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BULLETIN

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Society for the Advancement of Psychotherapy

2025 VOLUME 60, NUMBER 1

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PRESIDENT'S COLUMN

Stewart Cooper, PhD, ABPP

It is a deep honor to serve as your President for 2025 and a deep privilege to be able to work with so many of you. The clinical, scientific, educational, social justice, and advocacy talents among our membership are awesome.

This is the first of four Presidential Columns I will share with you this year, one in every issue of the Bulletin. Each will center on one of my four Presidential Initiatives, as highlighted in my July 8, 2024 President-Elect column linked here.

My first Presidential Initiative is furthering the deepening of the understanding and incorporation of identity and culture in the science, practice, and education of psychotherapy and psychotherapy supervision. The remainder of this column will feature what each of our seven Domains (in their alphabetic order) plan to do as aligned with this priority.

DIVERSITY DOMAIN

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Changming Duan, PhD, and
Susan Woodhouse, PhD

Committee Chair:
Wonjin Sim, PhD

Coordinator of AMPD program:
Rosemary Phelps, PhD

Social Justice Chair:
Linda Campbell, PhD

- Continue with the Advocacy & Mentoring Program for Diversity (AMPD) Scholar Program.
- Recruit more committee members and organize additional diversity initiatives.
- Propose a symposium and roundtable at Society for Psychotherapy Research (SPR) and American Psychological Association conferences.
- Develop more webinars on DEI issues in psychotherapy
- Do a review of Division 29 membership with goals to increase diversity in Division 29 membership
- Collaborate with Social Justice and International Domain in creating a Task Force on building/gathering toolkits. The Diversity Committee can work actively on this.
- Collaborate with the student representative on supporting BIPOC students and educators of BIPOC students as a part of a focus on the salience and incorporation of identity and culture in the science, practice, and education of psychotherapy and psychotherapy supervision

EARLY CAREER PSYCHOLOGY (ECP)

Domain Representative:
Yujia Lei, PhD

Committee Chair:
Peter Franz, PhD

- Aid psychologists in expanding the inclusiveness of their clinical practice and increasing competency regarding work with minoritized/marginalized groups.
  - Continue webinars on topics such a Suicide Risk Assessment for Ethnic Minorities that have previously been offered and expand to other marginalized groups.
  - Utilize networking to recruit experts in the field like my colleague, Aaron Breslow, whose research focuses on improving access to care in the trans community.
- Yujia's APA grant application, if funded, would support comprehen-

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sive programming to enhance training for bilingual immigrant women of color. This programming would become a major priority for the ECP domain in 2025, encompassing multiple initiatives and individual events.

EDUCATION AND TRAINING DOMAIN

Domain Representative:
Erica Marshall-Lee, PhD

Committee Chair:
Melissa Jones, PhD

- Offer webinars focused on culturally sensitive supervision, research (protocol, participant inclusion, etc.), education (i.e., curricula, diversity of subjects and materials) focused on the ADDRESSING (aka intersectionality wheel) and other models, e.g., the Simpson model, in service provision, case conceptualization, consultation, crisis intervention etc.
- Internal expertise to provide talks.

INTERNATIONAL DOMAIN

Domain Representative:
Xu Li, PhD

Committee Chairs:
Changming Duan, PhD and
Dana Tzur-Bitan, PhD

- **SAP conference in China**: Between November 6 to 9, 2024, a regional SAP conference was held virtually with the title of "Counseling and Psychotherapy in Practice: New Perspectives on Therapist Skills and Development." A summary of the meeting and its impact will be submitted for publication in the *Bulletin*.
- In 2025: We plan to explore opportunities to hold similar conferences in China or other regions.

MEMBERSHIP DOMAIN

Domain Representative:
Jairo Fuertes, PhD

Committee Chair:
Firouz Ardalan, PhD

- Goals to strengthen and cultivate deeper connections within the various Div29 committees.
- Increase engagement with students and early career professionals is essential to our vision. This emerging generation will play a crucial role in shaping the identity and culture we aspire to establish within Div. 29.

PROFESSIONAL PRACTICE DOMAIN

Domain Representative: Amy Ellis, PhD

Committee Chair: Marcy Rowland, PhD

- In an increasingly diverse and nuanced field, therapists with unique identity-based needs often lack tailored resources to support their journeys in private practice. This project seeks to empower therapists in professional practice by developing practical resources—including tip sheets and videos—that address the specific challenges faced by those whose identities intersect in ways that influence their work.
  - Some of the ideas that we have generated thus far include balancing a part-time practice, navigating biases as a e.g., Black or Jewish therapist, and managing caregiving responsibilities alongside client care.
  - We intend to recruit our committee members to take on one, maybe two, of these topic areas and stagger due dates across the year for a steady stream of content. Each resource will offer real-world strategies and insights on practice management, conducting therapy, and dealing with real world challenges from and for these identities.

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By creating accessible, identity-conscious resources, this project aims to fill a critical gap in support, helping therapists embrace both their personal identities and professional goals.

- We believe that this will be instrumental in fostering engagement with other domains (Diversity, International, etc.) and creating a tangible member benefit.

SCIENCE DOMAIN
Domain Representative:
Patricia Spangler, PhD

Committee Chair:
Harold Chui, PhD

- The Science and Scholarship domain can further SAP's focus on incorporating identity and culture into the science of psychotherapy through our grants in two ways: (a) Make these factors a key consideration in reviewing applications to the annual Gelso and Johnson grants and (b) Request funding for research grant that focuses on the intersection of identity, culture, and psychotherapy research.

In addition to our above Domains, our Publications areas will also have a focus on this first initiative.

- Jesse Owens, Psychotherapy Editor, has committed to two related special sections/features:
  - Spiritual and Religious Competencies (with a focus on training)
  - Culturally and Structurally Responsive Training in Psychotherapy
- Zoe Ross-Nash, Editor of Electronic Communications and Bulletin
  - For the second year, Zoe has invited a monthly call for submissions, recruiting topics on various areas of psychotherapy and intersecting identities. Authors are welcome to submit articles on any topic at any time, however, may use these calls as a form of inspiration to diversify the content in the *Bulletin* and website. Click here for more information!

January	New beginnings
February	Romantic relationships
March	Women
April	Religion
May	Military
June	LGBT+
July	Independence in psychotherapy
August	Humanitarian work
September	Fee setting and business practices
October	Older adults
November	Gratitude
December	Termination

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- Zoe has also started an SAP "Who's Who," the features psychotherapists who are members of Division 29 and would like to share their career accomplishments. Zoe encourages all members to be featured! Send an email to editor@societyforpsychotherapy.org to express interest.
- Amy Ellis, Publications Board Chair, is focused on bringing more diversity to the Publications & Communications Board. She is working to involve more students and diversify the committee with members who bring a wide range of personal and professional experiences. Amy also strongly supports Drs. Owens and Ross-Nash's efforts to publish articles that explore identity and culture. She is working to build a stronger connection between these two publication outlets, aiming to reach both professionals and community members. Amy is committed to increasing diversity in both the content and authorship of publications, ensuring that diverse voices and perspectives are represented. Her goal is to help position SAP's publications as foundational educational and skill-building resources for understanding and incorporating identity and culture into psychotherapy.

In looking at all the above, I am truly excited about what we will accomplish and grateful for all these Board members' energy and ideas. I would be remiss to not also express appreciation in advance to the other 2025 SAP Board members, Past-president Tony Rousmaniere, President-elect Joshua Swift, Secretary Astrea Greig, Treasurer Ken Critchfield, and our two Council of Representatives members, Libby Williams and Jeff Younggren.

Stewart Cooper, PhD
SAP President

WINTER EDITOR'S COLUMN

Zoe Ross-Nash, PsyD

Happy New Year, SAP!

We are so excited to start 2025 as this denotes the 60th volume of the *Bulletin*. We hope you enjoy reading *60*(1).

Lacy Sohn, Sarah Bondy, and Deanna Young will stay in their respective roles. Amanda Foster will be replacing Yashvi Aware as the social media coordinator. Thank you for the last two years, Yashvi! And welcome to the team, Amanda! It takes a cohesive unit to maintain a website and *Bulletin;* each of you are so valuable in your roles. While our team has set goals this year, we are open to feedback on the website and the *Bulletin*. You are welcome to email editor@societyforpsychotherapy.org for any ideas or suggestions to improve our publication and website.

Personally, I am very excited for my continued work with SAP President Dr. Stewart Cooper, who stepped into the role at the start of the year. I was privileged to learn more about Dr. Cooper after I interviewed him for SAP's first ever "Who's Who." You can find his video and interview linked here. We will have other amazing members featured, such as the former President of APA, Dr. Ronald Levant, in upcoming months. If you are interested in being featured, please email the contact above!

Bulletin 60(1) will have a special feature on eating disorders. However, we have articles on pathology within the media, such as Netflix hit show, *Baby Reindeer*, as well as grief and social media.

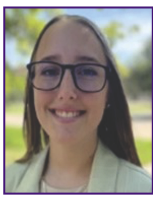
We are appreciative of Division 29's continued support of the *Bulletin*. This publication offers clinicians a unique opportunity to showcase their skillsets, all while amplifying different voices in the field. If you are interested in publishing with us, please click here for more information.

Sincerely,

Zoe Ross-Nash

Suicide Prevention Takes a Village at Universities: Eight Key Strategies

Layna Adams, MS
Christopher Leonard, PsyD
Jessica Provines, PhD



Engaging in suicide prevention on university campuses requires a comprehensive approach that involves a variety of strategies and invested partners. Universities have the unique opportunity to cultivate a supportive environment that promotes mental health and provides effective interventions for those in crisis. This article discusses how universities can implement a multifaceted approach to suicide prevention using 8 key strategies.

1. Support Access to Quality, Affordable Care at University Counseling Centers

University counseling centers are pivotal in providing mental health support to students, including those at risk of suicide. It is essential for university counseling centers to have the capacity to provide treatment and access to students, as well as the expertise to treat suicidal clients effectively. This involves having trained mental health professionals who can conduct thorough assessments, create individualized treatment plans, and offer immediate and long-term support. Counseling centers should also have protocols in place for crisis situations, including emergency interventions and referrals to external resources as needed. Use of university counseling centers has proven to reduce suicidal ideation for students regardless of initial risk or distress (Rallis et al., 2023). By ensuring that counseling centers are equipped to handle suicidal clients, universities can provide critical support during moments of crisis and work towards preventing suicide.

2. Create University Clinical Training Pipelines

University counseling centers play a crucial role in providing mental health services to students. Establishing a training pipeline can enhance the capacity of the university counseling center, ultimately enabling a greater number of students to be served. By establishing training pipelines within the counseling centers, universities can guarantee their staff are prepared to handle a wide range of mental health concerns, including suicide risk. Training pipelines involve continuous education and skill development for clinical professionals, including up-to-date practices, exploring emerging research, and gaining clinically-based skills for managing crisis situations. Having counseling centers function as training pipelines ensures that when positions become available, they can be filled by professionals who are knowledgeable in prevention and treatment. These individuals will then continue to play a vital role in training the next generation of providers. This ongoing training ensures that clinic staff can deliver a standard of high-quality care by staying informed about best practices in suicide prevention and treatment.

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3. Develop Campus Wide Initiatives

Creating an environment of support for suicide prevention can be accomplished via campus wide initiatives. Building an initiative through the lens of a public health approach should encompass the campus at large by engaging support from the student body, faculty and staff, student organizations, residential life, academic advisors, various departments, student affairs, and the surrounding community (Harris et al., 2022). For example, with initial funding from a SAMHSA GLS Campus Suicide Prevention grant, Wichita State University created the Suspenders4Hope mental wellness and prevention program—an evidence-based, four-part initiative that promotes a supportive campus environment through a stigma-reducing campaign. The initiative includes having students, faculty, and staff complete a 2-hour suicide prevention training, incorporate wellness activities in the classroom, and serve as mental health advocates. In the training, participants learn about various tools that can be utilized to navigate complex and sensitive situations to ensure that students receive appropriate care and intervention on campus. Those who complete the training receive a suspenders shirt to wear as a symbol of their commitment to mental health and their readiness to support those in need. Other examples of identify and refer trainings include Mental Health First Aid, Question, Persuade, and Refer (QPR), and the Green Bandana Project. The goal of the initiative should be to raise awareness about mental health and suicide prevention by engaging the university community in visible, supportive actions. The suspenders serve as a conversation starter, reducing stigma and encouraging open dialogue about mental health issues. By visibly fostering a culture of support, the campus wide initiative helps to normalize conversations about mental health and encourage individuals to seek help.

4. Introduce Mental Health Programs at New Student Orientation

New student orientation is a critical time for introducing incoming students to a university's mental health resources and support systems. Students indicate having a lack of knowledge about mental health services on university campuses (Hyseni Duraku et al., 2023), highlighting the need for a greater awareness of available resources. Some students noted their peers being unaware of the counseling center's physical location as another barrier to receiving supportive services (Cohen et al., 2022). Therefore, integrating mental health programs into new student orientation helps students become aware of available resources, learn about mental health and wellness, and know how to seek help if needed. Orientation programs can include workshops, presentations, and/or informational materials about mental health services, stress management, and recognizing signs of distress. By addressing mental health early in a student's university experience, these programs can help establish a foundation of support and awareness.

