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BULLETIN

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"When The Night Has Come. And The Land Is Dark"

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2024 VOLUME 59, NUMBER 3

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PRESIDENT-ELECT'S COLUMN

Stewart Cooper, PhD, ABPP

SAP 2025 Vision: Invitation To Co-Create Our Future

It is an honor to be President-Elect for the Society for the Advancement of Psychotherapy. The goal of this column is to share my four Presidential Initiatives for 2025 and ask you to collaborate with me to co-create their fulfillment. I hope you will share my excitement about them, as they have the capacity to propel us, as a unique Division within APA, to thrive now and in the future.

The SAP Board has approved that our focus will center on these four overlapping and synergistic priorities: (1) furthering the deepening of the understanding and incorporation of identity and culture in the science, practice, and education of psychotherapy and psychotherapy supervision, (2) increasing the global cross-fertilization of psychotherapy research, education, practice, and application, (3) retaining SAP members through their entire professional lifespan by enhancing the perceived value of and engagement in our efforts to make significant contributions to SAP and externally in the field, and (4) having SAP function as the authoritative voice in advancing psychotherapy science, practice, education, and application. The first two and last of these initiatives are external in focus while the third initiative is internally oriented. We are a mature Division in need of new membership revitalization

I would be delighted to hear your thoughts, recommendations, or reactions to these initiatives. You can backchannel me at stewart.cooper@valpo.edu. More importantly, I invite you to consider actively contributing to our goals. There will be many opportunities for you to do so.

We also will work on other priorities. As one example, APA is moving forward on developing masters level educational competencies while revising doctoral level educational competencies. I will create an SAP Presidential workgroup to keep us updated on ongoing conversations about these along with corollary titling and scope of practice definitions. As a Division, we may want to take advocacy positions.

Please let me know of any other priorities you feel we should focus upon. Your providing details would be helpful.

Together, and rowing in the same direction, we will all contribute to meaningful outcomes on behalf of SAP and our profession.

Stewart E. Cooper, PhD, ABPP
President-Elect

Society for the Advancement of Psychotherapy

SUMMER EDITOR'S COLUMN

Zoe Ross-Nash, PsyD

Happy Summer SAP!

I hope warmer weather and long, sunny days have been on your calendar. Summer can mean a lightened workload, more time with loved ones, or a conclusion to the academic year.

Given the American Psychological Association's annual conference on the horizon, the importance of collegial relationships within the mental health community has been on my mind. Conferences are an amazing time to connect with fellow researchers and clinicians, please look at our conference agenda linked here.

As once described by Amy Ellis, SAP/Division 29 offers a "professional home" to many clinicians. It not only provides countless opportunities for occupational growth, but also personal connection. Last year when Early Career Domain Representative, Yujia Lei, found out I was moving to her city, she immediately coordinated a lunch together and we bonded over our shared love for Netflix (and SAP of course!). When SAP President Tony Rousmaniere shared he over committed and was unable to write his presidential column for this quarter's *Psychotherapy Bulletin*, SAP Present-Elect Stewart Cooper stepped up to the plate, despite having a two week notice. I am so grateful to be part of this community, both personally and professionally. As we had our elections for our leadership a few months ago, I know the new cohort will continue to maintain the enthusiasm for the division we all so deeply care about. Congratulations to the newly elected officials! I look forward to our work together.

The Electronic Communications Team is looking for a social media coordinator. After two valuable years, our current member Yashi Aware is stepping down. We are looking for a social media coordinator to join our smaller "professional home" and family. Please click here for more information. We are happy to share the rest of the team, Lacy Sohn, Deanna Young, and Sarah Bondy have recommitted their contract. The Electronic Communications Team works together closely and have a lot of fun while doing it. It is the perfect role for someone looking to build their own professional network and community.

Please enjoy the publications from authors like you. It is our colleagues who truly advance psychotherapy! We'd love to hear your voice! Interested in submitting? Click here.

Additionally, due to high volume of enrollment Society for the Advancement of Psychotherapy Membership is currently closed. If you choose to join between now and December 31, 2024, your membership will be activated on January 1, 2025 and will remain active until December 31, 2025. All memberships are on a calendar year.

Finally, we are proud to announce our new website starting August 2024. Thank you so much to TJ Slade, our web designer, and Amy Ellis for being so critical and thoughtful in this update. If you have any feedback or comments about the website, please email me at editor@societyforpsychotherapy.org.

Best,

Zoe Ross-Nash

ARTIFICIAL INTELLIGENCE

Writing Psychotherapy Research With Generative Artificial Intelligence (This Article Was Mostly Written by a Human)

Wilson T. Trusty, Ph.D.

Wilson T.: *Hey ChatGPT, write an introductory paragraph for a paper on using artificial intelligence to help write psychotherapy research articles. Write it in the style of the Society for Psychotherapy Research's newsletter, "Psychotherapy Bulletin."*

ChatGPT: *In the dynamic realm of psychotherapy research, the emergence of artificial intelligence (AI) as a tool for assisting in the writing process marks a significant juncture in scholarly endeavors. While AI offers unprecedented opportunities for streamlining and enhancing various facets of scholarly writing, it also presents nuanced considerations that warrant careful attention. In this paper, we embark on an examination of the considerations essential for leveraging AI in the composition of psychotherapy research articles. From the preservation of scholarly integrity to the ethical implications of automated content generation, we delve into the multifaceted dimensions that shape this evolving landscape. Through this inquiry, we endeavor to illuminate pathways for researchers to harness the potential of AI while upholding the rigors of academic inquiry and maintaining the integrity of psychotherapy scholarship* (OpenAI, 2024).

As ChatGPT's introduction to this article states, generative AI (e.g., OpenAI's Chat GPT, Google's Gemini, Microsoft's Copilot) are changing the landscape of academic writing. As generative AI continues to evolve, authors are energetically discussing how these tools can help and hinder the writing process (Balel, 2023; Golan et al., 2023). Researchers are also discussing ways for clinicians, authors, and academic journals to use AI responsibly (Misra & Chandwar, 2023; Salvagno et al., 2023).

In response to these issues, the American Psychological Association (APA) recently released a policy statement on the use of generative AI in scholarly work (American Psychological Association, 2023, APA policy on the use of generative artificial intelligence (AI) in scholarly materials section). While these brief guidelines prohibit researchers from naming generative AI as an author on APA publications, they do allow for its use in the writing process as long as the following criteria are met: 1) The use is disclosed, described, and cited transparently in the method section of the publication; and, 2) The full output of the generative AI tool being used is included as supplementary material. This opens the possibility that psychotherapy researchers may not just be reading and writing about AI (e.g., Goldberg et al., 2020), but will also be reading from and writing with AI in the near future.

What Might Generative AI Look Like in a Psychotherapy Manuscript?

After reading APA's guidelines on generative AI use, I decided to try an informal experiment to see how well one AI platform, ChatGPT, would perform in completing a routine research writing task. I work with a wonderful team at the Center for Collegiate Mental Health (CCMH) and nearly all of our publica-

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tions use the Counseling Center Assessment for Psychological Symptoms (CCAPS; Locke et al., 2012). Although writing a description of the CCAPS for method sections of manuscripts is fairly routine at this point, it can become tedious and repetitive, making it a potentially straightforward task to delegate to an AI tool.

Scenario One: Asking ChatGPT to Write Without Providing Additional Information

For my informal experiment, I first passed this prompt to ChatGPT 3.5: *Write a one-paragraph description of the Counseling Center Assessment of Psychological Symptoms for the Method section of a peer-reviewed paper.* (Click here for the full input and output with ChatGPT).

After the initial output did not go into much detail on psychometrics, I requested ChatGPT to: *Describe the psychometric properties of the CCAPS.*

It wrote a paragraph that included psychometrics, but it did not include any citations. I then asked: *Please rewrite the description of the psychometric properties of the CCAPS using at least five different peer-reviewed citations.*

The paragraph gave a plausible narrative description of the CCAPS' psychometrics with in-text citations. The following instructions were then given: *Provide the bibliographic entries for the in-text citations in the CCAPS description above.*

I then took the three paragraphs it wrote in response to my three prompts and merged them. I rearranged the order of some sentences and deleted repetitive ones but otherwise did not make any additional edits. Afterward, I pasted the bibliographic citations it provided at the end of the composite paragraph. This is the final output with references (OpenAI, 2024):

> The Counseling Center Assessment of Psychological Symptoms (CCAPS) is a comprehensive self-report measure designed to evaluate various psychological symptoms prevalent among college students seeking counseling services. Developed by Locke et al. (2012), the CCAPS consists of multiple subscales assessing depression, anxiety, social anxiety, academic distress, eating concerns, hostility, substance abuse, and family distress. Locke et al. (2012) reported high internal consistency for the CCAPS subscales, with Cronbach's alpha coefficients ranging from .81 to .92. The CCAPS has exhibited favorable convergent validity, as evidenced by its significant correlations with established measures of psychological distress (Locke et al., 2012; Mallett et al., 2019; Hill et al., 2018). Additionally, Hill et al. (2018) highlighted the instrument's discriminant validity, showing that it effectively differentiated between clinical and non-clinical samples. Furthermore, the sensitivity of the CCAPS to changes in symptomatology over time has been demonstrated, indicating its utility in monitoring mental health issues among college students (Mallett et al., 2019; Hill et al., 2018).
>
> Locke, B. D., Bieschke, K. J., Castonguay, L. G., & Hayes, J. A. (2012). The utility of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62) in identifying depression and anxiety among college counseling center clients. Journal of Counseling Psychology, 59(4), 593–603.
>
> Mallett, R. K., Bacharach, S. B., & Turiano, N. A. (2019). A longitudinal examination of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62): Improv-

continued on page 6

ing the detection of psychological distress in college students. Psychological Assessment, 31(12), 1503–1512.
Hill, C. E., Smith, D. W., & Atkinson, B. J. (2018). A counseling center assessment tool: The development, reliability, and validity of the Outcome Questionnaire-45.3. Journal of Counseling Psychology, 65(1), 27–37.

After compiling this output, I shared it with the CCMH staff (who are all intimately familiar with research on the CCAPS) and asked them if they could spot any errors. Within about 10 minutes, the team found the main problem: all three of ChatGPT's references, which were generally well-formatted aside from failing to italicize journal names, were fake. What was even more notable was that the references were not only smoothly integrated into the narrative, but they also seemed plausible. For example, it would not be surprising to see "C. E. Hill" in the reference list of a psychotherapy article (presumably referring to Clara E. Hill, a highly published researcher and past president of APA's Division 29). However, the citation with her name is completely fabricated. Regarding the Locke et al. citation from 2012, Ben D. Locke, the founder of CCMH, did publish a paper on the CCAPS in 2012. However, the legitimate paper had a different title than the one listed, and it found slightly different internal consistencies than the ones ChatGPT provided. I was unable to find any connection of the Mallet et al. (2019) citation to real research on the CCAPS. In spite of these fabricated references and reliability coefficients, the paragraph was fairly well constructed and the overall claims about reliability and validity of the CCAPS were generally consistent with real research on the instrument (Locke et al., 2012).

Scenario Two: Asking ChatGPT to Write in the Context of Additional Information

After the first trial, I asked ChatGPT to wite a description of the CCAPS again. This time though, I gave it a list of real citations to reference. I also included bullet points under each citation with information from the articles I wanted to be included in the output. The specific prompt I gave was: *Write a one paragraph description of the Counseling Center Assessment of Psychological Symptoms for the Method section of a peer-reviewed paper. Use the following annotated reference list to support your description.*

Click here for the full reference list and ChatGPT inputs and outputs.

An example of one of the reference list entries is below. Note that the bullet points under the bibliographic citation are informal, similar to what I would do when taking personal notes (i.e., incomplete sentences, unexpanded abbreviations).

Locke, B. D., McAleavey, A. A., Zhao, Y., Lei, P. W., Hayes, J. A., Castonguay, L. G., ... & Lin, Y. C. (2012). Development and initial validation of the Counseling Center Assessment of Psychological Symptoms–34. *Measurement and Evaluation in Counseling and Development*, *45*(3), 151-169. https://doi.org/10.1177/0748175611432642

- Validation study of the CCAPS-34
- EFA and CFA supported the discriminant validity of each subscale
- Internal consistency of the subscales ranged from .76 (Academic Distress) to .89 (Depression)
- Subscales were positively correlated with related measures of psychological symptoms, supporting their convergent validity
- 2-week test-retest reliability ranged from .74 (Academic Distress) to .86 (Depression)

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- Replicated past findings supporting the internal consistency and convergent validity of the subscales
- They found that the CCAPS differentiated between psychotherapy clients and non-treatment-seeking individuals

ChatGPT wrote a paragraph that accurately reported the information in the references I provided, but it did not include in-text citations. I provided this feedback: *Write that paragraph again but include in-text citations based on the annotated references I provided originally.* This is ChatGPT's unedited output (OpenAI, 2024):

> The Counseling Center Assessment of Psychological Symptoms (CCAPS) is a comprehensive measure designed to assess various psychological symptoms commonly encountered in counseling settings. Developed through rigorous validation studies (Locke et al., 2011), the CCAPS-62 consists of 62 items across multiple subscales, demonstrating strong internal consistency ranging from .80 to .93 and supported by both exploratory and confirmatory factor analyses. Additionally, the CCAPS-34, a shorter version, maintains robust psychometric properties with subscales demonstrating internal consistency ranging from .76 to .89 (Locke et al., 2012), as well as good test-retest reliability ranging from .74 to .86 over a two-week period (Locke et al., 2012). These findings are further bolstered by evidence showing positive correlations with related measures of psychological symptoms, indicating convergent validity (Locke et al., 2011; Locke et al., 2012). Moreover, the CCAPS subscales have been shown to be sensitive to change during psychotherapy (Youn et al., 2020), making them valuable tools for monitoring treatment progress. Further clinical applications reveal the CCAPS' ability to differentiate between psychotherapy clients and non-treatment-seeking individuals (McAleavey et al., 2012), highlighting its utility in clinical practice for both assessment and treatment evaluation.

The quality of this writeup was not as high as when ChatGPT wrote without having additional information (e.g., it did not name the CCAPS subscales). However, all of the in-text citations and psychometrics reported were accurate, and the writing seemed fairly easy to refine with human input.

Implications

After scenario one of this informal experiment, the CCMH staff jokingly concluded that generative AI is "good at sounding good without knowing what it's talking about." On a more serious level though, it illustrated what current iterations of freely available generative AI are: tools trained to produce text that closely replicates their training data while incorporating human feedback (OpenAI, n.d.). This highlights the "artificial" component of AI. That is, generative AI is designed to create language in human-like ways, not necessarily to find and report objectively accurate information.

Scenario two of the experiment led to a related consideration. Specifically, researchers need to know enough about their topic to write on their own even if they use an AI tool. This can allow them to thoroughly fact-check AI outputs or, perhaps even better, provide the program with information to include ahead of time and then proofread and double-check for accuracy. Using AI in this way could be helpful for researchers who know their topic areas well but want to

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automate the initial drafting of certain manuscript sections.

Because of how quickly generative AI is being developed, it could easily become a common tool among psychotherapy researchers in the future. When using this tool, it is important to remember that it is not (yet) able to replace the content knowledge, creativity, and nuance that humans bring to the writing process. In spite of its current limitations, it is possible to use it as a writing aid if it is provided with the proper inputs, edited by subject matter experts, and acknowledged transparently. Regardless of how generative AI is used, it is critical that we as psychotherapy researchers remain committed to the ethical principle of promoting integrity and accuracy in our written work (American Psychological Association, 2017), including the use of content created with the help of AI.

