in social and counseling psychology from University of Maryland College Park, and subsequently served on the counseling psychology faculty at University of Missouri Columbia and Kansas City respectively before my current position as a professor in the counseling psychology program at University of Kansas. I have been a proud member of our Society and served as its APA convention chair, a committee chair, and a domain representative in the past. If elected, I will do all my best to serve with assiduousness and diligence toward promoting diversity and multiculturalism in psychotherapy research, practice, and training. ■

CANDIDATE STATEMENTS
Candidate for Domain Representative For Psychotherapy Practice

Amy Ellis, PhD

It is a privilege to be nominated for Psychotherapy Practice Domain Representative for the Society for the Advancement of Psychotherapy (SfAP). My role within SfAP has evolved over time – initially as the Associate Editor of the Website, and later nominated for Editor of the Website. I have come full circle and am the current Publications & Communications Board Chair. My respect and passion for the Society's journal and electronic communications is exemplified by my hands-on approach and my continued commitment to generating great content for our members and non-members. To that end, our team is working to make the website even more user friendly given that there are over 800 free articles, often expanding upon the great content in Psychotherapy, our official journal publication.

If elected as Domain Representative, my goal will be to create resources on psychotherapy for underserved populations who may also not be studied often in graduate programs. I intend to create tip sheets, videos, and case vignettes with the aim of helping psychotherapists foster treatment engagement, reduce barriers to and within therapy, and to enhance care that is both evidence-based and individualized for various populations.

My commitment to psychotherapy practice is in my career trajectory. I am the Director of the Trauma Resolution and Integration Program and an Assistant Professor at Nova Southeastern University, and also have a small private practice. My clinical and research interests focus on underserved populations who have increased exposure and risk to trauma, tailoring evidence-based trauma treatments, and training and supervision. ■

Arlene "Lu" Steinberg, PsyD

As a clinician in practice for over 35 years I am committed to issues related to Practice. Given the many technological changes that have occurred and are ongoing with implications for practice, including the most recent greater move to virtual, looking for ways to ensure good care and beneficial aspects, while minimizing the negative is paramount.

Also, for ways to extend practice to those with greater need, as social justice concerns have always been important to me. I would be honored to serve SfAP as a Domain Representative for Professional Practice. ■

GRADUATE AND UNDERGRADUATE STUDENT GRANTS AVAILABLE

The Society for the Advancement of Psychotherapy (APA Division 29) is offering 20 research grants in the amount of $500 each for graduate AND undergraduate students in the field of psychology. Half the grants will be awarded to graduate students and the other half will be awarded to undergraduate students; undergraduates are strongly encouraged to apply! The grant should be applied to a student research project supervised by a faculty member or licensed psychologist. The research project can be at any stage of investigation (e.g., designing the study, collecting the data, analyzing the data, presenting the results, etc.) with research broadly construed to include qualitative empirical studies, quantitative empirical studies, theoretical reviews, perspective editorials, meta-analyses, case studies, etc. to be used for expenses related to research. Grant funding may be used for a variety of costs including but not limited to: clinical handbooks, treatment manuals, transcription software, psychological assessments, participant reimbursement, data coder compensation, statistical software, conference registration, conference travel, publication fees, etc. The Society's goal is to facilitate student interest, involvement, and engagement in research relevant to psychotherapy.

NOTE: This grant is only available to student members of the Society. Students can become members of the society at https://societyforpsychotherapy.org/why-join/ Use discount code JOINSAP for free student membership!

Application materials should include:

Online Application Form (available at our website:
https://form.jotform.com/240486885034059
Be sure to indicate whether you are a graduate or undergraduate student on the form.

500-1,000 word research proposal that includes the following information:

- Purpose of the research project
- How the research project will advance psychotherapy
- Brief background literature for the research project
- Research project methods and timeline
- Budget for use of grant funds
- Brief letter of support from the supervising faculty member or licensed psychologist
- Proof of IRB under review or approved OR proof of conference/publication submitted or approved (or other proof of research project occurrence)
- Resume or Curriculum Vitae

Eligibility

- A graduate student or undergraduate student at an academic institution (e.g., college, university) OR a post-baccalaureate student conducting research at an academic institution.

- Be a member of the Society for the Advancement of Psychotherapy. If you are not already a member, graduate and undergraduate students can join at the link above. Prior years of membership is not required and new members are encouraged to apply.
- Have a faculty member or licensed psychologist able to supervise the research project.

Selection Criteria

- Research project addresses a problem/gap in the psychotherapy literature
- Relevance of the research project to advancing psychotherapy
- Meaningful use of the grant funds

Submission Process and Deadlines

First, students should join the Society for the Advancement of Psychotherapy at https://societyforpsychotherapy.org/why-join/ Use discount code JOINSAP for free student membership!

Second, students should complete the online application form, including uploading their proof of research project occurrence (e.g., IRB under review, conference poster submission) and all supporting documentation. Submissions will be reviewed at three different deadlines during the year. Deadlines are as follows:

- May 15, 2024
- August 15, 2024
- November 15, 2024

Students can expect to hear if they received the grant award within one-month of each submission deadline.

If you have any questions, please email: Dr. David Disabato (ddisabat@bw.edu), Society for the Advancement of Psychotherapy Membership Committee.

Thank you!

Society for the Advancement of Psychotherapy

Society For The Advancement Of Psychotherapy

THE ONLY APA DIVISION SOLELY DEDICATED TO ADVANCING PSYCHOTHERAPY

MEMBERSHIP APPLICATION

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

JOIN THE SOCIETY AND GET THESE BENEFITS!

FREE SUBSCRIPTIONS TO:

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

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

EARN CE CREDITS

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

DIVISION 29 PROGRAMS

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

SOCIETY INITIATIVES

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

NETWORKING & REFERRAL SOURCES

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

OPPORTUNITIES FOR LEADERSHIP

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

DIVISION 29 LISTSERV

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

VISIT OUR WEBSITE
www.societyforpsychotherapy.org

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

Name _____ Degree _____

Address _____

City _____ State _____ ZIP_____

Phone _____ FAX _____

Email _____

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

If APA member, please provide membership #

Card # _____ Exp Date _____/_____

Signature _____

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

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

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

PUBLICATIONS AND COMMUNICATIONS BOARD

EDITORS

PSYCHOTHERAPY BULLETIN

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

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