5. Give Tangible Support to Help in Crisis

Tangible support can function as a proactive tool used by universities to support students in mental health crises. Tangible support can be offering a Hope Kit, which can include materials designed to provide distress tolerance and emotion regulation resources, such as self-care items that provide health distraction and are self-soothing, inspirational messages, and information on accessing mental health resources. The purpose is to offer tangible support and encouragement to students who might be struggling, serving as a reminder that help is available and that they are not alone. Hope Kit items can also help students effectively manage in a time of cri-

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sis. Distributing tangible support, like the Hope Kits, can create a physical expression of support and provide students with tools to manage their mental health when alone.

6. Use National Evidence-Based Interventions

Having clinical staff in counseling centers trained in specific suicide treatment interventions is equally as essential as having prevention trainings accessible to students, faculty, and staff when establishing a supportive and proactive campus environment. These programs should emphasize universal screening and a collaborative approach to treating clients who screen positive for risk, work from an evidence-based foundation, and focus on understanding client needs, all while working together to establish safety plans and actionable steps to address suicidal ideation. For example, the Collaborative Assessment and Management of Suicidality (CAMS) training is an evidence-based approach designed to equip university staff and mental health professionals with the skills needed to assess and manage suicide risk effectively. Pairing CAMS training with other evidence-based practices, such as Counseling on Access to Lethal Means (CALM), Dialectical Behavior Therapy (DBT) Group Skills Training, and Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), strengthens the ability to provide a comprehensive approach to prevention and intervention, while addressing the various factors that influence students' mental health. So, while Suspenders4Hope offers an example of campus wide prevention that treats the water, these evidence-based trainings contribute to providing clinical treatment interventions that treat the fish.

7. Work with Campus Partners

Universities can work with various campus partners to enhance their suicide prevention strategies. Developing teams that include members from different departments across campus provides the opportunity to identify, assess, and implement interventions for students in crisis at the most critical time. Examples include Campus Assessment, Response, and Evaluation (CARE) Teams and University Behavioral Intervention Teams (UBIT), which are multidisciplinary groups that monitor and address concerns within the student population by reviewing reports, assessing risk, developing intervention plans, and providing ongoing support. By incorporating the standard use of a release of information, vital communication can be established between relevant campus partners who work together to ensure a student's well-being, ultimately strengthening campus case management services. This coordination between campus partners, such as counseling, health services, and academic support provides the best opportunity for student success, care, and safety.

Furthermore, it is essential to integrate peer support programs, Faculty Fellows programs, and partnerships within college courses to bring suicide prevention to the academic side of the university. This approach aligns with the academic missions by involving students and faculty in a proactive approach to support mental health, fostering a caring and informed campus community. These collaborations with campus partners ensure a coordinated approach to supporting students in distress, facilitating communication between departments, and implementing comprehensive interventions.

8. Collaboration with Community Mental Health Resources

It is important for universities to collaborate with community mental health resources to enhance their suicide prevention efforts, as a university counseling center should never operate in

continued on page 10

isolation, nor should the university itself. These partnerships provide students with access to a broader range of mental health services and resources. Community mental health centers, inpatient psychiatric facilities, and hospitals can offer specialized care and crisis stabilization that complement the university counseling center's outpatient services. By integrating community resources with MOUs and care coordination practices, universities can extend their support network, ensuring students have access to the help they need both on and off-campus. Students acknowledge they can face both structural and psychological barriers to accessing resources (Cohen et al., 2022), but collaboration with community resources helps bridge gaps in mental health care and provides a safety net for students in crisis, ensuring that no student falls through the cracks.

Conclusion

Suicide prevention on university campuses is a combined effort of a community working together to create a supportive and responsive environment. By utilizing community mental health resources, providing tangible supports, engaging in campus wide initiatives, implementing training, developing training pipelines, integrating mental health into orientation, collaborating with campus partners, and ensuring that counseling centers can effectively treat suicidal clients, universities can create a comprehensive approach to mental health and suicide prevention.

The strategies above highlight the importance of a holistic approach that combines immediate support with long-term prevention efforts. These interventions are effective on their own but become far more powerful when combined. Therefore, investing in a campus focus of prevention and intervention enhances the quality of care provided to students and positively impacts a campus and its surrounding community. Through collaboration and proactive measures, universities can foster a campus culture that prioritizes mental well-being, reduces stigma, and provides students with the resources and support they need to thrive. Universities can indeed become a village that is dedicated to preventing suicide and promoting mental health.

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Making Space for Spirituality While Treating Substance Use Disorders

Aileen Rands, MS

As a graduate student new to addiction treatment, I have felt a growing curiosity about the degree to which spirituality is brought into psychotherapy. I attend a private religious university, thus my first therapy patients routinely spoke of God, recited scripture, or wrestled with interpretations of morality. This simultaneously became a sublime and perilous feature of my graduate work. Now, as a new intern at a Veterans Affair clinic, spirituality has taken on a new form as I work to make sense of addiction in the therapy room.

I will start with some definitions, although many variations exist, for spirituality and religion. The two are commonly intertwined but, at times, are intentionally separated. Nolan et al. (2011) provides a comprehensive definition of spirituality: "the aspect of humanity which refers to the way one seeks and expresses meaning, purpose, and connection to the moment, the self, others, nature, and the significant or sacred" (p. 87). Religion might be viewed as the hardware to this software; the beliefs, the customs, the culture, the rites, and rituals. Religion is not necessary for spirituality, but commonly connects an individual to a broader community and history through membership.

When it comes to treating addiction, we aim to help our patients move towards recovery; this stands as our desired outcome. The word recovery itself has many definitions within psychological literature (Worley, 2016). Despite the inevitable range of definitions, all reference a form of change or growth. The American Society of Addiction Medicine (2013) defines recovery as "the process of sustained action that addresses the biological, psychological, social, and spiritual disturbance inherent in addiction" (p. 2). The incorporation of the spiritual into the typical biopsychosocial model (Engel, 1980) is not always made. This seems pertinent to addiction treatment specifically. The recovery experience has remained riddled with themes closely or directly tethered to spirituality, including moving from shame to compassion, isolation to connection, death to life, listlessness to meaning, etc. Perhaps the spiritual is more necessary or unavoidable in this space compared to psychiatric others.

A defining feature and foundation of addiction treatment is, of course, Alcoholics Anonymous (AA). From its origin, AA has emphasized spiritual awakening and the importance of relying on a higher power (Alcoholics Anonymous World Services, Inc., 2001). One qualitative analysis of AA members identified love as the most frequently cited trait of patients' Higher Power (Arnaud et al., 2015). Twelve-step programs have accrued empirical support for effectively treating those with substance use disorders, with noted short and long term benefits (Humphreys et al., 2014; Kelly, 2017; Tonigan et al., 2018). While spirituality is likely not an isolated mechanism of change for these desired outcomes, it is likely an integral aspect. Texts written by Bill Wilson, a co-founder of AA, highlights the spiritual

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fervor woven into the 12-step framework: "It was only a matter of being willing to believe in a power greater than myself. Nothing more was required of me to make my beginning" (Alcoholics Anonymous World Services, Inc., 2001, p. 12).

Systematic literature reviews of spirituality and substance use disorder (SUD) recovery have found significant links between the two, aiding individuals in achieving abstinence (Walton-Moss et al., 2013). Research has gone as far as to identify evidence for "spiritual struggles" as a possible risk for later development of addictive behaviors (Faigin et al., 2014; Stauner et al., 2019). It is important to note the more robust establishment of traumatic experiences a possible risk for addictive behaviors. It has been estimated that 30-50% of individuals seeking treatment for SUD have met criteria for post-traumatic stress disorder (PTSD) in their lifetime. In other words, individuals with PTSD are 4-5 times more likely to have a SUD compared to their peers without PTSD (Brady et al., 2020). The wounds of trauma can surely contribute to spiritual wounds. The latter, of course, is more elusive and not described within the Diagnostic and Statistical Manual of Mental Disorders (5th ed., text rev.; DSM-5-TR; American Psychiatric Association, 2022).

So, where do we begin? Engagement with spirituality/religion inevitably leads to a myriad of big questions; and often, the biggest questions. Measurement-based care is proposed to be an effective starting point for clinicians hoping to incorporate spirituality into their therapeutic care (Connery & Devido, 2020; Worley, 2020). This approach has gained momentum as an ideal clinical process that allows for routine incorporation of patient-reported data (collected via a standardized assessment tool) into treatment decisions. This process of gathering and analyzing information better allows clinicians to make an informed conceptualization as well as engage the patient in their care. Suggested instruments include the Spirituality Self-Rating Scale (Galanter et al., 2007), the Brief Multidimensional Measure of Religiousness/Spirituality (Stewart & Koeske, 2006), the Index of Core Spiritual Experience (INSPIRIT-R; Heinz et al., 2007), the Spiritual Transcendence Scale (Piedmont, 2004), and the Spiritual Well-Being Scale (Ellison, 1983). These measures can aid in information gathering, provide a starting point for discussions, and gauging patient willingness and openness to discussing certain topics. Assessment of a patient's spiritual/religious history and challenges, allows us to function as culturally considerate clinicians. It has also been recommended for the development of a therapeutic alliance to precede discussions about these topics (Post & Wade, 2009). It is additionally crucial to appreciate religious/spiritual diversity and be careful to not impose one's own beliefs onto patients (Johnson et al., 2007). While those struggling with addiction could be more willing to explore this portion of their identity, it should not be assumed that all are interested or willing to do so.

It is worth noting that the more abstract or vast the construct, the more error we are subject to in our reduction for the sake of measurement. The question of whether it is theoretically possible to conceptualize complex constructs with sufficient accuracy remains relevant today (McGrath, 2005). If there were to be a construct impossible to capture through measurement, spirituality might be at the top of the list. While we work as a field to improve the measurement of psychosocial phenomena, measurement of spiritual phenomena might be

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outside our wheelhouse at times. I would be remiss to not reference how Western, Educated, Industrialized, Rich, and Democratic (WEIRD) this point of view is to begin with; my point of view and maybe yours too (Henrich et al., 2010). This is especially pertinent when working with patients who may not identify with a WEIRD experience. I can't help but think about the degree of spiritual practice Western society has destroyed or delegitimized throughout history. Unfortunately, clinical judgment worsens as the religious beliefs of a patient become more unfamiliar (O'Connor & Vandenberg, 2005). At times, clinicians can even misinterpret certain religious beliefs as pathological. For example, O'Connor & Vandenberg (2005) found that American mental health professionals were more apt to rate Islamic beliefs as pathognomonic, contrasting significantly from interpretations of Christian beliefs. Acknowledging the flaws and biases in our field is critical in order to avoid perpetuating harm.

Regardless of its complexity, spiritual diversity is commonly viewed as a neglected dimension when considering multicultural competency. It is estimated that up to 89% of mental health professionals agree that clinicians should receive training in religious/spiritual competencies (Vieten et al., 2023). This same research estimated that 47% of mental health professionals had not received much training of this nature at all. Generally, there is a lack of research on providers' spiritual landscapes and interactions with their clinical work. Given the complexity and controversy of this cultural component, this is not surprising. Hollins (2008) proposed that clinicians should explore their own beliefs in order to best help patients. Yet, it is uncommon that therapists are encouraged to explore religious/spiritual beliefs and biases in graduate school (Hage et al., 2006). There is also evidence that the majority of individuals did not discuss their beliefs with their colleagues given worries about the potential for conflict (Pelechova et al., 2012). If not in graduate school and if not in our careers, where is the space to reflect on these features of identity and diversity? On both a micro and macro level, we should aim to increase our tolerance for discussion and difference.

Reviewing the literature and discussing this topic feels a bit as if I've entered the Wild West. I am aware of that sublime and perilous feeling referenced earlier. This space of religion/spirituality can become convoluted with biases, overstepping, and boundary crossing. Pelechova et al. (2012) beautifully shed light on the common conflict between science/academia and religion/spirituality. There is often an overt or covert dichotomous distinction between the two. The first being objective and evidence-based and the latter as anecdotal and illusive, thus leading to questions about the possibility of integration. Maybe the best thing we can do to improve our efficacy as professionals is to reflect on our own integration of spirituality and academia. Or, maybe the best thing we can do is gain insight into our resistance to do so.

I am sure most of us have felt in over our heads when confronting spirituality/religion in the therapy room. I am also sure most of us have felt in over our heads when confronting the complexities and challenges of addiction. Merging the two is quite the feat. Keep in mind, we are therapists and not clergy, let alone shamans. While we do not need to be spiritual leaders, we can exist as fellow travelers (Yalom, 2002). Through open personal reflection and interpersonal deliberation, we can improve our understanding as individuals and a whole.

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First-Generation Students in Higher Education: Resilience in the Face of Adversity

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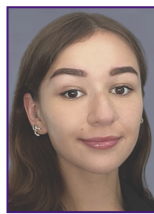

Navigating higher education presents challenges for most students. However, first-generation college students often face unique barriers that can make the path to higher education more difficult. As individuals who are a first-generation college student (Kaitlynn-Elizabeth H. Brooks; KHB) and a first-generation college graduate (Nicholas R. Morrison; NRM) invested in careers involving psychotherapy, we recognize the distinct challenges faced by first-generation students in making their dream of a career in psychotherapy become a reality. In this piece, we aim to identify some of these challenges and highlight the importance of support systems, access to resources, and early career preparation.