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Treatment Procedures for Behavioural Risks Associated with GPT-4 Artificial Intelligence Model

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The increasing influence and widespread use of artificial intelligence (AI) have prompted extensive discussions on its transformative potential and have raised numerous questions about its economic, political, social, and ethical implications. Academic institutions, regulatory bodies, the media, and the public are actively engaging in debates regarding AI's impact on various aspects of society. Topics under consideration include the effects of automation on future employment, the intersection of AI with human rights issues, ethical concerns related to autonomous weapons, and the development and potential misuse of dual-use technologies (Buolamwini & Timnit, 2018; Kulkarni et al., 2020; Paul, 2018).

While definitions of AI vary, the Dartmouth Research Project's (McCarthy et al., 1955) definition remains pertinent and states it is making a machine behave in ways that are considered intelligent when performed by a human. In a more detailed sense, AI is defined as a system's capacity to accurately interpret external data, learn from that data, and apply what's learned to accomplish specific goals through adaptive flexibility (Kaplan & Haenlein, 2019; Maddox et al., 2019). This capability enables AI to identify patterns and intricate associations in large, high-dimensional datasets that traditional analysis methods often overlook. For therapists and psychologists, AI can automate administrative tasks, summarize client notes, and analyze large datasets to identify patterns and personalize treatment plans. This frees up therapists' time to focus on building rapport and providing deeper interventions. Further, AI-powered tools can assist in faster and more accurate diagnoses, potentially leading to earlier interventions and better outcomes (Bohr & Memarzadeh, 2020).

Despite the considerable potential of AI in healthcare, concerns among stakeholders exist regarding the safety of AI and data security. Patients worry about the possibility of not having the choice to refuse AI usage in their personal treatment, as well as the potential for increased costs and issues with insurance coverage (Richardson et al., 2021). From a technical standpoint, the performance of AI models can be compromised by missing, erroneous, or insufficiently annotated training data, hindering their ability to generalize beyond their original population. Biased data can lead to biased outputs, resulting in discrimination against underrepresented subgroups. With the ongoing advancements in AI technology, there is a growing prevalence of AI applications, including service robots, chatbots, and AI virtual assistants (Gummerus et al., 2019). These

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technologies, if not ethically administered, could mislead clinicians and cause harm to patients.

Application and Risk of Utilizing GPT-4

Research by Nori and colleagues (2023) critically evaluated the capabilities of the state-of-the-art multimodal, large language model Generative Pre-trained Transformer (GPT-4) with Vision (GPT-4V) on the Visual Question Answering (VQA) task. Their experiments thoroughly assess GPT-4V's proficiency in answering questions paired with images using both radiology and pathology datasets from 11 modalities (e.g., Microscopy, Dermoscopy, X-ray, Computed Tomography) and 15 objects of interest (e.g., brain, liver, lung). The datasets cover a wide array of medical questions totalling 16 different types. During their analysis, they crafted textual cues for GPT-4V to guide it in integrating visual and textual data effectively. The results showed that the current version of GPT-4V is not recommended for real-world diagnostics due to its unreliable and suboptimal accuracy in responding to diagnostic medical questions. In addition, they delineate seven unique facets of GPT-4V's behaviour in medical VQA, highlighting its constraints within this complex arena.

In another study, Johnson and Williams (2022) assessed GPT-4's potential to perpetuate racial and gender biases in clinical decision making. A team of Brigham researchers analysed GPT-4's performance in four clinical decision support scenarios: generating clinical vignettes, diagnostic reasoning, clinical plan generation, and subjective patient assessments. The study found that GPT-4 has the potential to perpetuate racial and gender biases in clinical decision making. The authors suggest that further research is needed to understand the extent of these biases and how they can be mitigated. However, as clinicians, we already face considerable pressure to diagnose and treat patients accurately and fairly. Relying on AI tools prone to bias could introduce additional challenges, requiring clinicians to constantly evaluate and potentially override AI suggestions, adding to their workload. This could also create ethical dilemmas when faced with conflicting recommendations.

Further, Chen and colleagues (2024) conducted a study comparing the March 2023 and June 2023 versions of GPT-3.5 and GPT-4 across various tasks. They observed significant variations in the performance and behaviour of both models over time. GPT-4's accuracy in identifying prime versus composite numbers dropped from 84% to 51%, partly attributable to a decrease in its adherence to chain-of-thought prompting. GPT-4 became less responsive to sensitive and opinion survey questions in June, while GPT-3.5 showed improvements in certain tasks. Both models exhibited more formatting mistakes in code generation in June. For clinicians and mental health professionals integrating AI into their practice, these fluctuations in accuracy and behaviour underscore the need for ongoing monitoring and adaptation.

Observed Behavioural Risks and Safety Challenges of GPT-4

Privacy Bridge Issue of Artificial Intelligence

Research has revealed that GPT-4 trained on varied datasets may possess personal information from public sources, raising ethical concerns regarding confidentiality and informed consent in therapy (Ganguli et al., 2022). Capable of synthesizing diverse data types and performing multi-step rea-

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soning, it can access personal and geographic details, like phone numbers, locations, or educational institutions without internet browsing.

Harmful Content of Artificial Intelligence
Language models can be prompted to generate different kinds of harmful content, such as, content that violates policies or content that may pose harm to individuals, groups, or society (Dev et al., 2022; Rauh et al., 2022). As an example, GPT-4-early can generate instances of hate speech, discriminatory language, incitements to violence, or content that is then used to either spread false narratives or to exploit an individual. Such content can harm marginalised communities, contribute to hostile online environments, and, in extreme cases, precipitate real-world violence and discrimination (OpenAI, 2019). This is important for psychologists and therapists to be aware of as they may encounter clients who have been exposed to harmful content that can greatly impact their mental health.

Harm of Misrepresentation and Stereotypes from Artificial Intelligence
Language models can amplify biases and perpetuate stereotypes (Blodgett et al., 2020). Like earlier GPT models and other common language models, both GPT-4-early and GPT-4-launch, it was found that the model has the potential to reinforce and reproduce specific biases and worldviews. These include harmful stereotypes and demeaning associations for certain marginalised groups (Bender et al., 2021). This could undermine the trust between therapist and client, impede the therapeutic process, and perpetuate harmful stereotypes within the therapeutic setting.

Hallucinations within Artificial Intelligence
Hallucinations in the context of GPT-4 are the tendency to produce content that is nonsensical or untruthful in relation to certain sources (Lin et al., 2022). This tendency can be particularly harmful to humans as models become increasingly convincing and believable, leading to the potential for an overreliance on them by users (Goldstein et al., 2023). Additionally, as these models are integrated into society and used to help automate various systems, the tendency to hallucinate is one of the factors that can lead to the degradation of overall information quality and further reduce veracity of and trust in freely available information.

Disinformation and Influence Operations of Artificial Intelligence
Qualitative studies have shown that GPT-4 can generate plausibly realistic and targeted content, including news articles, tweets, dialogue, and emails, which often manipulate behaviour (Goldstein et al., 2023). The potential for misuse of GPT-4 exists particularly in generating content with the intention to deceive and mislead (OpenAI, 2019). Empirical evidence suggests that earlier language models could also be useful for generating content that is misleading, but persuasive. For example, researchers found that GPT-3 was capable of tasks relevant to changing the narrative on a topic. Persuasive appeals written by language models, such as GPT-4 on politically charged issues, were also found to be nearly as effective as human written appeals, potentially impacting therapist decision making (Kreps et al., 2022).

Economic Impacts – Job Loss and Career Displacement Due to Artificial Intelligence
The impact of GPT-4 on the economy and workforce should be a crucial consideration for policymakers and other stakeholders (OpenAI, 2019). While existing research primarily focuses on how AI and generative models can augment human workers, GPT-4 or subsequent

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models may lead to the automation of certain jobs. This could result in workforce displacement. Research shows the role that AI and generative models, including GPT-3 and GPT-3.5, can play in augmenting human workers, ranging from up-skilling in call centres to help with writing to coding assistance. Consequently, the prospect of job displacement for therapists and clinicians due to advancements in AI underscores the importance of reskilling or upskilling (OpenAI, 2019).

Acceleration of Artificial Intelligence

OpenAI has expressed concerns regarding the development and deployment of advanced systems like GPT-4 and their potential impact on the broader AI research and development ecosystem. This apprehension, referred to as "acceleration risk," stems from the fear of racing dynamics leading to a decline in safety standards, the spread of unfavourable norms, and expedited AI timelines, thereby heightening societal risks associated with AI (OpenAI, 2019). To address these concerns, OpenAI dedicated six months to safety research, risk assessment, and iteration before launching GPT-4 (Weidinger et al., 2022). An evaluation measuring GPT-4's impact on international stability highlighted that its global influence is likely to manifest through increased demand for competitor products in other countries (OpenAI, 2019), impacting clients' cultural beliefs, norms, and expectations around therapy and selection of therapists.

Overreliance on Artificial Intelligence

Despite the enhanced capabilities of GPT-4, it tends to generate inaccurate information and persist in errors, often presenting them convincingly (OpenAI, 2019). This increased believability coupled with an authoritative tone and detailed, yet inaccurate, information raises the risk of overreliance. Users might become less vigilant for errors, fail to provide proper supervision, or use the model in areas where they lack expertise. As people grow more comfortable with the system, dependency may hinder the development of new skills and mistakes may become harder to detect. This issue is likely to worsen with the model's increased capabilities and broader applications, making it crucial for therapists to remain vigilant and not blindly trust the model's responses (Marritt, 2019).

Recommendations for Clinicians Working with Artificial Intelligence

Mental health screening and support: There is a need for therapists and psychologists to establish mechanisms for identifying clients who are at-risk of experiencing psychological distress from GPT-4 model interactions, such as individuals prone to suggestibility or those with pre-existing mental health conditions (Chen et al., 2023). They can provide tele-therapy and support groups that cater to addressing the unique challenges stemming from interactions with AI, taking into account various cultural backgrounds and belief systems.

Therapeutic interventions: Clinicians should develop psychoeducational materials and therapeutic techniques to help individuals recognise and cope with AI-generated content that triggers anxieties, biases, or emotional distress.

Build resilience against manipulation: There is a need to foster critical thinking skills, media literacy, and healthy scepticism towards AI-generated information to prevent susceptibility to misinformation and harmful persuasion. Therapists and social workers alike can encourage clients to be mindful of their emotional responses and cognitive biases when interacting with GPT-4, helping them make more informed choices about their engagement.

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Evaluating access to AI: Individuals, clinicians, and psychotherapists can assist in evaluating the potential psychological consequences of differential access to GPT-4 and prioritise equitable distribution to minimise feelings of exclusion, frustration, and social disharmony (Horvitz, 2022). This can be accomplished by engaging with marginalized communities, promoting transparent distribution processes, and advocating for equitable policies and interventions. These efforts aim to minimize feelings of exclusion, frustration, and social disharmony associated with access disparities (Myers, 2023).

Understand AI capabilities and limitations: Mental health professionals should have a solid understanding of the capabilities and limitations of the GPT-4 model. This includes understanding the data inputs, the algorithms used, and the biases inherent in the AI model.

Specialized usage: It is important to recognize that although GPT-4 demonstrated promising accuracy in producing treatment recommendations for common disorders (Shea et al., 2023) it still needs expert supervision and cannot substitute consultation between clinicians and patients, as well as therapists and clients (Goldstein et al., 2023; Truhn et al., 2023).

Combat techno stress and digital exhaustion: Government and non-government organizations alike can help clinicians promote healthy technology use habits and mindfulness practices to manage stress and anxiety associated with constant connectivity and reliance on AI tools.

Encourage digital detox and human connection: Strong advocacy is needed for maintaining healthy boundaries between technology and human interaction, fostering face-to-face connections, and promoting mindfulness-based activities to support emotional well-being in a technologically integrated world.

Daily updates and research: Organizations and individuals who have the ability are advised to invest in robust security measures to safeguard sensitive data and AI systems from potential breaches.

In summary, clinicians should strictly adhere to relevant regulatory guidelines and standards when using AI, particularly GPT-4. This includes ensuring compliance with data privacy regulations (i.e., HIPAA in the United States) and following ethical guidelines for AI research and deployment. It is important to remain mindful of variations in large language model GPT-4's performance among diverse populations to ensure fair assessment and equitable access. Not abiding by the established regulatory guidelines can result in compromised patient confidentiality, potential legal ramifications, erosion of trust between clinicians and patients, and the perpetuation of biases and disparities in treatment outcomes. Further, failure to adhere to these guidelines could potentially impede the progress and acceptance of AI in psychotherapy, hindering its potential to improve mental health care delivery and outcomes for diverse populations.

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Addressing Religion and Spirituality in Psychotherapy: Why it Should be in Graduate Training Programs

Juliane Nguyen, MPsy

There has been a recent question in American Psychological Association's (APA) Monitor on Psychology asking, "Can religion and spirituality have a place in therapy?" (Abrams, 2023). APA's 2023 President Thema Bryant, PhD, and other mental health professionals believe religion and spirituality have a place in psychotherapy and also agree that clinicians should receive training in religious and spiritual competencies in training programs (Vieten et al., 2023). Discussions surrounding diversity encompass a variety of identity factors that an individual relates to or identifies with. Culture, race, sexual orientation, and other aspects of an individual's identity help clinicians explore a client's individual experiences as part of a wider community they identify with. Each aspect of a client's background informs the way they are present in the world and how the world interacts with them. Spiritual or religious beliefs and practices can impact an individual's identity development, their worldview, avoidance of risky scenarios, and the ability to cope with a variety of challenges and difficulties (Gall & Guirguis-Younger, 2013; King, 2003; McNamara et al., 2010). Personal faith, which is a concept of faith and spirituality that is more subjective and often deeper than religious affiliation, can be a source of hope for the future and can increase psychological resilience (Tolentino et al., 2022). Therefore, exploring the different systems of a client's life is crucial to understand the factors that influence how a client presents in the therapy space, and also helps to identify various protective factors that contribute to their overall well-being.

Recently, there has been increased focus in the literature on developing competencies in religion and spirituality (Vieten et al., 2013). However, most psychologists and trainees do not receive training in how to attend to the religious and spiritual domains effectively and ethically (Jafari, 2016). Additionally, research has demonstrated that the primary mode of support in religious and spiritual competencies in training programs is through supervisory and exposure in diversity courses (Jafari, 2016). Due to the limited exposure to religious and spiritual considerations in most training programs, there is a greater need for this to be an area of focus for psychology trainees in order to better understand this aspect of a client's identity.

It has been an integral part of my training as a clinical psychology doctoral student to be able to embrace religion and spirituality with my clients to meet them where they are and to join them on their journey. In particular, I am frequently reminded of the multitude of ways religion can provide perspective on the world and on their experience. Religion and spirituality can provide clients with a powerful perspective on a relationship with a higher being, the meaning of life, and the significance of the world around them. Similarly, engaging in psychotherapy provides clients the opportunity to examine their way of viewing the world, others around them, and, most importantly,

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themselves. As I considered the impact of my clients' spiritual life on their cognitive, emotional, and interpersonal functioning, I was opened to a deeper understanding of how they present to treatment. I gained particular insight into the areas that may inform their suffering, as well as what provides them with a sense of meaning and belonging. Additionally, being sensitive to religion and spirituality as a clinician allows this aspect of a client's identity to bring unique strengths and an enhanced sense of support into treatment. This provides clients with access to more resources, whether it be spiritual, community-based, or personal coping resources.