Navigating College as a First-Generation Student

Being the first in one's immediate family to pursue higher education can be intimidating. These students often balance multiple responsibilities, making it difficult to access the support they need. Imposter syndrome can cause feelings of inadequacy and a sense of not belonging in an academic setting. Additionally, there is the pressure of being the first to pursue higher education and overcome barriers (Reality Changers, 2024). As many as 56% of undergraduates identify as first-generation college students, yet they often face greater struggles than students whose parents attended college, commonly referred to as continuing education students. They are also less likely to use school services, be involved in extracurricular activities, complete internships, and conduct projects with faculty (Hamilton, 2023). Differences continue to be seen after graduation with first-generation students being less likely to pursue a master's or doctoral degree (Fry, 2021). In the field of psychology, this is an important consideration as many career paths require postbaccalaureate education. Understanding the barriers for students with these backgrounds can provide insight into the unique challenges they often navigate in higher education.

Barriers to Success for First-Generation College Students

For many first-generation college students, feelings of uncertainty initially present when completing and submitting applications. In fact, getting started can be the hardest part. Studies suggest that first-generation students are often less prepared than their continuing education peers upon entering college. For example, first-generation students tend to have lower grade point averages (GPA) and scores on entrance exams, such as the SAT and ACT (Katrevich & Aruguete, 2017). Atherton (2014) highlights that first-generation students often receive insufficient guidance from their parents, which negatively impacts their academic preparedness. The author reports that many students may not fully understand the importance of their GPA and standardized test scores. The combination of frustration and lack of

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success was shown to complicate the transition to college (Atherton, 2014). Across these studies mentioned, a consistent theme was the lack of confidence amongst first-generation students entering college, including feelings of inadequacy and a sense of not belonging. Relatedly, poor mental health is a growing concern among all college students. Lipson and colleagues (2023) found that for both first-generation and continuing education groups, 40% endorsed symptoms of depression and over 33% reported symptoms of anxiety. However, the authors note that first-generation students are less likely to utilize mental health treatment, compounding the effect of these symptoms. Additionally, untreated depression in college students is associated with a lower GPA and an increased risk of dropping out altogether (Eisenberg et al., 2009).

An additional consideration that often co-occurs with a first-generation college student status is foster status, which played an important role in my (KHB) personal and academic trajectory. Reflecting back, my years were shaped by resilience and determination, fueling my passion for psychology and affirming my commitment to a career in psychotherapy. However, for most students, the road to graduation is unfamiliar and often filled with challenges beyond perseverance alone. Both of these populations face lower rates of degree attainment compared to their peers with fewer than 5% of former foster youth earning a 4-year degree (National Foster Youth Institute, n.d.) and about 26% of first-generation students completing their bachelor's degree (Fry, 2021).

For foster youth, a significant amount of stress stems from financial insecurity with approximately 83% of foster youth facing financial hardship while enrolled in college. Moreover, most students from foster youth backgrounds work at least 35-hours per week (Mowreader, 2023). This increased workload intensifies stress, which can have a direct and significant effect on mental health. Notably, those who experienced foster care are 3-4 times more likely to have a mental health diagnosis compared to their peers. For many of these students, the primary source of stress stems from the financial burden of paying for their education (Lietz & Cheung, 2023).

The rising cost of education is a significant concern for those considering college. Tuition for public universities has increased 75% every decade from the 1970's through the 2000's (Hanson, 2024). One of the greatest barriers for first-generation students is the cost of an education and the options to pay for it. In my (KHB) case, I realized that the initial cost of university tuition coupled with day-to-day living expenses was unsustainable, even while working full-time. I ultimately had to transfer to a more affordable school due to these barriers. Fortunately, I live in a state that offers tuition waivers for former foster youth. It is important to acknowledge that only 28 states offer tuition waivers for public universities and colleges (Hernandez & Day, 2019). Other students may rely on financial aid, which is not always promising. For example, Pell Grants only cover approximately 29% of tuition, fees, and housing (Walsh, 2021). I had to work to put myself through college, at one point balancing two jobs, an internship, and studying as a fulltime student. While interning is an important experience to have for gaining hands-on training, many internships are unpaid, and students often hesitate to pursue these opportunities. Students often take out loans to alleviate this financial strain, allowing them to balance coursework with internship opportunities. However, many first-generation students are unaware of the programs that might ease fi-

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nancial strain in the long run, such as public service loan forgiveness. It is especially important for first-generation students interested in pursuing post-bachelor's studies to reflect on how best to balance these considerations, especially if they intend to pursue competitive masters- or doctoral-level programs in counseling and psychology.

Student Resources for First-Generation College Students

A common experience for first-generation students is a lack of guidance, which can perhaps be best addressed with mentorship. For example, both authors would have benefited from working with a graduate student through the American Psychological Association's (APA) Division 29 mentorship program, especially when considering graduate study options. Peer mentorship can be helpful for other groups of students as well, such as transfer students or former foster youth. Mentorship can also come from academic advisors and professors as building relationships with faculty can be greatly beneficial for first-generation students. Creating these connections can foster a sense of belonging and provide knowledge for students (Illum et al., 2023). In our experience, this has been one of the most crucial factors to our success. Academic advisors not only helped us create clear plans for graduation but also connected us with scholarships, practicum placements, and research opportunities. In our experience, the smaller class sizes further enhanced this support by allowing us to build relationships with professors who provided guidance when it was most needed. Establishing these relationships introduced us to new opportunities, such as collaborating with faculty on independent study projects and cultivating an interest in research by participating in a lab. Through this experience, we not only strengthened our research skills but also enhanced our overall academic and professional development. In the same way that faculty and programs should be mindful of facilitating these opportunities, especially for first-generation students, we also emphasize that students must take the initiative to ask for help. We highly encourage students to do so as having reliable support has made all the difference in our academic journeys.

Importance of Getting Involved

A piece of advice that is often repeated, but holds true, is to get involved. Our undergraduate experiences became significantly more rewarding once we immersed ourselves in activities outside of the classroom. First-generation students are less likely to be engaged in social experiences, such as interacting with other students (Stebleton & Soria, 2013). I (KHB) found that I was more focused on my academic and professional development commitments than on creating relationships with other students. In my third year, I started tutoring my peers and began to build connections around campus. I was also inducted into Psi Chi, which provided a network of peers with similar interests. Perhaps the most fulfilling experience was my participation in my university's practicum program. Gaining hands-on experience in the field allowed me to develop new clinical skills while applying the knowledge I have learned in my classes. While that period of my college years was the busiest, it was also the most rewarding. Even in my final year, I continue to discover new opportunities to remain involved, including my membership in APA's Division 29, which has expanded my professional network and experiences. Now, as I near the end of my undergraduate training, I am in a similar place as when I graduated high school—wondering what comes next. I am now

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navigating graduate programs and deciding which one is the best fit for me as I consider my future in psychology. This time around I feel more confident knowing that the experiences I have gained during my undergraduate years have prepared me for what lies ahead.

Beyond the Undergraduate Years

It is important to recognize the potentially compounding nature of the data and experiences outlined above. As first-generation students navigate the difficulties of pursuing a bachelor's degree, such as balancing finances with academics in a novel and unfamiliar environment, these students may be disadvantaged when it comes time to apply to graduate programs. This is especially important when considering the difficulty of acceptance and matriculation into a clinical psychology PhD program (Michalski et al., 2019). The sooner that students become aware of the resources available to them, the sooner they can set themselves up for success at the bachelor's level and beyond. We encourage more training programs to attend to the unique needs of this population, and foster outreach to first-generation students who may eventually go on to graduate study. Moreover, as a matter of representation, the field needs more first-generation college students to go on to careers as psychology educators, researchers, and practitioners. As first-generation students become more visible in these areas, they can inspire future first-generation students, participants, and clients to follow in their footsteps.

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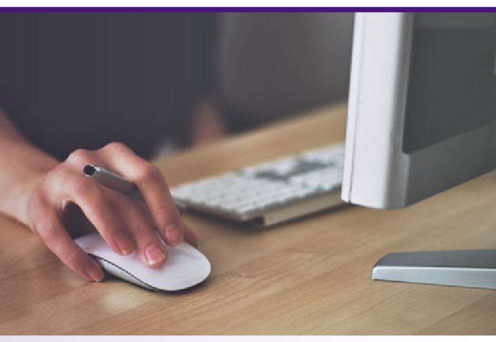

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Neurobiological Synchrony and Group Psychotherapy: A Potential Path Forward for Group Process and Outcomes Research

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Clinical Impact Statement

This article underscores the clinical significance of understanding neurobiological synchrony in psychotherapy, suggesting that such synchrony could serve as a biomarker for effective therapeutic processes. It highlights the potential for improving treatment outcomes by integrating insights from attachment theory and neurobiological research into both individual and group therapy settings, thereby enhancing therapeutic alliances and fostering stronger group cohesion.

Neurobiological Synchrony

Recent research on therapist-patient neurobiological synchrony in individual psychotherapy has suggested a potential connection between biological synchrony and therapeutic change mechanisms (Zilcha-Mano et al., 2021). This type of burgeoning research is an exciting step forward in psychotherapy process and outcomes research, given the extent to which other forms of nonverbal synchrony have been shown to be associated with treatment outcomes (Ramseyer & Tschacher, 2011; Reinecke et al., 2022). Neurobiological research in psychotherapy offers the potential to shed light on possible biomarkers underlying effective psychotherapy processes. It also provides an opportunity to paint a more specific portrait of the application of attachment theory to psychotherapy processes and outcomes.

Forms of nonverbal interpersonal synchrony has been studied within individual (Ramseyer & Tschacher, 2011; Reinecke et al., 2022) and couples psychotherapy contexts (Nyman-Salonen et al., 2021) and new research is emerging on patient-therapist neurobiological synchrony. Research focused on neurobiological interpersonal synchrony within group psychotherapy processes, however, is much more limited. This article provides a brief overview of the connection between attachment theory and interpersonal synchrony and the application of attachment theory to group psychotherapy. It also presents a short summary of recent neurobiological synchrony research in individual therapy contexts and explores the implications of nonverbal interpersonal synchrony research on factors underlying positive outcomes in group therapy. More specifically, this article suggests a need for further research on member-member and member-therapist neurobiological synchrony and potential associations with therapeutic factors underlying effective group psychotherapy.

Attachment Theory from a Neurobiological Perspective

Attachment theory, developed by John Bowlby in the 1980s, posits that attachment is a primary behavioral system that evolved to increase infant survival (Bowlby, 1988). At its core, attachment theory proposes that early attachment experiences with primary caregivers

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have a profound impact on psychosocial functioning. Despite being met with opposition at the time, Bowlby's work has been significantly expanded upon in subsequent decades. In a further exploration of attachment, Mary Ainsworth (1978) designed the Strange Situation study to examine attachment behavior in relation to exploration of surrounding environment, assessing the extent to which an infant views a parent as a secure base from which to explore the surrounding world (including a view of the parental figure as a source of comfort during distress). Her work ultimately differentiated between categories of attachment patterns, which are still utilized in attachment research and practice today (Ainsworth et al., 1978). Since Ainsworth's study, additional research has focused on the development of attachment patterns in infancy through the study of parent-infant interactions. Beebe and colleagues (2010) have examined mother-infant face-to-face-communication processes, including how mother and infant jointly regulate attention, affect, spatial orientation, and touch. An analysis of mother-infant joint regulation behavior at 4-months of age illuminated communication processes that predicted attachment patterns at 12-months, particularly within the resistant and disorganized categories (Beebe et al., 2010).

Attachment theory essentially posits that early attachment experiences impact the development of the nervous system and ultimately one's psychological functioning in both childhood and adulthood (Black, 2019). Advances in cognitive neuroscience have the potential to provide a window into the neurobiological aspects of attachment, particularly in terms of the mechanisms underlying interpersonal synchrony. One such finding, initially discovered in macaque monkeys in the 1980s, has involved the mirror neuron system. This system is comprised of a class of neurons that fire both when an individual performs a motor activity and when that individual observes another performing the same or similar type of activity (Iacoboni, 2008). The mirror neuron system is thought to be a biological mechanism underlying early development, particularly in terms of how an infant learns to relate to others. While research on the mirror neuron system has been ongoing, there have been "remarkably few studies that investigated the relation between neural mirror activity and interpersonal understanding" (Anders et al., 2020, p. 211). Thus, despite assumptions that the mirror neuron system likely plays an important role in interpersonal functioning, more research is needed to better understand the specific ways in which neuronal mirror activity might facilitate stronger levels of interpersonal understanding, as well as how the mirror neuron system plays a role in the development of attachment patterns in infancy. Such studies would likely have implications for how attachment theory is applied within clinical practice in psychotherapy settings.

Attachment theory is often utilized in the study of psychotherapy process and outcomes, with Bowlby himself initially proposing that the therapeutic relationship between patient and therapist can serve to replicate a primary attachment relationship, allowing a patient to utilize the therapist as a secure base from which to explore insecure attachment patterns that originated in early development (Bowlby, 1969). While attachment styles are often thought to be relatively stable across the lifespan, studies have shown that attachment patterns can shift as a result of both positive and negative life events (Bakermans-Kranenburg & van Ijzendoorn, 2009). This includes the result of engaging in psychotherapy, a

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finding that holds significant implications for clinical practice (Tasca, 2014). Multiple studies have assessed the relationship between attachment and psychotherapy outcomes, including a meta-analysis that found lower attachment anxiety and higher attachment security predicted stronger therapeutic outcomes (Levy et al., 2011). These findings contribute to a deeper understanding of the importance of the therapeutic alliance, a therapeutic factor generally shown to be more predictive of positive outcomes in psychotherapy than any other factor, including therapeutic modality (Bourke et al., 2021; Del Re et al., 2012; Howard et al., 2022; Kaiser et al., 2021; Murphy & Hutton, 2018).

The Application of Attachment Theory to Group Psychotherapy

The application of attachment theory to group psychotherapy research and practice has emerged over the last several decades (Marmarosh, 2017; Marmarosh et al., 2013). Among many others, Fonagy and colleagues' (2017) study of epistemic trust and mentalization, Whittingham's (2018) integration of interpersonal theory and attachment theory within the group therapy context, and Flores' (2010) work on neuroplasticity and group psychotherapy have all provided significant contributions to the application of attachment theory to the study of group psychotherapy process and outcomes. Importantly, the study of group psychotherapy processes and outcomes from an attachment lens has revealed associations between group member attachment style and treatment outcomes (Tasca et al., 2006), as well as insights into underlying therapeutic factors such as group cohesion.

Irvin Yalom initially identified group cohesion as a primary therapeutic factor in effective group therapy (Yalom & Leszcz, 2005) and subsequent studies have found that stronger group cohesion is associated with reduced attrition and higher levels of symptom improvement (Burlingame et al., 2011). Group cohesion can be understood from an attachment lens as "the client's experience of the group and/or therapist as a secure base from which to explore new internal models of self and other and to try new and more adaptive interpersonal behaviors" (Tasca, 2014, p. 54). While group cohesion has been demonstrated to be a key therapeutic factor underlying effective group psychotherapy, less research has been done to study group cohesion from a neurobiological standpoint, despite potential implications for clinical practice. Neuroscientific advances and, most importantly, the integration of such techniques into several clinical facilities have enabled researchers to study the application of attachment theory more effectively. This includes an increase in the utilization of neurological hyper-scanning as well as the ability to measure therapist-patient hormonal levels pre- and post-treatment. For example, in what appeared to be the first study to utilize fNIRS-hyperscanning to study inter-brain synchrony between counselors and patients, Zhang and colleagues found stronger working alliances and increased inter-brain synchrony in the temporo-parietal junction (rTPJ) between therapists and patients during psychological counseling, as compared to chatting (Zhang et al., 2018). The increased utilization of such techniques could pave a pathway for future research on mechanisms underlying group process and outcomes, with potentially significant clinical implications.

Neurobiological Interpersonal Synchrony in Psychotherapy

Studying interpersonal synchrony from an attachment-oriented, neurobiological

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perspective has the potential to provide us with a more nuanced understanding of the nature of the therapeutic alliance. To date, nonverbal patient-therapist interpersonal synchrony has primarily been studied from a motor and physiological perspective within individual therapy contexts (Atzil-Slonim et al., 2023; Gernert et al., 2023; Reinecke et al., 2022). However, researchers have begun to study patient-therapist interpersonal synchrony from a neurobiological lens within the last several years. In what appeared to be the first study to examine hormonal synchrony between therapist and patient, Zilcha-Mano et al. (2021) examined oxytocin (OT) synchrony between therapists and patients in psychotherapy treatment for depression, finding that "OT synchrony between therapist and patient may be a biological mechanism by which impaired interpersonal functioning undermines treatment outcome" (p. 49). Additional studies are needed to replicate the findings, particularly with larger sample sizes, but these results highlight the potential role of oxytocin as a biomarker for effective therapeutic processes. In another study looking at the psychotherapeutic relationship from a neurobiological standpoint, Levi and colleagues (2024) analyzed salivary cortisol levels in therapist-patient dyads, finding that patient cortisol levels pre-session predicted therapist cortisol levels post-session and that the strength of the therapeutic relationship moderates in-session cortisol changes. These findings highlight the complexity of the psychotherapy relationship and the extent to which the interactions between therapist and patient play out on a biological level.

Other recent neuroscientific research has shown that interpersonal brain synchronization (IBS) increased during psychotherapeutic engagement and that IBS is associated with the strength of the therapeutic alliance (Zhang et al., 2018). Koole and Tschacher's Inter-Personal Synchrony (In-Sync) model sits in alignment with these findings; the theoretical model posits that patient-therapist synchrony strengthens the therapeutic alliance, and consequently, treatment outcomes (Koole & Tschacher, 2016). These types of early studies on interpersonal brain synchronization in psychotherapy present many potential clinical implications, including questions about the impact of fostering such synchrony not just on the therapeutic alliance but also within other interpersonal relationships. In a review of interbrain synchrony, Sened et al. (2022) "proposes that patient-therapist synchrony might directly increase patients' ability to establish inter-brain synchrony in the future when interacting with their therapist, and ultimately, with other people" (pp. 1-2).

Neurobiological augmentation in psychotherapy continues to be an area of study with varying findings. One type of neurobiological augmentation that has received greater attention is oxytocin administration, with varying finding (Bartz et al., 2010; Bernaertz et al., 2017; Olff et al., 2010; Rockliff et al., 2011; Tzur Bitan et al., 2023). The mixed nature of the findings indicates the need for additional research on the impact of such neurobiological augmentation across patient populations. Tzur Bitan and colleagues' (2023) recent research on the moderating role of personality on the effect of oxytocin administration in psychotherapy treatment demonstrates the complexity of such neurobiological research and treatment. Their findings indicate that oxytocin administration was associated with improvement in depression symptoms and suicidal ideation for patients low in openness and agreeableness, respectively. Additionally, oxytocin administration was associated with lower therapeutic alliance

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ratings for patients high in extraversion, low in neuroticism, and low in agreeableness (Tzur Bitan et al., 2023). These findings caused Tzur Bitan and colleagues (2023, p. 1) to note the potential "double-edged sword" that oxytocin may play in facilitating treatment outcomes, pointing to the need for additional research on how to best identify patient populations who may benefit from this type of neurobiological augmentation (p. 1).

Further studies on patient-therapist neurobiological synchrony and neurological augmentation are needed, particularly in terms of the association between patient-therapist neurobiological synchrony and attachment styles. Other studies have explored the relationship between oxytocin synchrony and attuned attachment interactions, including between caregiver and child (Feldman et al., 2013; Vittner et al., 2018) and between romantic partners (Algoe et al., 2017). Do associations exist between therapist/patient attachment style and patient-therapist neurobiological synchrony? Do associations exist between change in attachment styles across treatment (either within the therapist or patient) and neurobiological synchrony? Further study on the associations between attachment and neurobiological augmentation in psychotherapy are needed as well; while Tzur Bitan and colleagues did not find that attachment moderated the effect of oxytocin administration on treatment outcomes, other studies have found some type of moderation (Bernaertz et al., 2017). Additional studies in both patient-therapist neurobiological synchrony and neurobiological augmentation in psychotherapy ultimately have the potential to paint a more detailed picture of the mechanisms underlying therapeutic change, and the same is true for the study of group psychotherapy mechanisms.

Opportunities for Studying Neurobiological Synchrony in Group Psychotherapy

The emerging therapist-patient neurobiological synchrony research provides a path forward for a more precise examination of biological factors underlying group member-member and member-therapist synchrony and potential associations with group cohesion and overall treatment outcomes. In particular, the multi-party structure of a group therapy context provides a rich environment through which to study interpersonal synchrony, especially in light of group member and therapist attachment styles. Researchers could ask important questions such as: Do associations exist between member-member or member-therapist neurobiological synchrony and treatment outcomes? Is group cohesion associated with neurobiological synchrony, either between members or between the therapist and members? To what extent is attachment style associated with interpersonal synchrony in group contexts, either in motor movements, physiologically, or neurobiologically?

To date, research on nonverbal interpersonal synchrony in group psychotherapy contexts has primarily focused on motor synchrony (Kirschner & Tomasello, 2009; McNeill, 1995; Miles et al., 2010; Tarr et al., 2016; Vacharkulksemsuk & Fredrickson, 2012). A recent meta-analysis assessed the impact of synchrony on prosocial behavior, perceived social bonding, social cognition, and positive affect, finding that interpersonal motor synchrony is associated with all four dimensions (Mogan et al., 2017). Other forms of synchrony have also been examined in group contexts. Prior work on perceived emotional synchrony in collective action demonstrated associations between perceived emotional synchrony and levels of social support, endorsement of social values, and emotional re-

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actions (Páez et al., 2015). Neuroscientific advances have allowed for the assessment of physiological synchrony in group as well. In a recent study on physiological and motor synchrony, Gordon et al. (2020) found both physiological and motor synchrony to be associated with individual experiences of group cohesion.

Despite more extensive research on motor synchrony (and to some degree, physiological synchrony), neurobiological synchrony in group contexts has been less studied. There is an ongoing opportunity for researchers to apply early learnings from studies assessing neurobiological synchrony in patient-therapist dyads to the study of groups. While empirical research has been more limited in this area, commentary on interpersonal neurobiology in group contexts has highlighted the potential for neuroscience to serve an important role in understanding group psychotherapy mechanisms. This includes the importance of investigating its potential clinical applications, such as providing an opportunity for greater psychoeducation for group members on brain processes underlying treatment efficacy, as well as the potential for more targeted therapeutic interventions (Badenoch & Gantt, 2013). In a recent editorial on interpersonal synchrony and network dynamics in social interactions, Müller, et al. (2022) highlighted the range of research that is currently being undertaken to better understand interpersonal synchrony in group. Such research includes the several hyper-scanning studies utilizing a range of methods such as electroencephalography, magnetoencephalography, functional magnetic resonance imaging, and functional near-infrared spectroscopy. Despite known limitations in cost, resource availability, sample size, and approval processes, assessing neurobiological synchrony within group psychotherapy contexts has the potential to shift how we conceive of the mechanisms underlying effective group therapy, with the potential to identify biomarkers underlying therapeutic change processes. Such work, while challenging, may hold significant implications for clinical practice. For example, a study utilizing hyper-scanning to examine interpersonal synchrony during various types of communication found that interpersonal creative tasks resulted in more "efficient interbrain states" (Wang et al., 2022, p. 1). Additional research in this area could help us determine whether certain types of therapies that are more creative in nature, such as psychodrama, table-top roleplaying therapy, music therapy, and art therapy, could support stronger interpersonal connections at a neurobiological level. From a clinical application standpoint, such research could support clinicians to better understand the types of therapies (and potentially interventions) that may facilitate various levels of interbrain synchrony.

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Introducing a 12-Step Approach to Change: Three Broad Strategies for Graduate Education and Training

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Foundational Evidence for 12-Step Approaches to Change

Across a range of disorders, self-help approaches to change are effective (Norcross et al., 2013). In many instances, their effectiveness approximates that of professionally delivered psychological services and commonly produces effects superior to no treatment at all (Barlow et al., 2000; Seligman, 1995). When the problem is substance use disorders and the change method involves 12-step approaches to addressing it, the research evidence mounts. This research establishes that this approach to change leads to specific and important outcomes, such as ceasing drug and alcohol use (Emrick & Tonigan, 2004; Fiorentine & Hillhouse, 2000; Humphreys et al., 2004; Moos & Moos, 2004; 2007; Tonigan et al., 1996).

Much of what undergirds contemporary substance use disorder treatment systems has historically shared and borrowed from12-step approaches. For example, it only took three years for elements of the Alcoholics Anonymous (AA; Alcoholics Anonymous, 1976) program emerging from Akron, Ohio in 1935 to appear in the menu of programs being offered at the Public Health Service's Federal Narcotics Farm in Lexington, Kentucky. It was also recommended as a method of aftercare for individuals struggling with narcotic use upon release from the farm (Magura, 2007; Vogel, 1948; White, 1998). Such reciprocal relationships continue today and scholars note that contemporary outpatient, residential, and medical substance abuse treatment programs share and borrow aspects of 12-step approaches (DeLeon, 2004; DiClemente, 2007; McKay, 2009).

More recently, studies with increasingly complex and stringent analyses have compelled the field beyond debates about sample bias, demonstrating that the influence of 12-step approaches in achieving successful outcomes lies beyond self-selection (Humphreys et al., 2014; Humphreys & Moos, 2001). Some scholars have been busy unpacking the social, cognitive, and affective mechanisms of change that facilitate this approaches' success (Kelly, 2016), while other scholars have conducted research demonstrating that even at follow-up, those involved in 12-step approaches to change have outcomes equal to those of professionally delivered services (Morgenstern et al., 1996; Ouimette et al., 1997; Wells et al.,1994).

Research also suggests that people participating in 12-step approaches experience benefits beyond remission of a substance use disorder, including increased psychological health through the promotion of effective social support and coping (Fiorentine & Hillhouse, 2000; Kelly, 2016; Tonigan et al., 1996). Finally, research also demonstrates that clinicians can influence the process of their client's entry into 12-step approaches (Nowinski, et al., 1999). At the

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very least, clinicians should be making inquiry into client's beliefs about their prior 12-step approach involvement. This line of inquiry represents an important clinical consideration for treatment planning and change (Timko et al., 2006; Tonigan et al., 1999).