As clinicians, reality-checking and cognitive challenging become difficult when we neglect the core beliefs of a client. It has been extremely helpful in my work to understand that religious and spiritual resources can be used to challenge core beliefs. An individual's view of God or their spiritual wisdom, for example, can be sources for clients to lean on to challenge beliefs that have increased their suffering or have made them feel unworthy or unloved. Additionally, religion and spirituality may be areas of exploration that contribute to negative thoughts and behaviors. For example, some clients may find themselves in a religious environment that does not acknowledge parts of their identity or does not agree with how they express their beliefs. Some may feel lonely practicing their faith when surrounded by co-workers or friends who do not share similar beliefs. By being curious and open to discussing and integrating spirituality and religion into clinical care, we can find out so much about the strengths a client has and the challenges they are experiencing that otherwise may be ignored.

For clinicians who strive to walk with clients through their anxieties, suffering, and pain, meeting them where they are in their spiritual or religious journey can provide an incredible sense of richness and depth to therapeutic relationship. I recall a client I had the privilege of working with that identified as a practicing Muslim who presented with symptoms of depression and anxiety. She felt that her interpersonal relationships were strained throughout her life, leading her to believe that others thought of her as a burden. During our work together, I picked up on her hesitancy to share her religious practices and faith background, so I began to inquire about her faith. This led to conversations about how her faith provides her with a sense of security and community. Her experience with a spiritual and religious life included a rich tradition filled with protective factors, such as reassuring passages and messages, a routine prayer life that provided consistency, and a community of like-minded individuals that decreased feelings of loneliness. If I simply treated her faith background as merely a product of her upbringing and country of origin, I would have missed vital community resources that could have increased resiliency, nurtured a sense of belonging, and provided a sense of purpose in her life.

As we move together in this field toward a deeper appreciation for all aspects of our clients' identities, I hope that we come to the realization that who we are is not just defined by our race, cultural background, political leanings, or gender identity. The perspectives and beliefs that inform how we live has profound implications in our profession as healers of the human mind and human experience. I included several resources below that were useful during my training experience regarding the integration of religion and spirituality in psychotherapy. Utilizing these resources

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that recognize the spiritual practices and religious identities of my clients has helped me to understand the intersectionality of emotion, cognition, and behaviors with meaning, purpose, and transcendence. These resources have aided in my understanding of ethical psychological care, including recognizing the limits of my own competencies surrounding spiritual care and how I can be most supportive and effective for my clients.

Resources

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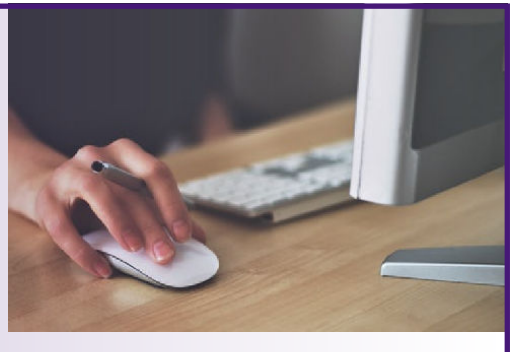

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Robots Revolutionize Learning: Special Education Soars with Artificial Intelligence Companions

Mohammad Tahan, PhD

In a world still reeling from the pandemic's disruption, a beacon of hope shines brightly in the realm of special education. Educational robotics, once a futuristic dream, is now a life-changing reality, offering exceptional children a lifeline amidst the challenges of isolation and disrupted learning. These are not just machines; they are artificial intelligence (AI) companions, bridging the gaps left by the pandemic and empowering children to reach their full potential.

Imagine a child with autism, struggling with communication after months of remote learning. Now, picture them interacting with a robot designed to understand and respond to their unique needs, patiently navigating the social nuances lost in virtual classrooms. This is the magic of educational robotics. These socially-aware robots programmed with emotional intelligence, create safe spaces where children can practice communication skills, build confidence, and express themselves freely, reclaiming the social interaction stolen by the pandemic (Tahan & Saleem, 2023).

But the impact goes far beyond communication. These robots, like personalized tutors unaffected by the pandemic's disruptions, can be programmed to cater to individual learning styles and paces, offering tailored instruction in math, science, and even social-emotional learning. Children with physical disabilities can control robots through voice commands or assistive technology, fostering a sense of independence and participation often diminished during remote learning. Studies have shown dramatic improvements in focus, problem-solving, and critical thinking skills in students using educational robotics, a testament to their ability to reignite the spark of learning dimmed by the pandemic (Tahan et al., 2023; 2024a).

The most heartwarming aspect of this revolution is the human connection. These non-judgmental companions provide a safe haven for learning and exploration, reducing anxiety and promoting social interaction in a way that transcends the limitations of virtual classrooms. For children who faced social challenges during the pandemic, robots can act as stepping stones to building relationships with peers, offering a much needed bridge back to social connection.

The future is now, and it's filled with robots that are more than machines. They are partners in learning, empowering exceptional children to overcome the pandemic's setbacks and reach their full potential. As technology advances and costs decrease, this transformative tool is poised to become accessible to more children, creating classrooms where robots seamlessly integrate into the learning environment, tailoring instruction and fostering growth for every student (Tahan, 2019; 2023). This is not just the future of special education; it's a beacon of hope, reminding us that even in the face of adversity, innovation and human connection can pave the way for a brighter tomorrow.

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The emergence of robotics in special education presents a paradigm shift with significant clinical implications. By leveraging adaptive technologies, robots offer tailored learning experiences that cater to the unique needs of students with diverse abilities. These interactive tools provide a platform for engagement and skill development, fostering motivation and autonomy in the learning process. Moreover, robotics can serve as a catalyst for social interaction and communication, offering a non-judgmental environment for practicing and refining these essential skills. Through real-time data collection and analysis, clinicians and educators can gain valuable insights into students' progress and tailor interventions accordingly, promoting personalized and effective learning experiences. Ultimately, the integration of robotics in special education has the potential to enhance therapeutic approaches, improve learning outcomes, and empower individuals with special needs to thrive in academic and social settings (Tahan et al., 2024b).

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Treatment Considerations for Co-occurring PTSD and TBI

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Trauma-related symptoms have been observed and documented in veterans of military engagement since the existence of the ancient Greeks. While these symptoms have been identified by a plethora of other names, including *shell shock, war neurosis, battle fatigue,* and *soldier's heart*, it wasn't until 1980 that these symptoms were formally recognized as post-traumatic stress disorder (PTSD; Chekroud et al., 2018). Due to the prevalence of veterans experiencing PTSD-related symptoms, the majority of the research on PTSD stems from studying veterans who experienced trauma related to their military experience and typically in combat settings. PTSD can develop, however, from a variety of traumatic events or stressors (i.e., motor vehicle accidents, sexual and physical assaults, natural disasters). Most individuals do not develop PTSD after experiencing a traumatic stressor (Howlett & Stein, 2016). One significant risk factor for PTSD that has more recently been recognized through studying Iraq and Afghanistan veterans is experiencing a traumatic brain injury (TBI). A TBI can result from any of the PTSD stressors (i.e., motor vehicle accidents, sexual and physical assaults, natural disasters). The injury sustained in TBI typically leads to some sort of disruption to the brain's normal functioning that is caused by a blow, bump, blast, or jolt to the head, or a penetrating head injury (National Institute of Neurological Disorders and Stroke, 2023). Studies on Iraq and Afghanistan veterans found high rates of co-occurrence between PTSD and TBI, which lead to further query in this area (Yoder & Norman, n.d.).

Although this observation has led to more focused attention on the co-occurrence of PTSD and TBI, the research remains unclear on the causality of this relationship. In fact, there have been zero randomized controlled trials to date on the impact of psychotherapeutic intervention on co-occurring PTSD and TBI (Howlett & Stein, 2016). This has put limitations on the development of evidence-based practices and resources for mental health professionals (MHP) who treat patients with this presentation. Additionally, the significant overlap in symptoms, high co-occurrence rates, and similar comorbidities between PTSD and TBI make it more challenging for clinicians to accurately diagnose and treat patients with this presentation. The aim of this paper is to provide: 1) An overview of the literature, the prevalence of comorbidity, and various co-occurring symptoms; 2) Considerations for psychotherapeutic intervention; and, 3) Recommendations for MHPs with a differential symptom table (Table 1) to reference.

Prevalence and Co-occurrence of PTSD and TBI Diagnoses

Concentrated research efforts on PTSD and TBI-related symptoms has revealed the importance of understanding the prevalence and co-occurrence of these diagnoses by MHPs. According to the current literature, there is a 6% lifetime prevalence of PTSD and a 5% annual

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prevalence for individuals living in the United States. In 2020 alone, about 13 million Americans lived with PTSD (Schnurr, n.d.). When looking at the data for TBIs, the Centers for Disease Control and Prevention (2016) estimated that 1.5 million Americans experience a TBI every year, remaining a leading cause of death for children and young adults in the United States. Of these 1.5 million people, approximately 80,000-90,000 will live with long-term disability as a result of the TBI. These numbers translate into the approximation that 5.3 million people in the United States live with permanent TBI-related disability (Centers for Disease Control and Prevention, 2016). Although the current research has not demonstrated a significant causal relationship between PTSD and TBI, it has identified a strong association between these diagnoses with up to half of the individuals with a mild TBI meeting criteria for PTSD (Simonovic et al., 2023). Another study found that patients presenting to a trauma center for physical injury were about twice as likely to develop PTSD if they experienced a mild TBI than patients who did not experience a TBI (Bryant, 2010). These significant findings emphasize the importance of distinguishing symptomology and integrating treatment modalities that address both conditions.

Symptom Overlap and Differential Diagnosis of PTSD and TBI

There are significant challenges to identifying and distinguishing PTSD and TBI symptoms, making it imperative for MHPs to acknowledge and understand the presence of these conditions when symptom criterion are met. Such overlapping symptoms that are observed in both PTSD and TBI presentations are described in Table 1 and represented in Figure 1. Some of these symptoms include depressed mood, anxiety, insomnia, difficulty concentrating, fatigue, hyperarousal, avoidance, irritability, derealization, depersonalization, decreased awareness of surroundings, and emotional numbing (Howlett & Stein, 2016).

While identifying the etiology of any mental health disorder and neurological condition can benefit psychotherapeutic intervention and a MHP's conceptualization, it may not be as clear when treating patients with co-occurring PTSD and TBI as overlapping symptoms may impact and cloud clinical judgment. For example, cognitive changes (i.e., impaired memory, difficulty concentrating), emotional dysregulation (i.e., irritability, anger, aggression), and behavioral challenges (i.e., impulsivity, avoidance) can be seen in both PTSD and TBI patients. Yet, etiology may not be as important in treatment. Most of the overlapping symptoms, apart from brain-based cognitive symptoms, can be treated successfully without identifying their etiology. However, differential diagnosis is crucial for certain symptoms that require more focused and individualized approaches to treatment. This is specifically important to successfully treat PTSD since there are particular evidence-based modalities (i.e., exposure-related interventions) that require diagnostic awareness by the MHP. Untreated PTSD in TBI patients can unintentionally worsen TBI symptoms and may impede a patient's ability to cope with TBI sequelae, emphasizing the importance of understanding the intricacies to each symptom expression (Vasterling et al., 2018).

Comorbid Diagnoses with PTSD and TBI

Further complicating the complexities that exist in co-occurring PTSD and TBI presentations is the potential presence of other psychiatric comorbidities that are prevalent in both conditions. Some of these comorbidities include major depressive disorder (MDD), substance use

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disorder (SUD), and chronic pain. In addition to this is the possibility that these conditions existed prior to the TBI, as a result of the TBI and/or PTSD, or are exacerbated by the TBI and/or PTSD symptoms (Howlett & Stein, 2016).

Symptoms of depression are highly prevalent in both conditions with many studies demonstrating that TBI increases the risk for developing depression (Kreutzer et al., 2001; Seel et al., 2003). Additionally, some of the core symptoms for PTSD and TBI are also found in individuals meeting criteria for MDD. These symptoms include difficulty concentrating, memory problems, reduced motivation, irritability, and fatigue (Jorge et al., 1993; Silver et al., 2001; Varney et al., 1987). The symptom overlap between TBI, PTSD, and depression can muddle the clinical presentation and make it more difficult to distinguish symptoms.

Another comorbid diagnosis that is frequently seen with PTSD and co-occurring TBI is SUD. Many studies have demonstrated a trend of increased substance use overtime for individuals with TBI (Corrigan et al., 2013; Parry-Jones et al., 2006). Additionally, PTSD is highly comorbid with SUD (Brady et al., 2009), creating an increased probability of substance use for patients with co-occurring PTSD and TBI. Substance use can greatly impede healing from TBI and exacerbate PTSD-related symptoms, further complicating psychotherapeutic treatment focused on PTSD and TBI-related symptoms exclusively (Gros et al., 2015). These findings demonstrate both the difficulty in differential diagnosis and the importance of gathering as much information as possible prior to ruling in or ruling out diagnoses.

In addition, chronic pain has been found to be commonly associated with diagnoses of TBI, PTSD, and depression, complicating this matter further for clinicians (Gasquoine, 2000). Pain can interact with TBI and PTSD in ways that may initially be difficult to distinguish. For example, pain from a traumatic injury that resulted in a TBI can trigger the re-experiencing symptoms of PTSD (Bryant & Hopwood, 2006). Identifying the etiology of the pain can be helpful to understand the complex interaction amongst these conditions. Adding on to these complications is the fact that several symptoms of TBI and PTSD are non-specific and may be unrelated to either TBI or PTSD. These include headaches, sleep disturbance, memory problems, irritability, somatization, and psychiatric pain generators (Bryant, 2022). This emphasizes the importance of understanding the history and onset of each symptom in order to provide the most appropriate treatment.

Clinical Implications When Treating Co-occurring PTSD and TBI

Accurately diagnosing a mental health disorder can be challenging. When attempting to identify and distinguish symptoms that are present in both PTSD and TBI diagnoses (i.e., cognitive, behavioral, and emotional changes, sleep disturbance, chronic pain, avoidance) this challenge takes on a whole new meaning that can cause unintentional harm if it is not handled with extreme care. If a MHP is not aware of the significant overlap in symptoms, it is even easier to misdiagnose, under-diagnose, or over-diagnose a patient. This could lead to a plethora of negative outcomes that are avoidable and unnecessary. For instance, requesting a brain imaging study to identify TBI-related brain damage when the patient's symptoms are an expression of PTSD. Many MHPs have extensive training in PTSD presentations but may feel less competent when confronted with co-occurring TBI-related

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symptoms and the inherent symptom overlap. This means that MHPs may misattribute symptoms to PTSD instead of TBI, unintentionally putting the responsibility for improved mental health on the patient who has little neurocognitive control. Additionally, when PTSD symptoms are misattributed to a physical brain injury, a patient's expectations of recovery are reduced, leading to a process called "diagnosis threat" (Howlett & Stein, 2016). This threat informs patients that their recovery is not in their control, potentially decreasing their engagement in psychotherapy, reducing feelings of hope, and limiting insight and awareness into their symptoms.

The treatment of PTSD when co-occurring with TBI presents special challenges that MHPs should be aware of in order to avoid treating these conditions in isolation of one another. It is crucial for MHPs to understand that patients with TBIs may underreport their PTSD symptoms for a variety of reasons (i.e., limited awareness of symptoms, misattributed symptoms to TBI diagnosis; Nash et al., 2015). This puts the responsibility on MHPs to continue gathering information throughout the treatment process to identify and distinguish symptom overlap more accurately. With the lack of evidence to inform and guide treatment for co-occurring PTSD and TBI, MHPs must incorporate the available research with an individualized approach depending on the symptom presentation and interaction. The importance of an individualized approach is emphasized in presentations where the cognitive and TBI sequelae interfere with treatment progress, the symptom overlap is significant, or when treatment indications for one diagnosis contradict treatment recommendations for the other (Bryant et al., 2010; Howlett & Stein, 2016).

Clinical Considerations and Treatment Options

In summary, PTSD and TBI symptoms are difficult to distinguish, often occur together, and necessitate recognition to treat effectively. In conjunction with the table referenced above, below is a list of treatment and intervention options for various symptoms present in both conditions.