Definition of Terms in 12-Step Approaches to Change

Understanding that the science supports people's participation in this approach, while foundational, is only useful if students and their educators have a working definition of what is meant by 12-step approaches to change. Here we borrow from the seminal work of Miller and Thoresen (1999) who delineated an approach to spirituality. Their definition fits squarely within the wheel house of 12-step approaches as an interrelated set of practices, beliefs, and experiences. This definition is intentionally broad in order to consider addiction as a disorder of lifestyle and change as an unfolding process with many elements. It is also specific enough to allow students to delineate each element into measurable and describable parts, thus serving as a useful educational tool.

A deeper analysis of the practices, beliefs, and experiences elements are provided in Magaletta and Leukefeld (2011). Briefly, practices are behavioral aspects of a person's participation in 12-step approaches to change. Common practices might include attending meetings, speaking at meetings, reading 12-step literature, conducting the action and/or reflection suggested in a step, praying, meditating, helping a new 12-step member, etc. Beliefs point toward cognitions and cognitive change concerning substance use, recovery, and various aspects of lifestyle. A stellar review of beliefs and other cognitive changes and cognitive techniques used in 12-step approaches can be found in Bristow-Braitman (1995), McCrady (1994), and Steigerwald and Stone (1997). Experiences are the center of gravity in 12-step approaches to change, yet remain the most difficult to illustrate. They refer to the reflections of a person who finds themselves being able to do something that they had previously been unable to do. In the case of people with substance use disorders, this may initially mean to cease using, however, this is only the beginning. DeLeon (1997) describes this process:

> The process of change is primarily understood by the participants themselves in subjective terms, through perceptions and experiences. Individuals not only must actively engage in the behaviors and attitudes to be changed but must feel the feelings associated with this engagement, understand the meaning or value of the change, and come to see themselves, others, and the world differently. (p. 11)

Three Broad Strategies to Impart Knowledge of 12-Step Approaches to Change for Graduate Education and Training

As demonstrated above, evidence supports the effectiveness of 12-step approaches to change, and can be defined as an interacting set of practices, beliefs and experiences. How can this all be transmitted to graduate students? Within a broad generalist training curriculum there are three equally broad strategies that can be used to impart knowledge of 12-step approaches into education and training. These strategies can be woven into various courses or aspects of training that students receive and can be considered didactic material, can be woven into ongoing supervision, or can be integrated into a student's work during a practicum or internship

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training experience. Considered together, these strategies can provide both educators and students an opportunity to learn about 12-step approaches to change through demonstration, participation, and facilitation.

Strategy 1: Demonstrate through readings and/or assignments the elements of the 12-step approach as they appear in 12-step literature. This first strategy challenges students to think from an implementation standpoint and demonstrates that 12-step literature provides individuals who want to change a description of the practices, beliefs, and experiences that lead to change. Similar to training clinicians toward fidelity within a particular model, people who participate in 12-step approaches to change often use 12-step literature (e.g., Alcoholics Anonymous, 1953; 1976) to guide their process and adhere to the approach. Not only can the stories of recovering individuals from this literature be scoured by students to answer questions about detecting substance use disorders, but they can also be used to highlight the peculiar mental twists that emerge when someone tries to change but remains unsuccessful. The 12-step literature can also be used to elucidate various theories of change that underlie various counseling practices. Using the practices, beliefs, and experiences definitional framework allows students to begin their readings with purpose. In unpacking the term 12-step approaches and in using the literature, illustrations of the complexities of both substance use and recovery phenomena emerges. And, if questions about a client's substance use arise later in treatment, students may recall that such reading resources are available to them and their client. While there are many examples of effective 12-step literature, below are two different ways that educators can use 12-step literature to demonstrate 12-step practices, beliefs, and experiences.

- The first chapter of the book, Alcoholics Anonymous (1976) provides robust diagnostic material from the life of Bill Wilson, an AA co-founder. It is replete with examples of the mental and physical features of alcoholism, features which map well onto the diagnostic criteria described in medical classification systems. For this reason, the reading is a perfect supplement for various active learning exercises in the application of knowledge for a general psychopathology or a diagnosis and assessment course. Individually, or as a group, students can pull out the diagnostic criteria and apply them to aspects of Bill's decent into alcoholism. Specifically, after a lesson on these addictions criteria, an instructor may have a copy of the chapter and ask students to read the story out loud in class while others list or discuss the diagnostic criteria they hear being read. his strategy makes available to students the experiences, beliefs and practices of others who have or are participating in the 12-step approach. This particular story also provides a historical review for the emergence of the approach in the form of a story.
- Similarly, a theory of change or counseling techniques class might benefit from assignments with the chapter called "How It Works" (Alcoholics Anonymous, 1976). This particular chapter, as well as the remainder of the Bill Wilson Story mentioned above, can supplement a lesson on the 12-steps themselves as both chapters provide the reader an overview of how individuals approach the beliefs, practices and experiences of the 12-step approach. For example, in a psychotherapy class a person's recovery story, amply available in 12-step literatures, can be read to illustrate cognitive

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changes that people experience both on the decent into substance use disorder and also the ascent to recovery. Such explanations are especially powerful when considered from the perspective of how the 12-step approach might relate to techniques proposed within various counseling theories.

Strategy 2. Participate in 12-step approaches by creating or supporting experiential opportunities for students via active learning assignments. This strategy allows students to co-create their own experience learning directly from others who are changing or trying to change using 12-step approaches.

- For example, students can be offered an opportunity to learn by assigning attendance at an open 12-step meeting. This is the easiest and quickest method for students to begin understanding the experiences element defined above, via reflection upon their own experiences. Here special consideration should be paid to the assignment sequence, with the following being recommended: 1. Complete readings that outline evidence for the approach and a definition of terms. 2. Learn how to find a meeting to attend and attend it. 3. Come to class ready to discuss meeting attended. 4. Attend a second meeting. 5. Write up a brief summary / reflection paper. This type of assignment can serve as an addendum within a psychotherapy, strategies and techniques, or family therapy courses. It is most important to prepare students so that they know what to expect and to look for, prior to attendance, via readings. Ask the students to listen for beliefs, practices and experiences among those in attendance. Other instructional tips that may prove important include teaching students to select an open meeting, one that is available not just to those with addictions. They will also need to understand that there are different types of meetings—including speakers meeting which feature a person in recovery telling their story; literature meetings where participants read from 12-step literature and discuss it; and discussion meetings where a topic is selected and commented upon. In some meetings everyone may be given a chance to talk (volunteer), but no one is forced. Students attending a meeting may or may not have a chance to introduce themselves. If they do, an appropriate introduction might be "Hi. My name is _______, and I am here to learn more about 12-step approaches to change. I pass." This would mean that the student is finished and someone else in the meeting can now speak. Students should not to bring a tape recorder or paper for note taking during the meeting. They may find that listening actively, but silently, takes a lot of concentration and will require their utmost attention. Although there are no rules, it is uncommon for students to ask questions during a meeting. It would be best to ask a question, if they are compelled, after the meeting. If students are already a member of a 12-step meeting they should be encouraged to attend a differently focused 12-step meeting with which they are less familiar. It is essential that students not ever reveal anyone's identity. Further, they should understand that they are there for their own learning experience of how others approach the 12-steps.
- An important element for learning to occur in experiential methods, is reflection. For this reason, after the first meeting is attended, a large class discussion should be generated with the question, "what about attending that meeting was most important to your learning" (Stanier, 2016). This allows for the nec-

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essary reflection upon the experience that allows students to begin applying or unpacking this experience—and to carry this learning forward as "experiences" when they attend a second meeting. After this second attendance, they have an experiential frame of reference and can begin translating this into their reflection paper.

- In order to extend and structure learning the following elements of the paper are suggested: Develop and pick a title for the paper, one that reflects the essential lesson learned. Begin the paper with a brief, general summary of the meetings attended. Students should review impressions of the meetings and whether or not they would refer a client to that meeting. They should consider the type(s) of people they think might do well in this particular group and describe how they, as a newcomer to this group felt. How do they think a new comer to this meeting might feel? If the majority of their learning occurred in one meeting (i.e., they attended the same meeting two different times), then they might focus upon that. In their reflection, students should integrate concepts already learned in class perhaps counseling theories or stages of change models or skills such as active listening, the 12-step approach beliefs, practices and experiences framework, or diagnosis and assessment of substance abuse and dependence.

Strategy 3. Facilitate professional outreach—learning to link professional communities with people practicing 12-step approaches. Properly armed with an understanding of the practices, beliefs and experiences inherit in the approach, students can begin to patrol the border between professional service delivery systems and the people and organizational elements of the 12-step approach system.

- For example, you can courage students to explore and understand how the 12-step approach can be understood organizationally, having them explore and propose how they would facilitate links or bring a 12-step meeting into their clinic, practica or internship site. This teaches basic skills such as learning about where meetings occur, and also teaches students to consider aspects of their current practice organization - what will and will not be done to support volunteer programs? If on practica or internship, does the setting already host meetings? If not, why not? Are there other policies beyond the volunteer policy that must be understood before initiating such links? Does the setting have restrictions on volunteers or types of volunteers that can be tapped to host events within the setting? This is practicing the administration and management of service delivery lines and promotes students exposure to and familiarity with the "organization" of 12-step groups and an experiences. It aids in understanding the nuances of working with such groups in closed settings where students may someday be employed.
- A similar facilitation practice would be to encourage a presentation by 12-step members for a class or part of a panel of presentations for a recovery month or other educational series in a given practice setting. Such community wide educational events can be used to educate other students and/or employees (if in a practica or internship setting) on how 12-step approaches can be used to support employees, colleagues, and others. Recognizing that many individuals and families face a multitude of difficulties when substance use disorders strike, and that these difficulties quite often spill over

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into the workplace and wider community, this type of presentation can reach a broad audience.

Conclusion

The perspective of service delivery through a workforce must be linked to and inclusive of the reality that many people can change on their own. The approaches these individuals use to recover are an important optimizer for the promotion of psychological health. Ultimately, service delivery and guided self-change approaches, both together and separately, are required to impact the substance use crisis and to support individuals along their path toward recovery. Now is the time for graduate training and education to become a part of that story. Each strategy presented here provides opportunities for exposure to the practices, beliefs, and experiences that form the 12-step approach to change. When educators and students are exposed to this influential framework, they are in the best position to increase access, reduce barriers, and encourage optimal use of this psychological health resource among those they will serve.

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Eating Disorder Symptom Presentation Across Different Athletes

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While eating disorders are prevalent across all communities, eating disorders in athletes have a higher occurrence rate than the general population. Approximately 19% of athletes endorse eating disorder pathology, while about 9% of the general population report similar symptoms (Ghazzawi, et al., 2024; Pike, 2024). Some research indicates these numbers are even higher, with 19% of male athletes and 45% of female athletes struggling with disordered eating (The Emily Program, 2023). Considering symptomatology globally, Eastern countries have higher rates of eating disorder symptoms when compared to Western countries. Additionally, indoor sports were more likely to engage in eating disorder behaviors like restriction, binge eating, and purging, while outdoor sports were less likely to engage in those behaviors (Ghazzawi, et al., 2024).

It has been observed for sports that require a designated weight class or aesthetic, like gymnastics or wrestling, are at a higher risk for eating disorders. Sports can be broken down into a two-prong system of "lean" and "non lean" athletes. Figure 1, as cited in Mancine and colleagues (2020), expertly describes how sports are categorized in this dichotomy.

Around 42% of athletes in athletics sports, 24% in endurance sports, 17% in technical sports, and 15% in ball game sports endorsed disordered eating pathology.

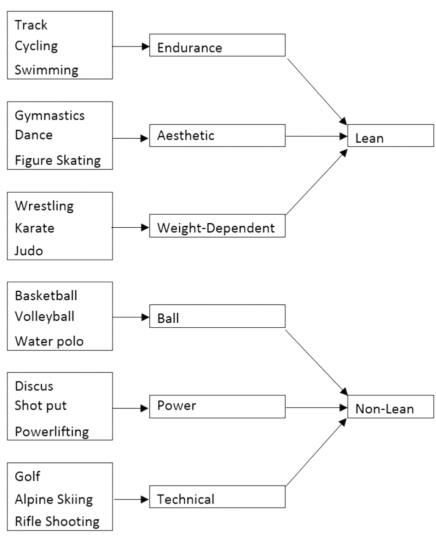

Figure 1

These athletes are also eight times more likely to be injured (The Emily Program, 2023). The term Relative Energy Deficiency in Sport (RED-S) has been coined to demonstrate the negative physical consequences that occur to the body specifically for athletes given the frequency of this occurring in these communities. Sadly, and unsurprisingly, disordered eating behaviors also increase the likelihood of injury and poor performance outcomes (Melin et al., 2014). Due to the diverse catalysts and reasons for maintenance of pathology, symptoms presentation of disordered eating across different sports may vary. Additionally, underreporting occurs frequently in male athletes when assessed on disordered eating concerns, which may impact clinical presentations and prevalence rates (Karrer et al., 2020).

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Distinguishing between eating disorders and disordered eating can be difficult for clinicians. An eating disorder is characterized by satisfying the criteria set forth by the Diagnostic and Statistical Manual of Mental Disorders, severity and persistence, and psychological distress or functional impairment (Dennis, n.d.) The two are interchangeable for the purpose of this review.