- **Cognitive Behavioral Therapy for Insomnia (CBT-I):** Restful sleep is a crucial aspect to physical and psychological healing. CBT-I should be introduced to treat sleep disturbances prior to referring patients for a sleep study or for a medication evaluation. This is a manualized therapeutic approach with a strong evidence base that takes approximately 10-12 sessions to complete.
- **Cognitive Processing Therapy (CPT) combined with a Cognitive Training Routine:** CPT is a type of trauma-focused CBT approach where patients focus on restructuring dysfunctional cognitions related to a traumatic event. Integrating CPT with cognitive training interventions can improve cognitive functioning in areas of verbal memory, working memory, and problem solving (Jak et al., 2019).
- **Cognitive Functioning Strategies:** Improved cognitive functioning can aid in better treatment outcomes. The following are strategy options: implement pomodoro technique when engaging in cognitively demanding activities to reduce cognitive fatigue and increase encoding, simplify delivery of therapy materials and discussions, utilize written instructions for memory impairments, form new strategies to minimize reliance on attentional focus, and utilize reminders and alarms for time management difficulties.
- **Behavioral Interventions:** Using an

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ABC (Antecedent-Behavior-Consequences) approach can be helpful in identifying the antecedent of the problematic behavior along with the associated consequences. Once those aspects are identified, altering the trigger for the behavior and related consequences are the next steps.

- **Pain Psychology Interventions:** Managing pain symptoms is crucial for improved treatment outcomes. It is also important to understand the biopsychosocial factors that modulate pain symptoms. The following are intervention options: implement activity pacing in the form of an activity-rest cycle, pace tasks based on time rather than pain symptoms, utilize relaxation training techniques, and employ coping skills training for pain. Alternative treatment interventions include biofeedback, pain sensitization and desensitization techniques, and monitoring when pain can trigger emotional trauma.
- **Mindfulness-Based Interventions:** There are a multitude of mindfulness-based practices that have demonstrated beneficial effects for TBI and PTSD symptoms, including Mindfulness-Based Stress Reduction, Mindfulness-Based Cognitive Therapy, and Self- Compassion approaches. These techniques have been shown to decrease somatic and emotional symptoms and improve a patient's ability to cope with and respond to stress (Lovette et al., 2022). Implementing present moment attention, a mindful cognitive approach, and a non-judgmental perspective are significant aspects to mindfulness-based practices that have proven effective in treating the overlapping symptoms seen in TBI and PTSD (Boyd et al., 2018).
- **Psychopharmacological Interventions:** Due to the significant symptom overlap, it can be beneficial to utilize interventions that target these symptoms specifically using psychopharmacological resources. SSRIs can be beneficial for mood symptoms in both conditions; Prazosin can decrease nightmares; hypnotics can be introduced for sleep impairments; anticonvulsants and antipsychotics may assist with affect dysregulation (Stein & McAllister, 2009). It is imperative to remain cautious when utilizing psychopharmacological interventions due to the varied impact the side effects may have on both conditions. It is imperative to consider the special risk factors involved with prescribing psychotropic medications as they may worsen TBI symptoms, including problems with balance, memory impairments, seizures, and sensory processing difficulties (Howlett & Stein, 2016).

Recommendations for Clinicians and MHPs

- **Be thorough when evaluating patients.** TBI patients may underreport PTSD symptoms, making it crucial to be curious and thorough to accurately diagnose and treat. Additionally, understanding the course of symptoms and their timeframe through detailed information gathering can assist in distinguishing etiology. While symptoms of PTSD may have a delayed onset and tend to worsen over time, TBI symptoms are typically expressed acutely and have a tendency to lessen over time (Carroll et al., 2004; Nash et al., 2015).
- **Avoid diagnosis threat phenomenon.** Diagnosis threat can be avoided by using a cautious approach when conclusively attributing symptoms to a physical brain injury when other causes can also explain the symptom presentation.

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Additionally, it is important for clinicians to emphasize the possibility of recovery and hope for an improved prognosis.

- **Remain flexible and adaptable.** Cognitive changes and other sequelae of TBI may interfere with treatment engagement and effectiveness. These sequelae include difficulty understanding, remembering, and engaging with therapy resources, challenges with impulse control, and cognitive fatigue. Remaining flexible and adaptable in the psychotherapeutic setting can model these skills for patients to implement in their recovery.
- **Consult with patient's medical team.** Coordination of care for this population is especially important due to the nature of TBIs. MHPs may benefit from consulting with neuropsychologists, health psychologists, physical medicine specialists, psychiatrists, speech, occupational, and physical therapists, ophthalmologists, and/or neurology specialists. Consulting with other professionals can provide support to better understand and differentiate organic, overlapping symptoms and non-organic symptoms.

Conclusion

Clarifying PTSD and TBI symptomatology is an ongoing effort. The literature presents significant symptom overlap, requiring MHPs to consider ongoing therapeutic assessment. This means that MHPs need to consistently monitor overlapping symptoms and initiate problem-solving techniques with patients to address them. By having an awareness of the comorbid prevalence of PTSD and TBI and the significant symptom overlap that is present, MHPs can incorporate treatment interventions to target these symptoms specifically. The range in treatment recommendations for co-occurring PTSD and TBI demonstrates the need for an individualized approach that is informed through curiosity, consultation, and re-evaluation. Although this can be a challenging clinical presentation to identify and treat, there is significant hope for symptom reduction and improved well-being for individuals seeking therapeutic support.

Keywords: Chronic Pain, Co-occurring, Intervention, Mental Health Professionals (MHPs), PTSD, Sleep, Symptom Overlap, TBI

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Figure 1: Overlapping PTSD and TBI Symptom Categories

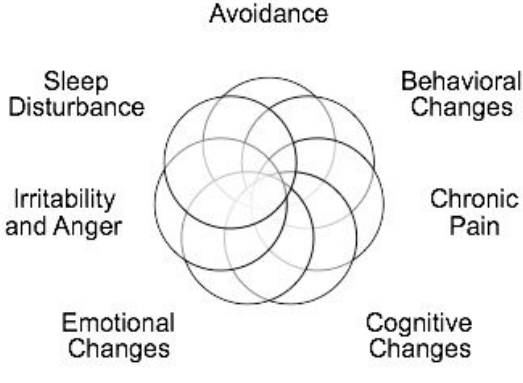

Table 1: Differential Symptoms in TBI and PTSD

Symptom Category	Traumatic Brain Injury (TBI)	Post-Traumatic Stress Disorder (PTSD)
Avoidance	Avoidance of engaging in cognitively difficult tasks; avoidance of people/places that serve as a reminder of baseline functioning	Avoidance of reminders or triggers of traumatic event(s); avoidance of people/places that serve as reminders of traumatic event(s)
Behavioral Changes	Difficulty with social interactions; refusal to engage in activities; lack of motivation to initiate activities; difficulty with task initiation; poor impulse control; limited awareness of TBI effects	Changes in irritability and impulsiveness; hypervigilant and easily aroused; reckless behavior; difficulty with reactivity; increased outbursts of anger
Chronic Pain	Headaches; nerve pain; spasticity of muscles causing pain; unidentifiable pain sensations	Increased pain due to dysregulated stress response from hypervigilance and arousal; increased pain detection; pain related or unrelated to traumatic event; pain as a reminder of traumatic event
Cognitive Changes	Slowed thinking; impairments with attention, memory, and problem solving; easily distractible; periods of confusion	Impairments with attention, memory, and problem solving; reduced social cognitive abilities; experiences with flashbacks, derealization, and depersonalization
Emotional Changes	Reduced emotional awareness; restlessness; anxious; depressed; dependent on area of brain injury; influenced by substance use	Poor emotional control; negative mood; panic; anxious; overwhelmed by emotions; emotionally numb; shame; guilt
Irritability and Anger	Sudden and unpredictable behavior; easily triggered; sensitive to surroundings; poor emotional regulation and awareness increasing frequency of these emotional expressions	On-edge; easily irritated due to hyperarousal; quick to anger depending on traumatic event(s)
Sleep Disturbance	Difficulty with sleep initiation; fragmented sleep patterns; insomnia (more common with mild TBI); excessive daytime drowsiness; increased risk of behavioral and emotional difficulties due to lack of sleep; restless leg syndrome; teeth grinding or clenching (bruxism); sleep apnea; sleepwalking	Nightmares; insomnia; restless leg syndrome; increased experiences with sleep talking; bruxism; avoidance of nighttime silence, increasing poor sleep patterns

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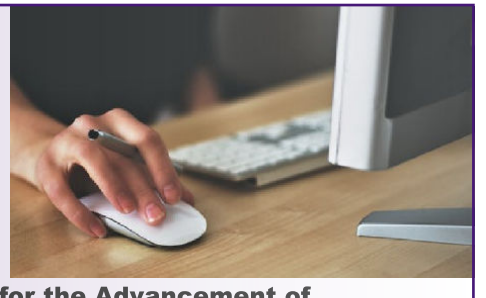

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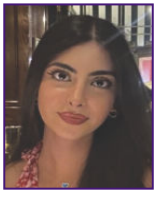
FEATURE

Refugees and Asylum Seekers: Building a Relationship of Trust and Stability

Eva Gharibi, MSc



It was in 2017 when I started to teach English to a group of refugees in the UK and became aware of the immense difficulties they faced in their lives. Many of them openly discussed the dangerous journeys they undertook to arrive in the UK. Several of these individuals had experienced or witnessed their boats sinking, leaving them with frightening and long-lasting memories that they struggled to process. Due to this, many of the individuals I worked with favored medical help rather than psychological support as they viewed drugs to be a more effective treatment method compared to therapy. This experience opened my eyes to the struggles that refugees and asylum seekers face and ignited my pursuit to engage refugees in psychotherapy to ensure that their mental health needs are being met. As often is the case for many, those who need psychotherapy the most are the most hesitant to begin.

The Refugee Experience and Mental Health

Leaving one's home encompasses immense feelings of pain and anguish. The refugee experience is riddled with loss; loss of home, culture, food, environment and family. Not knowing if they will ever be reunited with what they have lost creates a complex mourning process. This experience combined with pre-migration risk factors (i.e., persecution, war, imprisonment in their home country), peri-migration risk factors (i.e., dangerous journeys to the host country) and post-migration risk factors (i.e., uncertain asylum applications, unemployment, social isolation) can leave refugees prone to mental health issues, such as post-traumatic stress disorder (PTSD), depression, anxiety, and psychosomatic disorders (World Health Organization, 2023). Considering this, it is important that the needs of refugees in psychotherapy are re-evaluated in light of these risk factors to provide them with the most effective mental health care.

The topic of refugees and asylum seekers has gained widespread attention in the media in recent years, most of which has been framed as a "crisis." With the Russian invasion of Ukraine, the Taliban takeover of Afghanistan, the current conflict in Sudan, undocumented migrants at the US-Mexico border, and severe escalations between Israel and Palestine, the number of refugees worldwide reached a record high of 19 million people in 2022 alone (United Nations High Commissioner for Refugees, 2022). If all forcibly displaced peoples were to form a country it would be the 14th most populated country in the world, making this a pressing issue garnering greater attention (Al Jazeera, 2023).

Psychotherapy as the Treatment Method for Refugees

I believe that psychotherapeutic treatments are most effective and well-equipped to heal the deep-seated wounds and traumas (some of which are unconscious) that refugees experience. These experiences include recurrent intrusions of traumatic memories, a common symptom of PTSD and one that oftentimes leads to the suppression of

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memories that are unpleasant in nature. However, this can provoke the symptoms and increase emotional and psychological distress (Rubin & Moore, 2007). Therefore, psychotherapy can be an effective tool to bring these memories to the patient's awareness. This means that they become consciously aware of their emotions which enables them to work through and deal with these difficult thoughts and feelings.

Implementing strategies in psychotherapy that incorporate psychoeducation, building a strong therapeutic alliance, and keeping the therapy room consistent should be considered when working with refugees. It is essential to take additional steps to acknowledge the patient's cultural context (i.e., their belief systems) and assumptions about psychotherapy (i.e., what they expect psychotherapy to entail). These are important to consider when working with refugee populations as it contributes to building trust, whether that be trust with their therapist or trust of psychological treatments in general. When trust has been gained, meaningful work can begin to take place.

Gaining Trust When Working with Refugees

Trust plays a fundamental role when working psychotherapeutically with refugees. Many forcibly displaced individuals are often wary of whom they trust. This is especially true for those who are political refugees and who have escaped persecution, making them fearful for their own and their families' lives. Therefore, therapists must place an emphasis on and spend significant time gaining the trust of their refugee patients and prioritize the therapeutic alliance. This is a crucial aspect of psychotherapy in general. A strong therapeutic alliance has been shown to reduce patient dropout, likely contributing to patients feeling at ease and allowing them to continue their therapy (Connolly Gibbons et al., 2003; Martin et al., 2000), whereas a poorer therapeutic alliance generally predicts early termination from therapy (Roos & Werbart, 2013).

To create an environment that fosters trust and safety, it is crucial the therapist refrain from discussing or contacting their patient's local embassy of their country of origin. The embassy can be seen as a continuation of the government network and contacting them could impart anxiety in the patient from fear that the government will then be able to identify them (Tribe, 2005). Explaining to the patient who will and will not have access to the information discussed in therapy will forge a safe space where the individual will feel reassured to share openly with their therapist.

Another way the therapist can strengthen the therapeutic alliance with their refugee patient is to give them permission to openly voice any negative thoughts or emotions that they hold about the therapist and the therapeutic process. Additionally, being attuned to any slight indications of ruptures in the therapeutic alliance would serve to strengthen the relationship (Safran et al., 2001).

Cultural Competence in Working with Refugees

It is crucial that therapists who work with refugees demonstrate knowledge of their patients' culture, as a lack of culture-dependent knowledge can create barriers to developing a meaningful connection in therapy (Khairat et al., 2023). When the therapist is seen as culturally competent by the patient it instills the feeling of being understood. This was articulated by a refugee in a study by Khairat and colleagues (2023) when a participant stated, "He knows

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the whole refugee deal… he knew where I was coming from, he knew what was happening. So it was really helpful, he understood everything" (p.33). To increase a therapist's cultural competency, it is fundamental that they take the opportunity to understand their patient's history, their reasons for leaving their home country, and to also gain geo-political knowledge of their patient's home country (Liedl et al., 2017).

Psychoeducation When Working with Refugees

Psychotherapists working with refugees should also consider educating their patients on the process and expectations of psychotherapy. Oftentimes patients from different cultural backgrounds have various assumptions of what psychotherapy entails. Therefore, the therapist should spend time at the beginning of the therapeutic alliance to discuss any misconceptions the patient has about psychotherapy and explain to them realistic outcome goals, helping to prepare the patient, especially those who are doubtful of psychological treatments (Jacobs et al., 1972; Walitzer et al., 1999). This is especially important for refugee patients as they may be unfamiliar with Western psychotherapy and may be unaware that this is a collaborative process where the patient and therapist work together (Dahl, 1989). Forgoing psychoeducation may lead to unmet needs on the patient's side which have been shown to decrease attendance in therapy (Swift et al., 2012). When the patient has preconceived expectations of psychotherapy that are not met, dropout may occur, emphasizing the importance of providing psychoeducation.

Due to cultural differences, refugee patients often expect the relationship between the therapist and patient to resemble that of a teacher and student, which can lead the patient to place the therapist on a pedestal (Dahl, 1989). Therefore, those working with refugees should take time to explain that psychotherapy is a collaborative process whereby the patient is a master of their own feelings and the therapist is there to navigate the patient to a better understanding of these feelings.

Creating Stability When Working with Refugees

Upon arriving in their host country, the lives of refugees are often very turbulent and unstable. This can also act as a mirror to their internal world, as arriving in a new country can be a confusing and unsettling experience. Refugees are often riddled with mixed feelings: relief that they have arrived at their destination, guilt for leaving loved ones behind, and uncertainty about what the future will hold. Therefore, it is important that the therapist creates a consistent space for their patient to return to each week. Contemporary psychoanalytic theories have demonstrated the importance of consistency in the therapeutic environment and with objects in the healing stages for refugees (Akhtar, 1999; Volkan, 2018). This can look like keeping the furniture and objects in the room consistent, helping the patient embody feelings of cohesion and security within themselves.

Moving Forward

With all this in mind, mental health professionals working with refugees should tailor their work to suit each individual's needs. This can create a safe and trusting environment where patients are given space to be authentic, allowing them to mourn their losses and better navigate their feelings and emotions. This works to empower refugees, validate their feelings of self-worth, and enable them to regain their confidence.

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Many have reduced refugees and asylum seekers to the images we see in the media: boats of migrants crossing the Mediterranean and undocumented refugees entering the US through Mexico. However, we should not allow such depictions to cloud our judgment. These are human beings in search of safety and a chance at a normal life as "no one leaves home unless home is the mouth of a shark" (Shire, 2015, p.1). Psychotherapy is in a unique position to allow refugees to tell their stories and make sense of their past. Implementing strategies, such as integrating psychoeducation, elevating the therapist's cultural competence and establishing a stable therapeutic environment can help foster trust and stability, making the therapeutic journey one of hope and confidence.

In conclusion, the enhancement of psychotherapy for refugees necessitates a multifaceted approach. By addressing these key pillars, we not only facilitate more effective healing processes but also contribute to the overarching goal of promoting resilience and well-being among individuals navigating the complex challenges of displacement, trauma, and mourning.

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FEATURE

Internal Family Systems: Exploring its Problematic Popularity

Lisa Brownstone, PhD
Madeline Hunsinker, MA
Amanda Greene, PhD, MPH

Internal Family Systems: Exploring Its Problematic Popularity

Internal Family Systems (IFS) is a theory of mind organization developed by Richard Schwartz in the 1990s, which posits that the mind is an internal system of parts that exist separately and in conversation with one another. While this approach, on the surface, sounds like many theories of psychotherapy (e.g., any theory that discusses how contradictory internal experiences co-exist), IFS is unique in its labeling and separation of such parts into "vulnerable" and "protective" categories, and into roles like "exile," "firefighter," "manager" and "Self." IFS focuses on helping clients have their "parts" be in conversation with the goal of decreasing psychological symptoms. More specifically, an IFS therapist encourages clients to embody different parts of self in session, encouraging clients to verbalize needs, wants, and past hurts from the perspective of each part. This can include facilitation of splitting and dissociative processes, as well as therapist questions pertaining to each part's past or present experience at the exclusion of other parts (IFS Institute, 2024).

Notably, there is a strikingly small evidence-base in the literature for IFS, particularly given that it was developed 30 years ago. Three studies show some support for the acceptability or effectiveness of IFS with specific presenting concerns: depression, rheumatoid arthritis-related pain, post-traumatic stress disorder (PTSD), and dissociation (Haddock et al., 2016; Hodgdon et al., 2022; Shadick et al., 2013). Despite the limited research with selective samples, the IFS website makes sweeping claims about its healing power: "IFS is much more than a non-pathologizing, evidence-based psychotherapy to be used in a clinical setting. It is also a way of understanding personal and intimate relationships and stepping into life" (IFS Institute, 2024).

Furthermore, IFS usage appears to be increasing. We have noticed increasing numbers of trainees, supervisors, and colleagues who report using IFS across ranging presenting concerns (notably beyond concerns studied in treatment trials). Per the authors' investigation, as of April 2024, 45,764 psychotherapists on PsychologyToday.com mentioned using IFS. There also appears to be an extensive number of posts about IFS on popular social media sites, which have become major sources of official and unofficial mental health information (Cook et al., 2017). Also per the authors' investigation, on Instagram, there were 30,875 posts with #ifstherapy and 74,154 with #internalfamilysystems tags, and, on Tik Tok, there were 3 million posts mentioning "Internal Family Systems Therapy"

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and 1.2 million posts mentioning to "Internal Family Systems Technique." Given its increasing popularity, IFS should be examined regarding potential for harm as its application has expanded to clients with ranging diagnoses, severity levels, and personality structures, as evidenced by the spanning diagnoses that IFS psychotherapists claim to treat on PsychologyToday.com (See Psychology Today, 2024). Additionally, it is possible that the proliferation of IFS in the mental health ecosystem is due to a need for more structured and robust training on empirically supported psychotherapy, as well as trauma-informed psychotherapy.

Potential Harms of the Overapplication of Internal Family Systems

We believe that the current expansion of IFS across psychotherapy and social media has moved beyond its evidence base. The existing literature has excluded those with psychosis, and, based on our clinical observations in hospital and private practice settings, there is possibly an overapplication of IFS to individuals experiencing psychotic symptoms either due to an underlying schizophrenia-related disorder, mood disorder, or severe trauma-related disorder. We are not the first to express concern about IFS application to those with psychosis or reality testing difficulties (Deacon & Davis, 2001). Our concern is that encouraging splitting of the self into parts for those who struggle with reality testing might be disorganizing. We also know from the complex trauma literature that a primary goal of treatment for dissociative disorders and complex trauma is a careful, phasic approach that encourages integration of dissociated parts and experiences (e.g., Courtois & Ford, 2016). Encouraging conversation between parts and telling clients what to label parts of self (e.g., firefighter) without significant sensitivity to ways this could exacerbate splitting of self-states could be dangerous for some. Additionally, IFS practitioners have faced litigation from past clients regarding introduction of false memory (e.g., *Doe v. Riverside Partners*, 2022), possibly facilitated by splitting of self-states and decreased reality testing. As such, there is potential for harm. Clinicians using IFS who have not received sufficient training in trauma-informed care may be at particular risk of misusing IFS in ways that cause such harm.

Increased Popularity of Internal Family Systems

Many early career psychotherapists have graduated from programs that have required "Research Methods," "Counseling Techniques," and "Counseling Theories" courses per accreditation requirements (e.g., MPCAC, CACREP). Counseling techniques courses often focus on common factors in psychotherapy, while counseling theories courses often provide an agnostic overview of all classic psychotherapy theories. Research methods courses often focus on basics of research design and program evaluation. However, there is often a lack of integration across these courses, such that many students graduate as license eligible without an understanding of how to evaluate whether a psychotherapeutic approach has empirical support for addressing particular symptomatology. IFS is a marketable approach that likely draws in client interest (given the popularity on social media), and many of its practitioners are likely not aware of its lack of empirical support. We believe this lack of integrative education potentially leaves many early career psychotherapists to be susceptible to misleading trainings on approaches that are not sufficiently evidence-based.

Additionally, accreditation requirements for many graduate programs in psy-

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chotherapy do not include trauma-informed training (Cook et al., 2017). Relatedly, in a survey of doctoral psychology training programs, Henning and colleagues (2022) found that one in five programs offered a class in trauma-informed care. This may be because the roots of most of these disciplines are vocational psychology, adjustment concerns, and familial distress (e.g., Munley et al., 2004), and not the treatment of acute and persistent mental health difficulties. During training and afterwards, clinicians increasingly report working with clients with high acuity symptoms needing trauma-informed psychotherapy across various levels of care (e.g., Xiao et al., 2017). We suspect that many people applying IFS are doing so to meet the needs of their clients, particularly given IFS' reputation of being a go-to treatment for complex PTSD and dissociation. For example, many Eye Movement Desensitization and Reprocessing (EMDR) practitioner trainings suggest IFS integration with EMDR when clients struggle with complex trauma and dissociation (Brown, 2021). As such, the combination of less than adequate training in evaluating psychotherapies for empirical support and the lack of emphasis on trauma-informed treatment training likely sets the stage for psychotherapists to be interested in an approach like IFS.

IFS Online

As mentioned above, the current authors examined the popularity of IFS on Psychology Today, Instagram, and Tik Tok. These findings indicate a substantial amount of IFS-related content on these sites. Nonetheless, there are no current peer-reviewed articles that have examined the content of posts discussing IFS. As such, the general public is receiving unknown messages from content creators (many of whom are likely mental health providers) regarding IFS. Some of this content, such as TikTok posts on "Internal Family Systems Techniques" may be encouraging audiences to apply IFS without the supervision of a trained therapist. This may be shaping the broader publics' understanding of healing and psychotherapy and fueling a demand for IFS from psychotherapy clients. Such demand may, in turn, impact training and continuing education selection for psychotherapists. The popularity of IFS and related language (e.g., #innerchild, #partswork) on social media may also shape the publics' understanding of mental health, trauma, and identity outside of psychotherapy. As such, IFS content on social media likely shapes dialogue within and outside of psychotherapy spaces.

Future Research Directions for Internal Family Systems

There is a need for research to explore why psychotherapists pursue training in IFS, why and how psychotherapists use social media to talk about tenants of IFS, and what presenting concerns psychotherapists are implementing IFS. We hold concerns regarding potential diagnoses, severity levels, and personality structures that may not benefit (or may be at risk for harm) when considering application of IFS, however, further research is needed to better understand such nuances. Understanding etiologies of psychotherapists' pursuit of IFS training or integration of IFS tenants into their work may help identify training gaps in trauma-informed care. Understanding the prevalence of "therapy talk" on social media and the reach of posts to consumers may elucidate a need for ethical guidelines around therapy talk in the social media landscape (White & Hanley, 2022).

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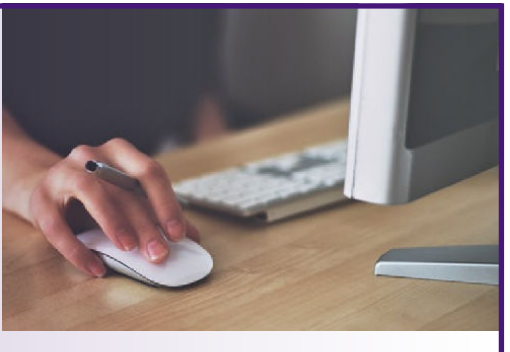

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FEATURE

Harmony of Psyche: Tracing the Nexus of Ancient Indian Psychology, Colonial Legacies, and Contemporary Cultural Synthesis

Khushi Mehrotra, MA

Ancient Indian Psychology

India, a land steeped in diversity, has a rich heritage encompassing various cultures, religions, beliefs, and traditions. From science, metaphysics, and astronomy to literature, art, and politics, this country has made substantial contributions to human knowledge. Beyond the more well-known domains, ancient Indian psychology stands out. Intricately woven with spirituality and devotion to a higher being, it provides profound insights about a holistic approach towards well-being and health (Miovic, 2004). Not only does it discuss concepts like *karma* (actions/deeds), *dharma* (moral duty), and *moksha* (spiritual liberation), it also places an emphasis on a*tma-vichara* (inner exploration), a*tma-jnana* (self-realization), and finding meaning in existence.

Long before India's encounter with European and American cultures, it had already developed a unique psychological perspective deeply rooted in spirituality. This indigenous viewpoint, distinct from Western models, interweaves the understanding of the mind, consciousness, and human behavior within the cultural and spiritual tapestry of the region.

This paper delves into the intricate terrain of ancient Eastern psychology, placing a particular emphasis on explaining the Hindu approach to understanding psychology. The pre-colonial face of psychology in India discussed the transitional journey from the unconscious to conscious, painting a different spiritual picture of concepts related to mind, body, and soul. These concepts were all intertwined until the Europeans and Americans swept away the authenticity of these concepts and amalgamated their influence, creating the recipe that we taste today. Furthermore, this paper scrutinises the impact of colonial influence on the psychological framework, unravelling the intricate dynamics of how Western perspectives changed, and shaped, the narrative.

Ancient Indian psychology, intertwined with philosophy and spiritual traditions, focused on comprehending the mind, consciousness, and human behavior holistically. Concepts such as *atman* (the self) and *manas* (mind) were central to this philosophy, guiding individuals from unconscious ignorance to ultimate consciousness. This process involves transitioning from *avidya* (spiritual ignorance) to *vidya* (spiritual awakening) according to the Advaita philosophy (Majumdar et al., 2023). Ancient Indian psychologists and philosophers believed in traditional interventions like meditation and yoga, including Patanjali's Yoga Sutras and Sri Aurobindo's Integral Yoga. The aim of these interventions is to achieve *sat chitt anand* (eternal bliss) by gaining systematic control of the body and its functioning to attain liberation from the cycle of suffering or *dukkha* (Salagame, 2011). They aim to transform and evolve individual consciousness with the ultimate goal of realizing one's true identity and experiencing the eternal

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bliss of unification with the divine (Shettar, 2021).

Sacred scriptures like the *Bhagavad Gita*, known as The Song of the Lord, explore complex psychological themes and provide intense analysis of life, emotions, and ambitions. They capture the teachings provided to Arjuna by Lord Krishna and encapsulate a therapeutic journey offering practical guidance for managing emotions, overcoming challenges, and achieving spiritual harmony (Gairola & Mishra, 2022). Even before India became acquainted with Western cultures, its rich and ancient heritage had already developed a distinct understanding of psyche.

The *Upanishads*, a sacred Hindu scripture serving as a culmination of Vedic thoughts on spiritual enlightenment, explored the nature of reality and that of self (Majumdar et al., 2023). It delved deep into the significance of dreams to understand the subconscious mind and laid importance on the stream of conscious thoughts and its connection between *atman* (true soul of an individual, true self) and *brahman* (the ultimate reality of universal consciousness; Osho, 2010). The Vedanta philosophy in Hindu scriptures talks about the concept of *neti-neti* (not this, not that) to negate the identification with the body and mind, leading to the realization of one's true nature. Vedanta contributes significantly to the understanding of the self and the psychological journey toward self-discovery and realization (Miovic, 2004).

The ancient philosophy proposed that unwavering faith in the divine Gnostic power, which transcends individual existence, can help overcome challenges and lead to prosperity in physical, emotional, spiritual, and material aspects (Majumdar et al., 2023). It suggests that a belief in higher spiritual realities and metaphysical forces can positively impact one's vitality and overall well-being. Culture and religion played a pivotal role in shaping the psyche of individuals due to the profound faith attached to them.

These ancient methodologies and interventions are regaining prominence in the wake of changing political tides and scientific evidence validating their efficacy. Practices of mindfulness, meditation, yoga, and Ayurveda have all gained recognition in the modern, holistic healthcare realm. Research supports their effectiveness in reducing stress (Khoury et al., 2015), depression, and anxiety (Cramer et al., 2013), as well as improving overall well-being. Concepts related to perception, memory, and reasoning found in several sacred scriptures, such as the Upanishads, Bhagavad Gita, Yoga Sutras, and Vedanta philosophy, are being revisited. This aligns with the current interest in the intersection of traditional knowledge and scientific inquiry.

Current political ideologies and philosophies in India are embracing these traditional. spiritual practices by actively encouraging citizens to engage in yoga and meditation. They are also promoting Ayurveda, which is deeply rooted in ancient Indian mythologies. These traditional practices served as a form of soft power in international relations. These traditional practices were means for heritagization of religion on national and international levels. Different countries showcased our cultural and spiritual heritage, which Indian leaders used as a means to enhance their global influence and strengthen diplomatic ties (Mazumdar, 2018). Before this resurgence, however, Western influence had significantly shaped the trajectory of psychology as a developing domain, painting its current fresco and presence.