Eating Disorders in Aesthetic Sports

Dancers. Dance requires high levels of perfectionism (Penniment & Egan, 2012) given the level of dedication required to obtain mastery over the technique. Dance schools also have a history of creating and perpetuating toxic environments, where social comparison is a driving force for negative self-evaluation (Rasheed & Runswick, 2024). Strict teaching methods, favoritism, and intense competition influence dancers to "do what it takes" to achieve the ideal body type: thin, lean, and slender. Unsurprisingly, dancers in particular have a higher risk of disordered eating patterns being three times more likely than the general population to experience an eating disorder. While other specified feeding or eating disorders occurred in 14.9% of one study sample, anorexia and bulimia nervosa occurred in around 4% of this specific athletic community (Arcelus et al., 2014). Around 83% of dancers endorse a history of eating disorder pathology throughout their lifetime (Ringham et al, 2006). Some studies have indicated that even when not satisfying the full criteria for an eating disorder diagnosis, dancers experience the same severity of body dissatisfaction and drive for thinness at comparable rates to folks who have a clinically significant eating disorder (Stice, 2002).

Equestrian. It has been documented that participation in appearance-based sports can increase the likelihood of disordered eating due to the pressure to be thin. Consequently, athletes may begin to engage in harmful eating behaviors like restriction (Torres-McGehee et al., 2011). Equestrian athletes may not be the first group that comes to mind for clinicians when it comes to being considered an aesthetic sport, however, in both English and Western riders, the prevalence rates of eating disorders were just as high as other appearance-based sports. Additionally, they were more likely to label their body as significantly larger than their actual size, driving a desire for a smaller body in both their normal clothing and competitive uniforms (Torres-McGehee et al., 2011). It has been documented that the rider's body type must be slender to enhance performance and complement their horse, and that riders may even be scored based on their physical appearance (Galen Hope, 2024). As such, it has been studied that body dissatisfaction and social comparison related to physique were elevated in this community (Monsma et al., 2013).

Figure Skating. When assessed using measures for disordered eating, around 13% of female figure skaters reported scores indicative of disordered eating. Additionally, prevalence did not change when accounting for elite or sub-elite female skaters (Voelker et al., 2014). However, one study detailed that on assessment for disordered eating behaviors, 36% of figure skaters were currently dieting and 11% of those dieting endorsed binge eating behavior (Wilmore, 1991). When considering gender, around 40% of male figure skaters reported feeling terrified to gain weight, while twice as many female figure skaters reported that same fear (Jonnalagadda et al., 2004). The drive for thinness is not simply an internalized pressure; outside pressure from society-at-large, coaches, and other community

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members is ever-present and impactful. Wilmore (1991) found that 55% of female athletes have felt pressure to lose weight or maintain a certain weight. For all figure skaters, females compose of 68% of the sport (US Figure Skating, 2023). Some folks in the skating community use safety for a skater's physical health as a precaution to stay thin, noting that when a skater lands a jump, they absorb around eight times their body weight (Liszewski. 2014). One female figure skating athlete described her experience of people openly sharing with her that she would "jump higher" during phases of her life where she was perceived as thinner and was "sluggish" during times she was seen as heavier (Chinault, 2019). The impact and harm of the idealized body type in this sport is pervasive, both internally and externally.

Gymnastics. Gymnastics requires long training hours, compliance with and submission to coaches, and perfectionism: a terrifying trio. This becomes a worrisome dynamic when it comes to food and body. Success in gymnastics judges athletes based on their body shape, the line the side of their body makes, and emphasizes how certain body parts, like the stomach and glutes, should remain "tucked in." With this in mind, it is no surprise one study showed that over 75% of gymnasts exhibit weight dissatisfaction, stating they believe they are bigger than what would be ideal for their body (Francisco et al., 2012). There is also a strong correlation between the competitive level within the sport and eating disorder behaviors, as higher-level elite athletes exhibit higher scores on eating disorder assessment tools than their non-competitive peers (Kontele et al., 2022). It is imperative to address the culture of this sport, including the common language used to motivate athletes toward success, like "thin to win" and "be lighter, flyer higher," while simultaneously contributing to the onset of eating disorders. Gymnasts can practice upwards of 36-hours a week starting from a young age, meaning they are consistently hearing these comments, internalizing these pressures, and using this language during their formative years. The normalized nature of disordered eating as a whole within this sport saw one study label the required criteria for eating disorders as "problematic" due to its inability to adequately transfer into such a high demand setting and standard (Tan et al., 2016). This is further confirmed by another study's findings that high level sports of this nature tend to normalize maladaptive eating behaviors and rigidity around body shape and size, while the medical setting pathologizes these symptoms (Bloodworth et al., 2015).

Eating Disorders in Endurance Sports

Swimming. There is immense pressure placed on swimmers to achieve a lower body weight due to the common misconception that it improves swim times (Melin et al., 2014). Some studies have suggested the high prevalence of disordered eating in swimming is due to the type of swimsuits required in competition (Benson et al., 1990; Melin, 2014). There is also evidence that sports with more revealing attire tend to facilitate more frequent body checking and social comparison amongst its athletes (Reel & Gill, 2001; Steinfeldt et al., 2013). Artistic swimming combines dance, swim, and gymnastics, perpetuating eating disorder behaviors of both endurance and aesthetic sport. The precise synchronization and homogeneity of bodies contributes to the overall performance result (Parlov et al., 2020), thus increasing the desire for thinness in order to not stand out. However, in one study, swimmers reported higher rates of body satisfaction outside of their sport likely due

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to the tendency to having a body that's more aligned with the thin ideal. Yet, this satisfaction plummeted when assessed while the athletes were swimming, likely due to the strict demands of their sport (Assyifa & Riyadi, 2023).

Track. Track is a sport that comes down to fractions of a second to win. This creates not only a physical challenge to be the best, but a mental challenge in order to remain focused on technique and timing that must be incredibly precise. Unlike some other sports, as mentioned above regarding gymnastics, some studies have not shown a strong correlation between division/level of sport and eating disorder pathology (Quinn & Robinson, 2020). The Latvian Academy of Sport Education found the primary apprehension within this population was body shape (Gabarajeva & Vazne, 2017). Track is unfortunately a sport that has a societal stereotype relating to body size and shape, creating a unique pressure within the sport to "look" like a track athlete (Quinn & Robinson, 2020). Another study solidified this stereotype by finding there is often an emphasis on being lean over focusing on the actual physical demands of training (Hulley & Hill, 2001). There does seem to be a dissimilarity between male and female track athletes, with female competitors reporting correlations between their eating patterns, performance, weight, and emotions more consistently than their male counterparts (Krebs et al., 2019).

Eating Disorders in Weight-Dependent Sports

Wrestling. Cutting weight is a commonly accepted practice in the wrestling community. Cutting weight is the term used to describe athletes that will engage in extreme behaviors to be able to compete in a weight category that varies from their typical weight. Once the season is over, the lost weight is usually gained back rapidly (Shriver et al., 2009). According to Perriello (2001), the motivation to cut weight varies, with some wrestlers being in a lower weight class to avoid competing with a better wrestler at their natural weight, or to help their team by filling a weight class spot. Along with calorie restriction, there are additional behaviors associated with cutting weight in wrestlers than what is typically seen in other aesthetic sports. Running/jogging (73%), exercise using a device, like biking or jumping rope (59%), wearing a rubber suit/nylon top (34%) and using a sauna (14%) were the most common behaviors wrestlers engaged in to cut weight. Vomiting and diuretics only occurred in 8% and 2% of wrestlers, respectively (Perriello, 2001; Rea, 2013). Assessment around gradual and acute weight cutting is an important and distinct clinical consideration for this community (Rea, 2013).

Eating Disorders in Sports Using a Ball

Volleyball. Though society would not quickly associate volleyball and eating disorders, this sport is not immune to this pathology. One study found that 50% of participants were in line for being at-risk of disordered eating, with these athletes reporting one or more episodes of bingeing per month, as well as restricting their caloric intake (Vargas et al., 2013). This is a sport where clothing is short and tight, allowing for increased body comparisons as well as pressure to fit in the uniform. One study found that 60% of athletes reported feeling there is aesthetic judgement within the sport of volleyball (Fochesato et al., 2021). This is exacerbated by media pressures, as illustrated in a World Nutrition study showing a strong negative correlation between media exposure/comparison and body image satisfaction (Türkmaya Şanal et al., 2022). Volleyball is another example of a sport where division or level of competition influenced risk of eating disorder development (Beals, 2002).

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Though considered non-aesthetic, assessment for pressures relating to aesthetic appearance cannot be ignored in this population of athletes.

Eating Disorders in Power Sports

Body Building. This sport has a strong and specific emphasis on visual physique, creating a culture that normalizes eating disorder symptoms and presentations. This sport showed an increase in the presence of bulimia behaviors and overall dissatisfaction with appearance in men, even when compared to other male athletes (Goldfield et al., 2006). There is an extreme lack of research and resources relating to the impact and prevalence of eating disorders specifically in the female body building community, though special attention has been given to the responsibility and accountability of training professionals and coaches in this industry (Money-Taylor et al., 2021). Body building also emphasizes the utility and function of food rather than enjoyment or satisfaction, with 74% of participants in one study reporting they eat based off their recommended schedule requirements and not off their level of hunger or desire for food (Mangweth et al., 2001). Though physique is a priority, there is special attention given to fat percentage in the body, resulting in significant levels of discrepancy reported between actual versus perceived ideal fat percentage in male body builders (Devrim et al., 2018). More attention needs to be given to eating disorder symptom presentation for women within this sport, as shown by glaring differences in available research.

Eating Disorders in Technical Sports

Golf. This sport of technicality, precision, and repetition sees a prevalence rate of eating disorders between 11-17% (Miracle, 2013; Torres-McGehee et al., 2011). There is extremely limited accessibility to resources relating to eating disorder prevalence and prognosis associated with these athletes. Golf is a "non-lean" sport, meaning body weight and shape is not associated with success, achievement, or progress (Mancine et al., 2020). Golfers are under an immense amount of pressure to be perfect, with mastery of their craft being assessed 18 times within a single game, making the frequency of overall sport performance evaluation incredibly high (Fleming & Dorsch, 2024). Not only do they have the similar experience to other athletes of comparing themselves to others in the match, but they also have the unique experience of comparing themselves to the set "par," which significantly increases the impact of judgement relating to failure versus success (Fleming & Dorsch, 2024). Perceived failure within athletes should be considered a risk factor associated with the origination of an eating disorder. Assessing for perception of success versus failure is paramount in this community, as well as associated punishments, rewards, or superstitions/rituals.

What Coaches Can Do

Education. Coaches should do their own research, attend continuing education conferences/presentations on eating disorders, and keep up with new literature about these disorders. It is imperative that coaches learn the warning signs and symptoms of an eating disorder to be able to spot them if they come across their track, studio, mat, or field. Not only is it important to know the general or common symptom presentation for disordered eating or eating disorders, but it is also more important for coaches to know what this presentation looks like within the specific sport itself. Studies have shown that coaches are lacking education and understanding of eating disorder presentations within athletes, including how risk factors present, the

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nature of the disorder, treatment protocols, and prevention efforts (Turk et al.,1999). Coaches need to be educated on what to look for and what to do if/when these factors present.

Awareness. Know the eating disorder prevalence within your sport. Studies illustrate that most coaches will report they do not believe their sport has a strong association with eating disorders, even if they have personally coached athletes with a known eating disorder diagnosis (Nowicka et al., 2013). Coaches can be a frontline individual to notice and ask athletes if they could use support relating to food and body. Coaches often see their athletes for multiple hours a day, giving them access to information about individuals and their behavior that even family members or friends may not have. This is where the importance of education comes in, as coaches must know when to ask and how. One study found that most coaches would score between 70-79.5% on an assessment relating to multiple aspects within the scope of eating disorders; almost 10% of coaches even scored below 60% (Turk et al.,1999). For disorders with the highest mortality rate among all mental health disorders, these percentages could lead to catastrophic outcomes. Coaches should be screening their athletes for healthy eating habits and appropriate amounts of exercise and use language that strengthens the idea that food is fuel and is crucial to the long-term success in life and in sport. The Eating Disorder Screen for Athletes assessment found here can be a great resource.

Action. Coaches need to be aware of their local resources and referral options. Many coaches, specifically in college athletic environments, may be aware of their specific services offered within the school. However, it is imperative that individuals with eating disorders receive specialized care, not just generalized psychological or nutritional support. Coaches should reach out to local agencies or national organizations for eating disorders if they need help or guidance with how to move forward. Early intervention is key for improving prognosis. Quick, efficient, and adequate steps to help an athlete receive help is so vital to their long-term health and well-being. Coaches also need to play a crucial role on a treatment team, and their involvement is essential for adequate treatment. Coaches can follow their own philosophy, that athletes need help and guidance for success on the mat. They might just need the same amount of help off it too.

Eating Disorder Resources

Looking for more resources? Check out the National Eating Disorders Association toolkit specifically for coaches and athletes linked here or the National Association of Anorexia Nervosa and Associated Disorders resource list here.

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FEATURE • EATING DISORDERS

Disordered Eating in Asian Americans: Background and Clinical Implications

Yashvi Aware, MS, MPH

Eating disorders are diagnosable mental illnesses as outlined by the American Psychiatric Association's (2022) Diagnostic and Statistical Manual of Mental Disorders (DSM-5 TR), which can originate from disordered eating (DE) behaviors (Neumark-Sztainer et al., 2006). In contrast to a diagnosable eating disorder, DE refers to problematic eating behaviors and attitudes that an individual may experience, such as skipping meals, binge eating, excessive use of diuretics, or even dieting practices (Pereira & Alvarenga, 2007). The critical feature to note is that while these non-normative eating behaviors range in severity and may not meet the strict criteria for a psychiatric disorder as outlined in the DSM-5 TR, they still lead to significant health impairments and distress for the individual (American Psychiatric Association, 2022).