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Colonization and its Psychological Impact

Frantz Fanon, a prominent Martinican psychiatrist and philosopher, described colonialism in his book *The Wretched of the Earth* (1963) as, "not just about holding a people in its grip and emptying the natives' brain of all form and content. By a kind of perverted logic, it turns to the past of the oppressed people, and distorts, disfigures, and destroys it" (Quinn, 2017). Colonialism went beyond economic and political control and aimed to shape a particular way of thinking, resulting in what is known as colonial consciousness.

The concept of colonial consciousness reflected the psychological effects of colonization, including power imbalance, domination, and oppression experienced by the colonized. This sense of superiority and entitlement among colonizers contributed to the feeling of inferiority, self-hatred, and disconnection from cultural roots among the oppressed. It also attempted to erase and distort their cultural and historical identity. Ashis Nandy, Indian political psychologist and social theorist, explored this phenomenon in *The Intimate Enemy* (1989), highlighting colonialism's profound impact on mental health and emotional well-being. It left lasting psychological scars on the collective psyche of Indians, resulting in dynamics of resistance, adaptation, and internalization of colonial norms. This impact extends beyond the individual, influencing the collective psyche of communities (Nandy, 1983). Despite external control, colonized people actively negotiate their identities and preserve elements of their cultural heritage.

The Euro-American colonial character significantly influenced the field of psychological science, often neglecting other cultural viewpoints. The pioneers of psychological schools are predominantly Western, leading to the adoption of Americanized curricula and techniques in psychology (Rao, 2010). The marginalization of indigenous concepts and knowledge within the field was evident. The adaptation of Americanized curricula, textbooks, and prevailing diagnostic frameworks, along with using Western interventions and paradigms in teaching and research, might not completely encapsulate the diverse ways mental health is understood in non-Western societies.

Numerous psychological concepts from Eastern traditions were revised and reintroduced in the context of Western understanding. The concept of *anant atman* became known as transcendental self-actualization, popularized by Abraham Maslow (Miovic, 2004). Both concepts emphasize the realization of one's full potential and a deeper understanding of oneself. Experience of flow was an idea already highlighted by the Bhagavad Gita and has been combined with the concept of being completely present in the moment. Constructs, like *manas* and *buddhi*, have new identities consistent with emotional intelligence and cognition. Freud emphasized the importance of dream analysis, a concept also discussed in the Upanishads, showcasing the vibrancy and complexity of the human mind (Miovic, 2004). The cross-cultural exchange of psychological constructs between the Eastern and Western traditions has demonstrated a multi-dimensional understanding of the human psyche.

The argument here is not that the Western forces stole the authentic Eastern traditions and ideas and transformed them into a colonial byproduct in this realm, but that they shaped the point of view beyond spirituality. The Western influence played a crucial role in providing scientific evidence for constructs that were once considered highly sacred and

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spiritual. The concepts of cognition, intelligence, emotions, and actualization became more observable, experimental, and scientific (Arulmani, 2007). It is crucial to approach this discussion with sensitivity, recognizing that positive influences were often intertwined with challenges and negative consequences. The influence of Western psychology during the colonial period led to a complex and multifaceted impact on the understanding of the human mind and behavior in our societies. There were many regions where the colonial powers discredited traditional healing practices, contributing to the marginalization of indigenous knowledge about mental health and well-being. However, colonialism also introduced psychiatric practices and institutionalization, influencing how mental health and illness were understood and treated post-colonialism. This affected the local perception of mental health and contributed to the medicalization of psychological issues.

Many South Asian communities navigated colonial influences by selectively adopting Western ideas while maintaining indigenous psychological constructs, fostering a dynamic and evolving cultural identity. The constructs of resilience, posttraumatic growth, and adaptive coping strategies combined with indigenous techniques helped build a holistic worldview. Such Western ideas enabled individuals to incorporate modern psychological concepts into their worldview, fostering a more comprehensive understanding of human behaviour. Despite its colonial touch, India achieved a nuanced balance between indigenous and denaturalized approaches. The integration of Western psychological concepts, though associated with colonialism, contributed to the evolution of a unique psychological landscape. This blending resulted in culturally sensitive approaches that acknowledge and respect diverse cultural contexts.

During the era of British colonial rule, known as the British Raj, psychological concepts in India were significantly modernized and confounded by an evolving consciousness of colonial influence. While the Euro-American colonial character in psychology presents challenges, it has also contributed to the synthesis of diverse perspectives, fostering a more inclusive and culturally aware approach. Though there were discrepancies among the problems of the Indian population and the solutions provided by the Western approach, decolonizing psychology has led to a more inclusive representation of human experiences within Indian culture. One positive outcome of Western influence on therapy is evident in the assimilation of therapeutic modalities that seamlessly integrate with indigenous cultural contexts, enriching the therapeutic landscape in India.

Decolonizing Psychology in India

The current approach to therapy employed by psychotherapists in India is a positive outcome of the Western influence on psychology. The introduction of such therapeutic modalities has left a lasting impact, offering valuable insights for mental health professionals. This influence has enriched the therapeutic landscape in India, providing practitioners with a diverse set of methodologies that integrate seamlessly with indigenous cultural contexts. The assimilation of these Western approaches has facilitated a more comprehensive and adaptable framework for addressing mental health concerns, contributing to the evolution of a nuanced and effective therapeutic practice in the country.

Relational Cultural Therapy (RCT), for example, is a treatment modality that demonstrates the synthesis of Euro-American psychology and its relevance

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to the Indian context. An indigenous approach emphasizes the connection between one's self and others, focusing on relationships and incorporating ethnic competency, multiculturalism, and diversity. In a country where familial and social relationships along with cultural insights are of paramount importance, RCT emphasizes relational dynamics with traditional values. By recognizing the impact of relationships on mental health and fostering culturally sensitive adaptations, therapists in India leverage the positive aspects of Western-influenced modalities, like RCT, to enhance the effectiveness of therapeutic interventions (Comstock et al., 2008). It focuses on individual differences, and promotes inclusivity by respecting cultural diversity (Frey, 2013). Thus, the modality contributes to the ongoing process of decolonization within therapeutic practices.

Current political influence plays a prominent role in advertising the indigenous psychological concepts and interventions in contemporary India. Political leaders often highlight the importance of preserving and promoting India's cultural heritage, portraying spirituality and traditional wisdom as integral components of its cultural identity. Integrated healthcare initiatives have endorsed practices of yoga, meditation, and ayurveda as preventive measures, potentially reducing the burden on conventional healthcare systems (Mazumdar, 2018). Additionally, promoting cultural events and festivals showcasing ancient practices further enhances the visibility of Eastern spiritual concepts, portraying them as symbols of strength, integrity, and deep religiosity. This emphasis on national heritagization underscores the inherent character strength of Eastern psychology.

To continue, Mindfulness-Based Cognitive Therapy (MBCT) combines elements of purely Western cognitive therapy with Eastern traditions of meditation. Eastern philosophers, particularly those rooted in Buddhism, have long embraced mindfulness as a central component of mental well-being. The interaction of Buddhist meditation with mindful awareness of sensations, thoughts, and emotions fosters greater self-awareness (Allen et al., 2021). The integration of MBCT with Indian mindfulness practices provides individuals with a versatile toolkit to manage stress, anxiety, and depression (Evans et al., 2008; Marchand, 2012; Rizwana, 2020). By combining cognitive restructuring techniques with mindfulness, individuals can cultivate a more balanced and adaptive approach to their thoughts and emotions.

Another such decolonizing influence is the emergence of culturally inclusive and competent professionals in the field. Many prominent healthcare practitioners are actively advocating for ethnic minority inclusion in various ways. These include offering counselling services in regional languages, placing an emphasis on the cultural background and ethnic beliefs of the clients, and exploring cultural stigma they may face. They are asked to adapt a dual lens approach, which involves understanding a client's situation using a therapeutic modality while also appreciating and effectively incorporating the diverse cultural roots of those they serve. Culturally competent practitioners in India are now adept at recognizing and respecting the values, beliefs, and practices of their clients. They skilfully adapt Western therapeutic interventions, infusing them with a touch of cultural heritage and Eastern traditions to meet the unique and varied needs of individuals in the Indian context.

Indeed, the journey towards decolonizing the field of psychology in India involves embracing indigenous approaches. How-

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ever, its crucial to acknowledge that the development of psychology and therapy in India bears the significant imprint of Western influence. Without the interference of the Euro-American approach, the fresco of psychology in the country might have lacked the diversity, depth, and range of vibrancy that we obverse today. The synergy between indigenous perspectives and Western insights has fostered a dynamic and inclusive framework, marking a unique chapter in the evolution of psychology and therapy in India.

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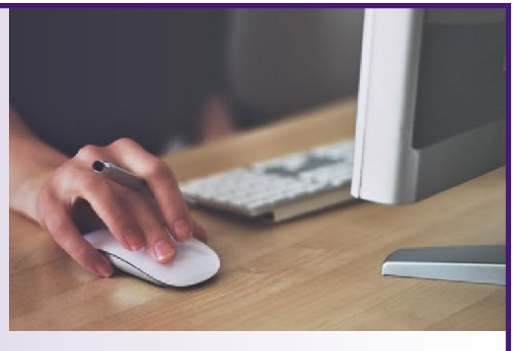

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ETHICS

Five Myths Students May Have About Ethics

Samuel Knapp, Ed.D., ABPP

The strength of a profession lies in its ethical foundations. Yet, students often enter graduate study with misconceptions about professional ethics, and some practicing psychologists may still hold these beliefs. These misconceptions include the notion that ethics is only about following one's personal beliefs or adhering to laws or codes, ethical infractions are made only by the "bad apples" in the profession, ethics should instill fear, and reaching ethical potential is a solitary journey. While containing a grain of truth, these myths can be misleading and harmful if not addressed. Whether they teach in graduate or continuing education programs or work as supervisors or mentors, ethics educators have a crucial role in promoting ethical conduct. As such, they must be vigilant about these myths and ready to debunk them.

Myth 1: Being Ethical Means Following My Personal Beliefs

One student confidently stated that she understood ethics and morals and felt an ethics course was unnecessary. She said, "My parents instilled a strong sense of ethics in me. If it's wrong, I simply won't do it." Assuming that her self-assessment is accurate, this student has a commendable moral compass and a solid foundation to build upon. However, ethical behavior in the context of psychology is far more intricate.

Like most myths, this has a grain of truth to it. There are some absolutes that everyone with a moral foundation would agree to. In one's personal life, one does not lie, cheat, steal, or intentionally harm others. Similarly, in one's professional life, one does not falsify insurance forms, cheat on the licensing examination, or sexually exploit vulnerable patients.

Nonetheless, personal virtues have their limits of usefulness in a professional role, and, in some situations, the virtues of a psychologist may be counterintuitive to students. Consider, for example, a graduate student who, when moved by compassion, felt an impulse to lend money to a patient with financial problems. In one's personal life, lending money to a friend or family member in need would be considered a virtue. Nonetheless, what is ethical in one's relationships with friends and family may not be ethical in a professional relationship. Similarly, psychologists do not engage in reciprocal self-disclosure with patients as with friends or family members, although limited self-disclosure that focuses on patient needs can be helpful. Such behaviors risk moving the focus away from the patient, risk turning the professional relationship into a personal one, and may compromise the objectivity needed for effective psychotherapy. The goal is not to squash compassion, empathy, or the desire to help others but to learn to channel those feelings in a manner that best helps patients.

I have known psychologists or psychologists-in-training who gave money or gifts to patients in need. Often, these gifts strain the professional relationship and undercut the value of psychotherapy. If appropriate, ethics educators could describe those situations. In addi-

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tion, educators could present ethical dilemmas without easy answers. Students who give too much priority to their personal belief systems quickly become aware that they can make mistakes by acting on their initial impulses. They begin to appreciate the importance of knowing the standards of the ethics code and engaging in a deliberative decision-making process.

Myth 2: Being Ethical Only Means Adhering to Ethics Codes and Laws

Again, there is an element of truth in the statement that being ethical means adhering to the ethics codes and laws. Many students study the American Psychological Association's Ethics Code (APA, 2017) closely and strive to adhere to its standards. This provides a strong foundation for them in their professional careers. The standards of the Ethics Code give flesh to the overarching ethical principles such as, beneficence, justice, or respect for patient autonomy, and they also save psychologists the effort of figuring out what to do in many clinical situations. For example, psychologists may question their obligations or roles when they encounter a patient in an emergency and they lack the required competence in that patient's problem area. Fortunately, those who know the Ethics Code (see Standard 2.02) have a standard to follow when deciding how to act.

Nevertheless, this statement is misleading because no ethics code can tell psychologists what to do under all circumstances. For example, educators could explain that many standards within the Ethics Code include modifiers such as "reasonable" or "feasible," which require psychologists to use judgment to interpret the standard. Furthermore, many ethical problems are not addressed in the standards at all. Psychologists need a decision-making process to rely upon when they can find no direction from the Ethics Code. Finally, ethics codes and laws only mandate minimal levels of competence. They do not require psychologists to go the extra mile to become the best professional they can be. One can follow the Ethics Code conscientiously and still be a marginally competent psychologist.

Therefore, a balance is needed. Just as students should not assume they are ethical simply because they follow their personal belief system, they should not assume that they are ethical simply because they follow the laws and standards of the profession. The optimal attitude is to try to live out their positive and prosocial values within the parameters set by the rules of the profession.

Myth 3: Only "Bad Apples" Make Ethical Errors

This statement has a grain of truth in that a few psychologists have serious character flaws, addictions, or serious illnesses that prevent them from meeting the minimum requirements of their profession. However, we make a mistake if we draw too sharp a line between "them" and "us." The problem with this myth is that it implies that as long as one does not have a severe character flaw, then one is immune to making ethical errors. In reality, any of us under the right circumstances could make an ethical error of consequence. If students recognize that they have the potential to make ethical mistakes, then they can prepare themselves for that potentiality and take preventive measures. Ethical misconduct often occurs due to a complex interaction between psychologists, patients, and contextual factors. All of us risk situations in which family issues (such as the severe illness of a child) or professional stressors may tax our resources and we suddenly find ourselves

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tempted to cut corners in our professional practice. Or, for some reason, a particular patient may activate maternal or paternal feelings, which may cause us to cross boundaries inappropriately.

The optimal solution may be to help students cultivate a sense of humility, defined as "having an accurate view of oneself, particularly of one's limitations" (Davis et al., 2017, p. 243). Humility does not mean debasing oneself or becoming servile. Instead, it guards against moral narcissism ("I am too ethical ever to do that"). It furthers an accurate self-perception by developing the habit of accepting feedback and criticisms without being overly defensive. One exercise is to have students create a set of circumstances that would cause them to commit an unethical act or to recall the circumstances surrounding an incident where they acted in a way they later regretted. If they perform this exercise honestly, they could identify potential weak spots and sensitize themselves to the possibility that they could make an ethical error.

Myth 4: I Need to Fear Discussions of Ethics

Ethics can sometimes be scary. The topics covered in an ethics class may be unpleasant, such as how to respond to suspected child abuse or how to respond when patients present a serious and imminent danger of harming themselves. In addition, students may fear the consequences if they make an error and misinterpret a standard in the ethics code or if their actions harm a patient. Finally, being accused of making an ethical violation could be a source of great shame and personal humiliation.

Like all myths, this contains a grain of truth. One should have a certain amount of healthy fear or respect for licensing boards, malpractice courts, and other disciplinary bodies. However, fear needs to be kept in perspective, as it is seldom the best motivator of behavior.