It is important to note that research on eating disorders (and, by extension, DE research) has traditionally focused on White, European American women (Sun et al., 2023; Wildes et al., 2001). As the population of ethnic minorities in the United States continues to increase, Asian Americans are the second fastest-growing group (U.S. Census Bureau, 2018). As such, it is more relevant than ever for psychological research, assessment, and treatment to incorporate inclusivity and diversity.

Disordered Eating Behaviors in Asian Americans

One population-based study found that the prevalence of unhealthy weight control behaviors among men was higher for Hispanic/Latino American (60.7–68.0%) and Asian American (41.9–56.7%) identifying men compared to Black/African American (24.6-36.9%) and White American men (25.7-34.9%; Simone et al., 2022). The literature also suggests that Asian American adults experience elevated mean scores for DE symptomatology when compared to their White counterparts (Bucchianeri et al., 2016; Rodgers et al., 2016; Uri et al., 2021; Yoon et al., 2023). Asian Americans reported higher mean restriction scores (defined as deliberately consuming less food) compared to White Americans, higher mean scores on body dissatisfaction than non-Asian people of color, and higher mean scores of purging (self-induced vomiting, and abuse of diuretics and laxatives) than any other ethnic group (Uri et al., 2021).

Among college students identifying as either White Americans, Asian American, or non-Asian people of color (NAPOC), Asian Americans had higher mean scores of purging, muscle building, and cognitive restraint (effort to regulate food intake and its influence on body weight and shape) than White and NAPOC students (Uri et al., 2021). Additionally, Asian Americans scored higher on restriction (Uri et al., 2021) and endorsed more binge eating than White Americans (Lee-Winn et al., 2014).

Another recent study found that after adjusting for sociodemographic variables, DE behaviors were greater in all racial/ethnic minorities compared to non-Hispanic White Americans (Yoon et al., 2023). More specifically, associated symptoms of binge eating were more

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prevalent for Asian Americans than for non-Hispanic White Americans (Yoon et al., 2023). Associated symptoms of binge eating are defined as "eating much more rapidly than usual, eating until uncomfortably full, eating large amounts of food when not feeling physically hungry, eating alone because embarrassed by how much you were eating, feeling disgusted with oneself, depressed, or feeling guilty after overeating" (Yoon et al., 2023, p. 6).

Understanding Disordered Eating Behaviors in Asian Americans

Several concepts have been described in the literature to explain the increased prevalence of DE behaviors in Asian Americans. Using the ecological systems theory (Bronfenbrenner & Morris, 2006) in a sample of Asian and Asian American women, intergenerational family conflict and the value of honoring family through achievement was indirectly associated with restricted eating via thwarted psychological needs (Han, 2020). Here, restricted eating was measured using the 10-item Restrained Eating Subscale of the Dutch Eating Behavior Questionnaire (van Strien et al., 1986). Ecological systems theory is a theoretical framework that suggests that the macrosystem of culture impacts the individual through the impact of culture on the microsystem of family, peers, and school (Bronfenbrenner & Morris, 2006). Therefore, understanding the cultural context of the individual and the impact culture has on micro-level factors is an important consideration in disordered eating treatment and research (Han, 2020).

Asians' rates of higher DE behaviors may also, in part, be contributed by the concept of acculturation and the related stressors individuals may experience (Aware, n.d.). Acculturation is defined as the process through which individuals from one culture are introduced to a new culture (Berry, 1997). This process is complicated by the choice of individuals to adopt the beliefs, attitudes, and behaviors of the majority culture or maintain their original cultural identity. It is also possible that the prevalence of DE behaviors among Asians in the literature is an underestimation due to the lower rates of mental health service utilization within this group (Chu & Sue, 2011; Gupta et al., 2011).

Clinical Considerations for Disorder Eating Behaviors in Asian Americans

It is important for clinicians to consider and be aware of the clinical presentation of various DE behaviors amongst Asian Americans, as assessment will be relevant to treatment. Asian Americans may endorse different forms of body dissatisfaction related to their height, facial features, or skin tone (Grabe & Hyde, 2006; Frederick et al., 2016). Additionally, it is theorized that Asian Americans may be less likely to report distress or DE symptoms due to cultural differences in the experience of these symptoms and the mental health stigma that surrounds them (Lee-Winn et al., 2014). These factors provide important considerations for the clinical interview portion of the assessment with this population.

Yu and colleagues (2019) provide an integrative framework for practice recommendations when working with the Asian American population. Highlights of these recommendations are presented below:

- Motivational Interviewing techniques can be utilized when encountering resistance to psychological services.
- When shame, guilt, or stigma are present, psychoeducation surrounding the complex nature of DE and eating disorders can be beneficial.
- When doubts surrounding the efficacy of psychotherapy are present, it may be helpful to sperate the individual from the illness and using action-oriented techniques rooted in

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solution-focused therapy.

- Conceptualizing the intersectionality of DE behaviors and related factors, such as acculturative stress, can inform treatment.
- When possible, clinicians are encouraged to include family members in aspects of assessment and treatment to address familial and cultural factors contributing to DE.

Conceptualizing DE behaviors among the Asian American population through a lens of cultural competence is crucial to obtain the most appropriate assessment, accurate diagnosis, and effective treatment. This may be accomplished by utilizing the multicultural guidelines promoted by the American Psychological Association (2017), which include cultural humility, utilizing a strengths-based approach, and recognizing one's biases and beliefs. Ultimately, applying evidence-based treatments through culturally-informed practice will be helpful in tailoring interventions for a population that has traditionally been under-represented in DE literature, therapeutic intervention strategies, and assessment development.

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Psychotherapist Professional Wills: Easy to Avoid, Crucial to Address

Robyn B. Miller, PhD

Clinical Impact Statement
The ethical duty to plan for patient care in the event of a psychotherapist's sudden incapacitation or death is often overlooked. The field of psychotherapy inadequately prepares clinicians to understand and to fulfill this responsibility, leaving therapists feeling overwhelmed and guilty for procrastinating the creation of a Professional Will and naming a Practice Executor. Important patient and practice considerations which influence the complex decisions a therapist must make in order to plan are elucidated. Recommendations are made to improve available Professional Will and Practice Executor resources for the fulfillment of this ethical obligation. Additionally, a list of recommended readings and resources along with a Professional Will template are included in links at the end of this reading.

Importance of Creating a Professional Will
As therapists, we take time, intention, thoughtfulness, and care in developing our relationships with clients. Many of us see this bond as a vehicle for change. We may acknowledge our clients' attachments, sometimes even dependency, on us at certain stages of treatment, and we strive to operate with integrity and beneficence as our ethics codes demand. However, we often avoid an important ethical duty to our clients, i.e., planning for their wellbeing if the worst were to occur to us. Consistent with our therapeutic efforts, we owe it to clients to consider how they would be impacted if faced with such a sudden loss. While statistically unlikely that a tragedy would befall any one of us, we have the responsibility to face our discomfort with mortality and to plan for the needs of those in our care.

Consider the impact of a sudden termination. At a recent state psychological association convention where I was promoting professional wills, a colleague teared up remembering her anger and confusion banging futilely on her therapist's office door 25 years ago, only to learn two months later that her therapist had died. Now, as a clinician herself, she prioritized creating a detailed and comprehensive plan for patient notification and continuity of care, in case the unexpected happens. She vowed she would never leave her patients in the position of feeling abandoned.

Some patients are at heightened risk for regression or decompensation. When I notified the patients of a colleague's incapacitation, most people expressed grief, but some reenacted trauma. One woman told me, "What a waste of a decade of spilling my guts, only to be screwed over by the one person I trusted. Well, I'm done for good now. I have lost all trust." This same person shared six months later, "I was heartbroken when Dr. B was sending me somewhere else after going to her for a dozen years.... I am sorry."

Colleagues shared their work with patients who had come to them in great distress following the sudden death of a previous therapist. Still, others spoke of

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rummaging through a colleague's office, basement, or garage, trying to find files and patient contact information to notify them following a death. The practitioners I spoke with who have personal experience with unexpected therapist loss appreciate the importance of a professional will, and while they do not intend on leaving this for others to handle, they still procrastinate their initiation of this process. In fact, at the recent conference I attended, many therapists gave a range of responses, with some muttering as they passed by, "No, no, no," while shaking their heads. One elderly man would not make eye contact but joked, "If I drop dead, you can take over." Another woman stated, "I'm leaving it all to my daughter to figure out! I know that's terrible!"

As a Maryland psychologist in private practice for almost 25 years, I have learned from personal experience that appointing a close colleague as a Practice Executor is not best practice, though it has been the standard way of handling this. In days past, a neighboring colleague was the best option because someone would need access to paper calendars and files, typically locked in the therapist's office. While these arrangements were made with the best intentions, a colleague has her own full set of professional and personal obligations and cannot come close to meeting all the urgent demands of clients and the practice. Clients would likely not be well-served, and having a close colleague serve is likely to place an unintentional emotional and practical burden on your loved ones.

Considerations for Clinicians When Creating a Professional Will

Many therapists are aware that creating a Professional Will is a way to document your plan and intentions, carefully specifying details about your practice and instructing a qualified individual on how to resolve your practice. In order to construct an adequate Professional Will, you should contemplate the following questions:

- How do you want clients to be notified of your death?
- Who will reach out to your clients?
- How will you protect their confidentiality?
- To whom do you want to refer them? How will available matches be identified?
- Where are your passwords located to access client contact information?
- Where are confidential records stored? How should they be transferred or retained?
- How will your estate collect payment for services rendered by you?
- How will clients get the statements they need for insurance?
- What will be demanded of your family in their time of grief as clients are looking for you, for information, for their records?
- Will your estate face a financial liability to pay your Practice Executor?
- What will happen with your office? Your automatic bill payments? Your license and malpractice insurance? Your website?
- How will your colleagues be impacted? How will they manage their personal grief while shouldering the professional burden? How will they cope when calling your patients or greeting them in the waiting room?
- Who can you ask to take care of this job for you as your Practice Executor?
- How long will this job take? Who will have the time?
- How long will it take for your clients to be reached and assisted with referrals?
- How much detail is ok to share with clients who ask about your condition?

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- Would clients be welcome to attend a memorial service if they ask to?
- Which clients should have a specialized plan due to the potential of your loss being particularly destabilizing for them?

The Dilemma of a Professional Will
Our field has a Professional Will dilemma. Through conducting trainings, surveys, and consultations, I have learned just how overwhelming it is for clinicians to think through the above questions. Not only is it upsetting to consider the possibility of your sudden incapacitation or death, but it is also difficult to contemplate the impact that your sudden absence would have on those charged to your care. Most psychotherapists understand the obligation as outlined in our ethics codes, but many do not know how to fulfill the responsibility. Moreover, even if a therapist creates a comprehensive Professional Will that lays out a succession plan, it is often not clear how this plan will be carried out. Practice Executors are not under any legal obligation to comply with Professional Will instructions and may not be available to do so. Unless the Practice Executor also signs your Professional Will, it is not considered a contract but only an expression of your wishes. For colleagues who do try their very best to step up and serve, there is little guidance or support in the literature or trainings as to how to perform these duties. And now that you may understand the complexities and time required to serve as a Practice Executor, it becomes even more difficult to identify who you can ask to take on this responsibility.

Lawyers will tell you that a Practice Executor is an administrative job. If you are a fellow psychotherapist, you will understand that this is a clinical job, as you will face grieving individuals who feel bereft and adrift. Depending on the executor's relationship with the deceased, they may be deep in mourning as well. The job, on behalf of the absent therapist, is to gently bring their clients to shore by sharing the terrible news, listening to their shock, responding to questions about the therapists' condition, and fielding inquiries about memorials. The Practice Executor will identify referral sources, maintaining contact with clients to facilitate their transfer of care and records. This emotional and draining process is then followed by many more duties that may fall under an administrative category, but which also rely on clinical judgment regarding confidentiality, risk assessment, and anticipation of the impact on clients and on the therapist's family as matters of the practice are resolved.

Each and every time a therapist is suddenly incapacitated or dies, we recreate the wheel and there is no telling what gets overlooked or slips through the cracks. This emphasizes the need for a better system. Here are some suggestions based on my experiences:

- **We need an easier means to comply.** Instead of having therapists research Professional Will templates on the internet to best suit their practices, we need to offer assistance and provide a service to guide the creation of individualized plans. We need expert consultants available to assist with the clinical and business elements of this arduous task.
- **We need ways to outsource this duty.** Similar to the outsourcing that is done with many other aspects of practice that require professional expertise (i.e., insurance submission, billing, electronic health records, administrative assistance, legal and accounting services), this is a necessary condition for practicing ethically and with integrity.
- **We need to create a mandate for Professional Wills.** State Boards of all disciplines of psychotherapists

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need to mandate that therapists create a Professional Will as a way of protecting the public. Despite most therapists' best intentions, it is too difficult to overcome our intrinsic avoidance of mortality to really think about and allocate resources for the possibility of our untimely demise. While we understand this, it cannot be an excuse. It should not take a psychotherapist's exposure to the chaos and crisis following a colleague's sudden death to appreciate the need to act.