Ethics educators can reduce unnecessary fear by giving students confidence that they know the basics, creating a safe space to discuss their worries and concerns, and assuring them that they can get the support and resources needed when they do not know what to do. Educators can assure them they will make mistakes, but with proper preparation, they can significantly decrease the likelihood of big mistakes (I often shared my mistakes with my graduate students). When faced with ethical questions or conundrums, psychologists aim to be open about their concerns, be receptive to correction, and develop acceptance of their limitations. To paraphrase Nissen-Lie et al. (2017), students should learn to doubt their ethical conduct but love themselves as a person. They should be conscientious but avoid the pitfall of perfectionism, which involves relentless self-criticism without the benefit of self-compassion.

One ethics educator stated that ethics education should be fun. Dr. Small (2005) wrote:

> In the workshops I have conducted on positive ethics, we try to create a stimulating, enjoyable, and nonjudgmental atmosphere. We avoid using the word unethical, just as in a clinical workshop, we would try to avoid labeling participants or even behavior as *incompetent*. We assume that most psychologists continue striving to reach higher levels of clinical and ethical excellence. (p. 8).

Without being maudlin or overly sentimental, one goal of the ethics educator is to help students feel valued as people

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and professionals and to convey confidence that they will make meaningful contributions to society as they live out their life goals.

Myth 5: Ethics is Entirely An Individual Affair

When I taught ethics, one of the first questions I asked my students was, "What do you want the person next to you to get out of this class?" This question surprised them, but they soon described goals for their fellow students. Then I would ask them, "Why did I ask that question?" The students could then identify ways their goal of promoting public health could be better fulfilled if their fellow students with the same goals did better at their jobs.

Finally, I would ask them, "Do you want to do good, or do you want good to be done?" Doing good means that we directly help another person, such as providing them with high-quality psychotherapy. However, wanting good to be done means we want to promote public health even if we are not delivering the service directly. This could include, among other things, being available as a consultant to other psychologists, mentoring early career psychologists, or advocating for policies that promote the public's well-being.

The myth of the solitary ethical agent has an element of truth. In the final analysis, each psychologist determines how they can act, and in some ways, everyone must take on their own journey. However, this statement is also misleading because we can reach our ethical best when we embed ourselves within a community of those with shared values and mutual concerns. Johnson et al. (2012) called this the competence community. Seeing that good is done necessarily means interacting with other healthcare professionals, and we can do our best at doing good when we similarly create a community of like-minded professionals with similar goals.

In addition to helping others, embedding ourselves in a protective community also benefits us. By working within this protective social network, we will cultivate relationships with colleagues who will:

- Monitor our behavior and give feedback when we slip.
- Keep us up-to-date on changes in the profession.
- Share resources if asked.
- Be a friend and allow us to debrief or vent after a difficult day.

Conversely, we can promote public well-being by informally monitoring our colleagues and reaching out to them when they seem to be struggling. We can share our ideas and resources with them and be a sounding board when they have difficult emotions they need to process.

Educational Recommendations

We can help students develop a healthier perspective on ethics by assisting them to:

- Understand the unique rules of psychology so they can channel their prosocial instincts to best benefit patients.
- Appreciate the values and limitations of ethics codes and laws.
- Recognize that all of us have the potential to make ethical mistakes.
- Respect the disciplinary processes, but do not fear them so much that they stifle discussions and reflections on ethical topics.
- Create a professional community that challenges and supports them to be their best ethical self.

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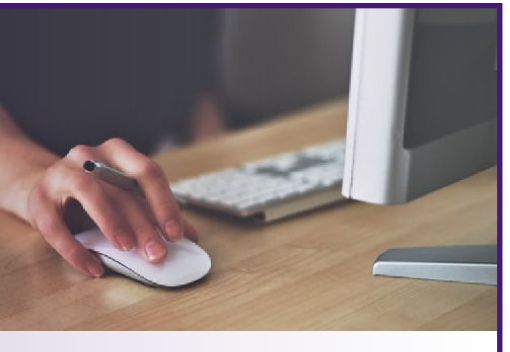

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What Deliberate Practice Supervision Has to Offer Traditional Supervision: Nine Take-Home Messages

Hanna Levenson, PhD

Editor's Note: *This article is part of the "Deliberate Practice in Psychotherapy" series which explores Deliberate Practice (DP) supervision following the Sentio Supervision Model (SSM). The SSM was developed for the Sentio Marriage and Family Therapy masters level online and in-person programs (www.sentio.org) and the Sentio Counseling Washington practicum, which provides affordable low-fee online therapy for Washington state residents (www.sentiocw.org). Sentio 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 supervisors meet to provide feedback to each other's videotaped DP supervision sessions. For more on the Sentio Supervision Model, see the introductory article in this series. Video demonstrations of Deliberate Practice supervision are available at the Sentio YouTube channel.*

For the past year and a half, I have been sitting in on Supervision of Supervision (Sup-of-Sup) meetings led by Alex Vaz and Tony Rousmaniere as part of their one-year Deliberate Practice Supervision Residency Program at Sentio Counseling Center. Initially, I planned to attend just one or two online meetings but after the first meeting, I was hooked. In what follows I'll share nine take-home messages of what Deliberate Practice Supervision (DPS) has to offer traditional supervision (TS) in the hopes it might encourage some of you to integrate DPS into your supervision sessions.

To provide some context, I have recently become acquainted with and committed to using DP in training and have co-authored three DP books as part APA's *Series on Essentials of Deliberate Practice*. For over 40 years I have been very involved in psychotherapy training and supervision—having taught over two thousand graduate students and supervised several hundred of them, researched and written on supervision, done workshops and training DVDs on the topic, and produced/hosted 11 videos and edited 11 books for the APA series *Essentials in Supervision*. In other words, I felt I knew the supervision terrain rather well. However, what I observed in these DP Sup-of-Sup meetings was not like anything I had seen in supervision before. It was challenging, refreshing, and impactful.

Sup-of-Sup Meeting Format

In the Sup-of-Sup meetings, Alex and Tony work with six supervisors who want to learn the Sentio Supervision Model (SSM). These supervisors give their time supervising two Sentio Counseling Center trainees for one year in exchange for in-depth group training in how to use DPS. In the 60-minute meeting, Alex usually consults with three supervisors on one of their supervision sessions for that week, having already reviewed their supervision videos. (Did I mention that *all* of the supervision sessions are video recorded?) Alex then chooses one video per supervisor, making it transparent why he has chosen

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that particular video, and the following consultation is based on what unfolds in that video.

Each video shows the supervisor working with a trainee following a prescribed series of seven steps. Detailed information on this step-by-step model can be found in the March 2024 issue of this Bulletin. During the supervision session, the supervisor not only talks with the trainee about the case, but also watches specific portions of the trainee's video-recorded therapy to evaluate and assess various aspects of the trainee's work with the client. This includes looking for difficulties the trainee may be having with the client, reviewing the client's progress by consulting their routine outcome monitoring scores, constructing a personalized DP skill exercise designed to ameliorate the trainee's difficulties (skill deficits), and modeling and practicing the skill with the trainee. Before I continue, I want to make sure you caught that in the Sup-of-Sup meeting a video of the supervision is used to look at how the supervisor worked with the video of the trainee's therapy to devise DP skill exercises. In the past, I have written about how supervision has been the most closeted component of psychotherapy training—no one records or shows their supervision sessions. In these Sup-of-Sup meetings, however, the door is thrown wide open!

Take-Home Message #1: Use Video to Focus on Specifics

One unique aspect of DPS is the way it uses video to hone in on specific, observable examples of whatever is being discussed. Frequently in TS there are abstract discussions (albeit often fascinating ones) of what is going on with the client (e.g., "I think the client has attachment difficulties given his neglect when he was a child."), what is going on with the supervisee (e.g., "I am getting triggered by this client."), and what is going on in the therapeutic relationship (e.g., "Quite clearly you need to meet the client where he is and develop a stronger therapeutic alliance.").

While there has been an increase in the use of video in TS, the procedure for using video in DPS is more focused on specifics. In DPS, the supervisor watches a video of the trainee's therapy, and in collaboration with the trainee, identifies a specific place where the trainee does not respond to the client in a helpful manner. This is what DPS calls a "client challenge."

Here is a DPS example: The supervisor stops the video when they see that the client was becoming overwhelmed and the trainee's interventions were not regulating the client. The supervisor said, "Notice what the client's eyes are doing. They are blinking. Her hands are trembling. She is overwhelmed. The challenge here is that your client is not well regulated. And what you are doing that is not working is giving her more information, overwhelming her further. Can you see that?"

Take-Home Message #2: Practice, Practice, Practice

As a kid, I loved to play the piano but disliked practicing and I don't think I'm alone in this. Practice is challenging. Repeatedly returning to something you find difficult is hard work. While it pays off in the performance, of course, the aspect of practice is demanding and not always enjoyable. In DPS, the supervisor has the trainee practice a new skill in the supervision session. At first the practice is kind of clunky, especially if the skill has several distinct criteria. I have observed supervisors breaking the skill into bite-sized chunks, or if the trainee were particularly anxious, asking them to write down a script following the skill

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criteria and read it over and over again until they could perform the skill without reading the script.

In the Sup-of-Sup review of the supervisors' videos, Alex and Tony often explain that "gravity pulls us away from practicing." Did I mention practice is often not enjoyable? After the trainee does one round of behavioral rehearsal and the supervisor gives corrective feedback, the supervisor uses a key supervisor intervention: "Let's try that again," to bring the trainee back into practice. Playfully, Alex might start off a supervisory consultation by congratulating a supervisor for practicing a skill with the trainee "on time." (The Sentio Supervision Model timeline indicates that behavioral rehearsal should begin at the half-way point of a 50-minute supervision session.) More about the importance of a "playful vibe" below.

Take-Home Message #3: Give Homework

Practicing with the supervisor is critical; however, a key tenant of DP is that it is not enough. This leads us to a discussion about homework. The DP supervisor gives the trainee an assignment consisting of the exact same skill rehearsed in supervision to practice on their own for at least 10 minutes. For example, in DPS the trainee might have been practicing the skill of asking about missing details or vague parts of a client's narrative (e.g., "Can you describe how you experience your depression?"). Then the trainee would be expected to practice the exercise on their own, since solitary practice has been shown to be a critical factor in achieving expertise (Ericsson & Pool, 2016).

The DP supervisor might suggest that the trainee watch the video of their therapy session and stop the video several times to try out the new skill (e.g., asking about missing details) while looking at the client. Using a video of the client during practice provides a great simulation of the actual therapy. Furthermore, if the trainee needs a reminder of what to do or how to do it, they have access to the supervision video and can review it.

Take-Home Message #4: Use Focused Role-Play

In TS it is not uncommon to have free-form role-plays where the trainee and the supervisor (or two trainees) improvise a back-and-forth dialogue, approximating a therapy session. These experiences can certainly give trainees a sense of what it might be like to do therapy and the challenges involved, but what they do not provide is the repetition and successive refinement that occurs in DPS. In a DP role-play, the "therapist" focuses on one skill and repeatedly improvises responses consistent with that skill to prewritten challenging "client" statements. The beauty of this method is that with sufficient practice, one can see the trainee finding their own voice in the behavioral rehearsal. On more than one occasion Alex has quoted the famous jazz musician, Miles Davis, "Sometimes you have to play a long time to be able to play like yourself."

Take-Home Message #5: Be Clear and Crisp with Corrective Feedback

Practice without feedback is useless. Blindfold someone at the archery range and they will not increase their ability to hit the bullseye no matter how much they practice. Research has indicated that most supervisors doing TS are comfortable giving general positive feedback (e.g., "I can see you are really improving over time.") but are very reluctant to give precise negative feedback (Hoffman et al., 2005). Ironically, receiv-

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ing only positive feedback makes most trainees nervous. They wonder what isn't being said and why.

Repeatedly in the Sup-of-Sup meeting, I saw Alex and Tony help guide the supervisors to give their trainees very explicit, actionable feedback (e.g., "You nailed it with the first part of your sentence. The second part should be eliminated entirely." "Leave twice as much silence between your sentences.") This type of constructive feedback not only helps shape the trainee's behavior, but it also helps consolidate the learning.

Take-Home Message # 6: Have a Playful Vibe

I love the "failure facing" attitude of DP. In the Sup-of-Sup meeting, Tony and Alex create an atmosphere where mistakes are seen as opportunities to learn through play and experimentation; and this spirit gets recreated in the supervisors' supervision sessions. In DPS there is more laughter and lightheartedness than I have witnessed in TS. DP is difficult and demanding for both supervisors and trainees. Creating a lighter vibe relieves some of the heaviness that can easily occur in supervision. The fun and laughter in the session remind trainees that DP is a no-stakes environment, but the repeated focus on practice gives it a high-stakes feel. This allows for a playful yet intense vibe. Because the attitude that one learns from mistakes is baked into DP, I have found trainees' anxiety and shame are lower than in TS.

Take-Home Message # 7: Be Transparent

DP discourages supervisors from setting up residence on a pedestal of knowing. Watching the supervision videos, I heard more than one DP supervisor say to a trainee, "I'm talking too much. Let's get back to practicing." Supervisors are encouraged to do self-observation in the supervision and call themselves on "mistakes" they make. Many DP supervisors keep a printout of the Sentio Supervision Model's (SSM) seven steps clearly visible on their computer desktop in full view of their trainees. The trainees know that their supervisors are learning how to supervise using DP. The less hierarchical frame does not inhibit the learning—quite the contrary, it sends the message that in this profession, we are all involved in life-long learning. In addition, DP supervisors report that following the SSM outline during supervision in a transparent manner "feels freeing and containing" at the same time.

Take-Home Message # 8: Let The Practice Do The Teaching

Tony and Alex are fond of saying, "The supervisor isn't doing the training; the skill rehearsal is doing the training." At first I was perplexed by this, but I have now seen it enough times to be thoroughly convinced it's true. For example, sometimes it is hard to discern what is the client challenge or what is the most relevant skill to rehearse. Having the trainee repeat the not fully understood behavioral rehearsal often answers these questions. In one Sup-of-Sup meeting, Alex advised, "If you don't know why something isn't working, keep practicing, and it will become clearer. Fumble around, buy time, try it again." In my own work doing DPS, one trainee's awareness of his countertransference started emerging as he repeatedly practiced an intervention (e.g., "I feel like I am being too intrusive."). If we had talked about what was going on in a more TS manner, I doubt he would have reached such an experiential realization so quickly or meaningfully.

Practicing also reveals how easy or difficult the skill is for a trainee. Often times supervisors cannot judge ahead of time where supervisees will struggle;

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skill rehearsal can bring this to the surface. Rehearsal can also help with conceptual clarity, providing a deeper sense of how and even why a particular intervention works.

Take-Home Message #9: Use Restraint
Restraint is perhaps the most difficult thing for all supervisors to learn, but it is the DP supervisor's sidekick. Psychotherapy training is customarily conceptual; inhibiting ourselves from saying more can feel like we are shortchanging our trainees. After all, we have so much wisdom to impart and we want to share the clarity we have learned from our experience. We believe that if we can include more, describe more, and explain more, then more learning will take place. In DPS the assumption is that focusing on experiential learning is often a more powerful teacher.

Conclusion: Incorporate Deliberate Practice Supervision Methods
I'll end by urging TS supervisors to seriously consider incorporating some DPS methods into their training sessions. Since DP methods are atheoretical, they can be used regardless of a supervisor's theoretical orientation. Supervisors can apply their clinical theories and case formulations to identify relevant client challenges and skills they want trainees to learn, and then use DP methods to encourage experiential learning in their supervision sessions. A good place to start might be reading one of the brief training manuals from APA's *Essentials of Deliberate Practice Series*. Each manual is a self-contained guide of theoretically-based DP exercises using simulation-based learning techniques. And for a deep dive, consider joining Sentio's Deliberate Practice Supervision Residency Program and participate in your own Sup-of-Sup group. (You can thank me later.).

References

Ericsson, K. A. & Pool, R. (2016). *Peak: Secrets from the new science of expertise*. Houghton Mifflin Harcourt.

Hoffman, M. A., Hill, C. E., Holmes, S. E., Freitas, G. F. (2005). Supervisor perspective on the process and outcome of giving easy, difficult, or no feedback to supervisees. *Journal of Counseling Psychology, 52*, 3-13. https://doi.org/10.1037/0022-0167.52.1.3

"When The Night Has Come. And The Land Is Dark"

Pat DeLeon, PhD, MPH, JD
Former APA President

Enhancing Psychology's Public Policy/ Political Presence: Reflecting upon the APA/APA Services' Grassroots Fly-In, Katherine McGuire, APA's Chief Advocacy Officer, noted: "We were thrilled to host 70 psychologists representing over 40 states during our June Fly-In, *Advancing Health Equity Across the Lifespan* in Washington, D.C. Participants included Federal Advocacy Coordinators (FACs) and Directors of Professional Affairs (DPAs) from State, Provincial and Territorial Associations (SPTAs); Federal Education Coordinators Advocacy (FEDACs); leadership and members of the APA Board of Directors; and members of the Advocacy Coordinating Committee (ACC).

"Participants led over 175 meetings on Capitol Hill to advocate for policies to strengthen access to Medicare mental and behavioral health services, including telehealth services and services furnished via integrated care models. They advocated for three key pieces of legislation: 1). The Telemental Health Care Access Act (H.R. 3432/ S. 3651) which would repeal a Medicare requirement that patients must be seen in-person for continued coverage of their telehealth services. 2). The Increasing Mental Health Options (IMHO) Act (H.R. 8458/ S. 669) which would increase Medicare beneficiaries' access to mental health care by removing outdated Medicare requirements for physician oversight and referral for services provided by psychologists; and, 3). The COMPLETE Care Act (H.R. 5819/ S. 1378) which would increase access to mental and behavioral health services by adopting a 'model-neutral' approach to assisting practitioners with adoption of integrated care.

"We are proud of these members for their work elevating APA priorities and the needs of their profession and communities, especially since this was the first time advocating for some of these participants. We are grateful for the time they took to share insights and anecdotes from their experiences as clinicians, educators, researchers, and especially students—the future of the profession."

Earlier in the year with similar success, the 2024 PSLC conference brought together over 300 colleagues under the leadership of APA President Cynthia de las Fuentes and enthusiastic APA staff including soon retiring Dan Abrahamson. Jared Skillings, APA Chief of Professional Practice and a second-generation psychologist: "PSLC started as a grassroots effort for state leaders to connect to learn from each other and to develop national approaches for profession-wide issues. We are here to honor that legacy.

"On Saturday evening we will hear more about that legacy from Dan Abrahamson, Deputy Chief of Professional Practice. After owning and managing a successful independent practice and then a nearly 20-year career as senior APA staff, Dan let me know last year of his intention to retire, at the end of this month. We are so pleased that his wife, Lynn, has joined us. We will honor Dan

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at the closing session, where he will offer reflections on his career and the legacy of PSLC and the connections between APA and SPTAs. [Dan's moving, heartfelt message: "PLC/SLC has changed the lives and professional trajectories of so many psychologists over 40 years. There is something infectious about coming together with others who share your passion…. And for many who attend PLC, they never look back."]

"Today we are a profession awakened to crisis and called to improve the health and mental health of all. We must ask the hard questions about how to utilize our psychological science, our cultural and contextual expertise, our clinical wisdom to expand our reach. Our world has changed significantly in recent years. We are here to face these new challenges head-on! We must ask ourselves: What can we do? What should we do? to meet the needs of people in our changed and changing world? How are we strategically positioning psychology and psychologists for the future?

"Consumers have increasingly more options for healthcare, including digital. High-touch in-person care is no longer the only option. Psychotherapy isn't the typical entry point to access care for a person in mental distress; within the health system it is primary care or the emergency department. In the community, it is the school, barber/hairdresser, bartender, or a spiritual leader. Population and value-based care holds the promise of cost savings, operating efficiencies, and improved care quality and safety. To make this happen, it requires leadership commitment and ongoing culture change; and, having actionable, clear data and meaningful partnerships and infrastructure to support these models. I am very pleased with the vision of APA's Council of Representatives to pass our profession's first population health policy in 2022. We are working to make structural changes, and thus the transition to a population approach will be easier." As always, this year's PSLC remains the highlight of my professional year.

Our Ever-Changing Health Care Environment: As Jared consistently notes, the advances occurring within the technological fields has resulted in unprecedented change and accompanying different societal expectations within all aspects of health care, including behavioral and mental health care. From a public policy perspective, this is evident clinically, educationally, and scientifically; thereby requiring significant structural changes which can be quite unsettling for many with the anticipated unpredictable consequences. For example, Jin Lee, President of the Colorado Psychological Association, recently reported that her legislature has expressed renewed interest in enhancing the availability of telehealth care which is especially critical throughout rural America. Hopefully, this will allow providers who are outside of the state to practice to the fullest extent of their home licensure (including RxP). Over a year ago, Brad Potts alerted us to the substantial interest within the leadership of one of Ohio's medical schools in developing a cadre of mental health physician assistants (PAs) which were initially conceptualized as possessing somewhat restrictive diagnostic and prescriptive authority, while their license to practice would be limited to the "Buckeye State." At that time, the proposed authorization legislation was not expected to become law. However, times are "a' changing" and it now appears that Brad's legislature may act favorably on this proposal.

Further, as Jared has also postulated, our evolving health care environment has placed a greater priority than ever be-

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fore on team-based, integrated interdisciplinary care. To be successful, this evolution requires developing an appreciation for the skills, expectations, and culture of the various other professional disciplines. Under the leadership of President Steven Curtis Division 55 (the Society for Prescribing Psychology) recently bestowed Honorary Fellowship to three military physicians, one of whom was a psychiatrist, who were absolutely instrumental in the shaping and implementation of the DOD psychopharmacology program in its earliest stages. In so doing, the Division has formally recognized the invaluable contributions of another discipline to psychology.

Steve Ragusea: "These visionaries understood that defending physician turf was not consistent with the traditional Hippocratic Oath. They chose to stand in defense of patients rather than their wallets. The Hippocratic Oath requires that physicians not practice malfeasance, intentionally wrongful behavior that harms patients. They are required to adhere to the idea of beneficence which is the principle that a physician is obligated to act only to benefit the patient and to remove conditions that cause harm to any patient. It is clear that medicine has not trained enough psychiatrists to meet society's needs for many decades now, and there has been no indication that this shortage will end anytime soon. In addition, psychologists are demonstrably the best trained mental health providers in the nation who, with the addition of a post-doctoral master's degree in psychopharmacology, are clearly qualified to prescribe psychotropic medications. These three courageous physicians recognized that patients seeking care would get more care, better care, sooner if psychologists were permitted to prescribe a limited range of medications. Their combined faith in psychology was proven accurate because psychologists have now been prescribing safely and effectively for over a quarter of a century!"

Licensure Mobility: When I served as APA President in 2000, we considered the issue of licensure mobility for practitioners; however, it was clear that the time had not yet arrived. Today, the health care environment and societal expectations have dramatically changed. Advances in technology and our personal experiences during the recent pandemic have generated a new wave of change. The underlying public policy issue has resurfaced: Why should practitioners be required to take several state-based licensing examinations in order to provide care to their patients? Is it that some state psychological association leaders possess a belief that their standards are higher than other jurisdictions' standards or a sense of disgruntlement that not all of the licensed psychologists in their jurisdiction would qualify and so could not join PSYPACT (due to those jurisdictions having equivalency in education requirements when PSYPACT requires APA-accreditation)? Patients and practitioners *do* travel and expect that the advances in communications technology will allow them access to whatever services (health, shopping, or otherwise) they might require. Is change really that difficult to us to accept?

Currently there are 42 jurisdictions which have adopted the APA endorsed PSYPACT Commission legislation. This provides their psychologists with Licensure Mobility by authorizing interjurisdictional practice from their home state into the receiving state (where the patient is located) and further authorizes psychologists to temporarily provide face-to-face psychological services in the distant PSYPACT state. However, there are still 13 jurisdictions in which practi-

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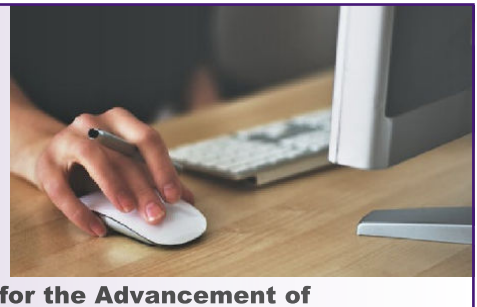
tioners *and* potential patients do not possess this flexibility; 10 of which have never even introduced the necessary legislation (the Sleepy Ten).

Reasonable colleagues can disagree, especially if looking from the ground level rather than a higher level policy perspective. Long time colleague Jeff Younggren: "We need interjurisdictional practice. However, PSYPACT was a great concept that has suffered severely in application. First, those who practice interjurisdictionally agree that they will understand and operate consistent with the requirements of the licensing laws in the distal state. My experience so far is the most providers do not know that and do not even review the regulations of distal PSYPACT jurisdictions. Second, the PSYPACT Commission decided to limit membership to psychologists who graduated from APA approved programs and internships when there is no evidence that those who graduate in other programs are more at risk in any way. Third, the home boards of psychology are in the position of disciplining their regulated psychologists for violations of acts that are not part of their regulation. This, frankly, is very unlikely and clearly creates potential appellate issues. And fourth, when a complaint is made in a receiving state, the home state licensing board is required to apply receiving state law and regulations. This will be a challenge, especially when state laws vary significantly. Where does this take us? A solution would be to just let duly licensed practitioners practice in a distant jurisdiction for up to 30 days and if they need more than that, they need to get a license. This design has worked just fine in states like California." "Stand by me, stand by me" (Stand by Me, Ben E. King). Aloha,

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

Society for the Advancement of Psychotherapy



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

SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY – 2024 AWARDS CEREMONY AMERICAN PSYCHOLOGICAL CONVENTION – SEATTLE, WASHINGTON

Our Awards Ceremony was held on August 9th at the Sheraton Grand Seattle. Several of our grant and award winners were able to attend so that we could honor them in person.

Dr. Gerry Koocher, Awards Chair, opening the ceremony.

Dr. Tony Rousmaniere, SAP President, Dr. Koocher and APF/SAP Early Career Award Recipient Dr. Alice Coyne.

Dr. Coyne accepts her award and discusses her research project.

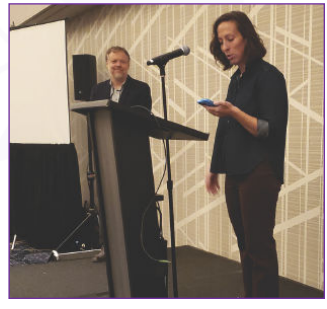
Dr. Rousmaniere and Mira An, recipient of the Jeffery Barnett Psychotherapy Research Student Paper Award.

Dr. Rousmaniere and Sabrina Ge, recipient of the Donald K. Freedheim Student Development Paper Award.

Dr. Alice Coyne was a double awardee this year, and the recipient of the Norine Johnson Psychotherapy Research Grant of $20,000. She is congratulated by Dr. Rousmaniere.

Award Winners, continued on page 65

This year, the Society awarded three Charles Gelso Psychotherapy Research Grants of $5,000 each. Mira An received one of these grants, presented by Dr. Rousmaniere.



This year, the Society offered two grants of $10,000 each to fund the advancement of qualitative research on psychotherapy. One of the recipients, Dr. Sebastian Barr, who could not attend, asked Dr. Joanna Drinane to read his remarks and express his thanks.

This year, the Society offered 10 $500 grants to students. We congratulate those who attended: Isabella Panagos, Anabel Salimian and Eliana Clapps.

Dr. Andres Perez Rojas is congratulated on his APA/SAP Fellow status by Dr. Rousmaniere.

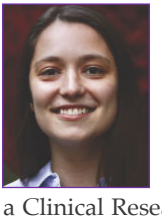
PLEASE JOIN US IN CONGRATULATING OUR 2024 STUDENT AWARD WINNERS!

Donald K. Freedheim Student Development Paper Award – Sabrina Ge, University of British Columbia

Sabrina Ge (she/her) is a second-year Clinical Psychology PhD student at the University of British Columbia in Vancouver, Canada. Sabrina is currently completing practicum placements at a university-based psychology clinic and an outpatient psychiatric clinic. Sabrina has been trained in psychodynamic and cognitive-behavioural therapy and she has worked with individuals with mood disorders, interpersonal difficulties, trauma, and perfectionism. Sabrina has a particular clinical and research interest in psychodynamic and insight-oriented therapies.

Mathilda B. Canter Education and Training Student Paper Award – Omer Sedoff, University of Haifa

Omer Sedoff – Omer is a doctoral student at the Department of Community Mental Health in the University of Haifa and a cognitive psychologist. In her work at Shalvata Mental Health Center, she studies psychotherapy process and outcome among patients suffering from severe mental illness. In recent years, Omer manages the Psychotherapy and Psychiatry Research Lab, and focuses on understanding the complex interplay between neurobiological processes driving psychotherapy efficacy in naturalistic settings, in the hopes of improving mental health care for patients treated in the public service.



Lillian Comas-Diaz Diversity Student Paper Award – Averi Gaines, University of Mass- Amherst

Averi Gaines – Averi Gaines is a sixth-year graduate student in Clinical Psychology at the University of Massachusetts Amherst (UMass). In 2017, Averi graduated with honors from Haverford College with a BA in Psychology. After graduating, she worked as a Clinical Research Coordinator in the Center for Psychotherapy Research at the University of Pennsylvania in Philadelphia, PA. She began her graduate work at UMass in 2019, and she was awarded a Graduate Fellowship during her first year. She received her M.S. in Clinical Psychology from UMass in 2022. Averi's research centers on patient, therapist, dyadic, and systemic factors that influence psychotherapy processes and outcomes, including how such factors influence mental health care disparities. Her work has been funded by research grants, disseminated at professional conferences, and published in peer-reviewed journal articles and book chapters.

Student Award Winners, continued on page 67

Jeffery E. Barnett Psychotherapy Research Student Paper Award – Mira An, University of Maryland

Mira An – Mira An is a Ph.D. candidate in Counseling Psychology at the University of Maryland, College Park, currently interning at the George Mason University Counseling Center. She is committed to improving the effectiveness of psychotherapy for diverse clients. Her research explores the transformative potential of relational aspects of psychotherapy and the profound influence of cultural factors on the therapeutic process. By integrating her roles as a clinician and researcher, she aims to provide clinically beneficial and culturally sensitive insights that can be translated into tailored clinical applications.

Student Excellence in Teaching-Mentorship Award – Rachel Hughitt, University of Denver

Rachel Hughitt – Rachel Hughitt is a PhD student at the University of Denver in counseling psychology. She has completed clinical experiences ranging from community mental health, group practices, and college counseling centers. In the 2024-2025 year, she will be completing her pre-doctoral internship at the University of Minnesota's Student Services Center.

Student Excellence in Practice Awards – Nishi Ravi, Marquette University

Nishi Ravi (she/her) is currently pursuing her Ph.D. in Counseling Psychology at Marquette University after completing her master's in psychotherapy from Scotland. She is passionate about dynamically working with adults from a relational, anti-colonial, and identity-affirmative perspective. Nishi trained in public and private health sectors in the UK before returning to India to establish an independent psychotherapy practice. Her clinical service to the profession also extends to public psychoeducation through media engagements, including podcasts, panel discussions, and interviews.

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/

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

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

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PSYCHOTHERAPY BULLETIN

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

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

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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!