With patient care as our priority, psychotherapists need to better understand the impact of traumatic terminations and the importance of the ethical obligation to plan for continuity of care in the event of the therapist's emergency. Psychotherapists are burdened with the complexity of this duty, as we are asked to contemplate mortality in a way that challenges human defenses. The status quo for fulfilling this responsibility calls on psychotherapists to draft documents with legal intent, and to seek ad hoc arrangements with colleagues to fulfill crucial clinical services for patients. As a field, we need to do better. Psychotherapists strive to operate with integrity and want to comply with ethical standards. There needs to be a more reliable and efficient means to do so in regard to creating a Professional Will and naming a qualified and available Practice Executor. Additional resources for professionals are included below.

Additional Resources

For recommended readings and resources, see here.

For a Professional Will template, see here.

FEATURE

A Dissertation Study on Prolonged Grief Disorder and Mourning via Social Media

Sarah Bondy, MA
Craig Wetterer, PhD

I grew up in a time when social media was gaining popularity and spreading into several different platforms. As a doctoral student in a PsyD program at California Northstate University, I have gained an appreciation for research seeking to understand the intersection of social media and mental health. My dissertation chair, Dr. Craig Wetterer, and I decided to focus my dissertation study on understanding how people use social media as a form of mourning practice. I came to find that while I was not alone in my interest in this topic, social media and mourning is a relatively new area of interest in psychology with plenty of room for new research to better understand these concepts. More specifically for my study, I chose to focus on social media use related to mourning in the first month after a loss to better understand factors that may contribute to the subsequent development of Prolonged Grief Disorder. The following is a summary of what I have learned so far, more information on my study, and how you can participate.

Prolonged Grief Disorder and Current Research

Grief has been defined by the American Psychological Association (APA; n.d.) as, "the anguish experienced after significant loss, usually the death of a beloved person" (para. 1). Grief is a common experience and often involves distress; however, it is also an experience that is personalized and unique to an individual based on both cultural and personal factors. Despite variations in how individuals grieve, the intensity of one's grief tends to diminish over time (Shear, 2015). However, for approximately 13% of grievers worldwide, the intensity of grief does not diminish over time and clinical intervention may be necessary (Comtesse et al., 2024).

Prolonged grief disorder (PGD) is a newer diagnosis that was added to the 5th edition text-revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) in 2022 to help explain the symptomatology for individuals experiencing a grief response requiring intervention. To meet the criteria for PGD, the following symptoms must be met:

> (A) the death of an individual close to the bereaved at least 12 months ago in adults, (B) intense yearning for the deceased and/or preoccupation with memories of the deceased most days, (C) at least three of the following symptoms experienced most days for at least one month: identity disruption, disbelief about the death, avoidance of reminders that the deceased has passed, intense emotional pain, difficulty reintegrating into relationships and/or activities, feelings of numbness, feelings of life as meaningless, loneliness, (D) clinically significant distress, (E) a grief response that exceeds the norms of one's culture, and (F) the symptoms are not better explained by another disorder. (American Psychiatric Association, 2022, pp. 322-323)

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Several risk factors have been identified through research to better understand why some people may develop PGD after a loss. A systematic review and meta-analysis conducted by Burr and colleagues (2024) examined 120 studies published between 1989 and 2023 that looked at risk factors for PGD. The results identified the following as statistically significant risk factors for this disorder: pre-loss grief symptoms, pre-loss depressive symptoms, loss of a child, loss of a partner, attachment anxiety, income, violent/unnatural death, education level, gender of the bereaved, the death being unexpected, the bereaved being single, and the number of losses. Identifying risk factors for the development of PGD informs researchers about different courses of grief and may help identify individuals who would benefit from early intervention.

Mourning Practices

Mourning and grief are often used interchangeably although they are distinct constructs. The American Psychological Association (n.d.) has defined mourning as, "the process of feeling or expressing grief following the death of a loved one, or the period during which this occurs" (para. 1). Due to mourning being an expression of grief rather than an internal experience, it may be easier to observe than grief. Mourning behaviors include outbursts of anger or social withdrawal.

Mourning practices are culturally bound and reflect the traditions of a given community; however, many cultures include grief rituals as a form of mourning practice to help exert social control over a loss (Silverman et al., 2021). In a scoping review of cross-cultural mourning practices, Goodwyn (2015) identified eight themes commonly found in grief rituals: (1) containment of emotions experienced as part of grief within a cultural context, (2) acceptance of the loss gained through close contact between the deceased and the bereaved, (3) tasks that help the deceased transition to the afterlife, (4) recognition of the vulnerability of the bereaved and their community after a loss, (5) recognition of the vulnerable state of the bereaved after a violent loss, (6) a framework to reorganize the relationship between the deceased and the bereaved, (7) culturally bound methods to express emotions, and, (8) ways to integrate knowledge of the death into belief systems.

Research has also explored how grief rituals can be utilized in psychotherapeutic treatment. Sas and Coman (2016) interviewed 10 therapists (six from the United Kingdom and four from the United States) with expertise in grief rituals and grief therapy to determine the main types of grief rituals and their functions. The authors found three types of rituals: honoring rituals, which are meant to celebrate the bond between the living and the deceased; rituals of releasing negative emotions associated with the loss; and, rituals of self-transformation in which clients will evaluate where they are in their lives, what they need to process, and their goals for the future. Wojtkowiak and colleagues (2021) extended the literature on the use of rituals in grief therapy by conducting a scoping review of studies that used grief rituals in outpatient therapy for PGD. They identified 22 studies published between 2009 and 2019 conducted throughout various countries, including the United States, the Netherlands, Portugal, Rwanda, Germany, India, Japan, Denmark, and Iran. Nineteen of the studies reported significant symptom reduction on measurements of different symptoms, including grief, depression, post-traumatic stress, distress, despair, intrusions and avoidance, emotional loneliness, and emotional numbing. All 22 identified studies included some kind of ritual, such as meditation, symbolic

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communication with the deceased or with an imaginary friend, writing assignments, use of religious texts, having a commemorative or drumming ceremony, visiting the funeral with the therapist, visiting the gravesite, and having a dialogue with the deceased (Wojtkowiak et al., 2021).

Mourning Through Social Media

Mourning via social media shares elements with other types of mourning rituals, such as revisiting pictures and memories of the deceased (Kakar & Oberoi, 2016). However, mourning through social media can change the visibility of one's grief, creating a unique context for one's mourning process (Morehouse & Crandall, 2014). In some ways, social media has also changed the cultural norms for mourning. In a qualitative study on social media posts (primarily Instagram), Khumairoh (2023) examined the cultural impact of grieving in Indonesia after the invention and widespread use of social media. They found that prior to widespread social media use, many Indonesian mourning practices were strictly enforced; however, social media forced a "cultural expansion" such that previous norms unique to a single culture blended with other norms seen online (Khumairoh, 2023, p. 84).

Communicating About Grief Through Social Media

Research indicates that individuals use social media to communicate about their grief in a variety of ways. In an interview study of adults aged 22 to 60 in the United States who lost a loved one, Moore and colleagues (2019) identified three different types of communication used on social media regarding grief: (1) one-way communication, (2) two-way communication, and (3) immortality communication. Participants reported that one-way communication via social media, like sharing information with others about their loss, was beneficial as it helped alleviate the pain of discussing the death repeatedly with others. Motivations for using social media to engage in two-way communication included discussing the death with others and creating a community where people could mourn together. However, participants expressed concerns about their privacy when using social media for two-way communication. Immortality communication involved using social media to commemorate and continue a connection with the deceased (Moore et al., 2019).

Research on communicating about grief via social media has also investigated various platforms used and the frequency of posts on these platforms. Facebook has been identified as the most used social media platform for expressing grief; however, some individuals indicated Facebook was better for engaging with family members while Instagram was preferred for engaging with friends (King & Carter, 2022). According to one study, posts about loss and grief experiences tended to be most frequent in the first 10 days following the loss, but engagement was still common in the first month post-loss (Brubaker & Hayes, 2011). Some mourning behaviors on social media, however, were found to persist throughout this three-year study, including sharing memories of the deceased, posting updates about one's own life, and maintaining a connection with the deceased (Brubaker & Hayes, 2011).

Motivations for Social Media Use in Mourning

Several research studies have examined motivations for why people use social media as a platform for mourning (King & Carter, 2022; Rossetto et al., 2015; Varga & Varga, 2021; Willis & Ferrucci, 2017) and the following have been identified:

- Sharing news about the death
- Seeking support

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- Emotional release
- Continuing a bond with the deceased
- Creating an online memorial for the deceased
- Social norms to post about a death
- Advocacy

Understanding why social media is used in mourning is helpful for contextualizing grief in the digital age. Motivations also highlight the needs of grievers throughout the mourning process and can serve as a guide for those seeking to provide support.

The Current Study

My study seeks to answer how social media use related to mourning in the first month post-loss might impact the development of PGD. The study will consist of a series of surveys and should take approximately 30-minutes. There will be an option to enter into a gift card raffle where I will be giving away five $25 Amazon gift cards.

Requirements to participate

- At least 18 years of age
- Loss of a loved one at least 1 year ago
- Have at least 1 social media account
- Ability to read English

To learn more and access the study, please click here.

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FEATURE

Counseling Baby Reindeer: Insight into Male Stalking Victimization and Guidance for Treatment

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In early 2024, the world was captivated by the release of the miniseries *Baby Reindeer* (De Greef et al., 2024). Richard Gadd's dramatization of his real-life experience with a female stalker. The series follows a fictionalized version of Gadd (Donny Dunn), a struggling comedian and local bartender in England who encounters a lonely woman named Martha while working. Sensing her sadness, Donny offers Martha a cup of tea on the house. This small act of kindness would lead to years of innumerable emails and voice messages, alleged stalking of Gadd at his place of residence, workplace, and comedy shows, and harassment of Gadd's family members and romantic partners.

Baby Reindeer (De Greef et al., 2024) put a spotlight on the unspoken phenomenon of male stalking victimization and the complicated psychological processes that can present. Gadd's experience highlights the gendered stigmatization against male victims and emphasizes the many systemic and psychological barriers they must navigate to secure justice from their perpetrators. This article serves to introduce the complexities of male stalking victimization and to offer therapeutic guidelines for therapists working with this population.

Male Stalking Victimization in the Literature

According to the Department of Justice, stalking is defined as "a course of conduct directed at a specific person that would cause a reasonable person to feel fear" (Baum et al., 2009, p. 1). Common behaviors of stalking perpetrators include, but are not limited to, following the victim, sending unwanted text messages, phone calls, emails, or gifts. Stalking laws vary across the United States, making it difficult to capture the concept of fear in this context and the level of fear a victim must feel to receive justice against their perpetrator. This subjectivity of characterizing fear and the inconsistent degrees of fear across states makes it incredibly difficult for victims' cases to even enter the legal system. Approximately 50% of both female and male stalking victims in the United States felt that their situation did not change after speaking to law enforcement, and 20% stated that law enforcement took no action when contacted (Baum et al., 2009).

The current literature on stalking primarily focuses on female victims and male perpetrators, highlighting the prevalence of intimate partner violence and female victimization. Although it is important for the literature to continue to address female victimization, it appears that the victimization of males in stalking cases is relatively underreported and under researched. This could be due to the stigmatization society has against male victims of interpersonal violence. While the aftermath of the MeToo movement created space to address male victims of interpersonal violence, including stalking victimization, the influence of gender roles for

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and the stigma against male victims continues to dominate the conversation and overshadow victimization.

The reported rate of male stalking victimization in the United States is approximately 8 victims per 1,000 males ages 16 and older, with 41% of victims having a male stalker and 43% having a female stalker (Baum et al., 2009; Morgan & Truman, 2022). Research has shown that men are less likely to report their stalking victimization to law enforcement and feeling like their reports of stalking were taken seriously by law enforcement (Sheridan, 2003, as cited in Wigman, 2009). Male victimization of stalking has been seen as less serious by law enforcement compared to female victimization, and men were more likely to be held responsible for their victimization. More specifically, law enforcement had a tendency to overlook male reports of stalking if the perpetrator was female, perceiving males as being able to handle the situation with the female stalker themselves (Sheridan, 2003, as cited in Wigman, 2009).

Baby Reindeer (De Greef et al., 2024) begins with Gadd attempting to report his stalking victimization to local police. The police officer responds with skepticism, asking if Gadd was in a sexual relationship with Martha and probing for an explanation as to why he waited six months to report the stalking to police. This interaction highlights the resistance male victims often receive when taking the difficult step of asking for help and seeking justice; a resistance also experienced by female victims (Independent Office for Police Conduct, 2022).

Clinical Implications of Male Stalking Victimization

It's important for therapists to recognize the numerous systemic obstacles that male victims must navigate when reporting victimization. Additionally, there are numerous psychological barriers that exist for male victims of stalking that might prevent them from disclosing their experience. Spitzberg et al. (1998, as cited in Wigman, 2009) postulated that men may not perceive their stalking victimization as serious enough to speak about it with others, or they may fear being received negatively by others if they were to disclose their experience. This presumption emphasizes the impact of male gender roles on male victims of interpersonal violence. In many societies around the world, men are expected to be strong, independent, and stoic; qualities that are not often considered when thinking about what it means to be a victim (McCarthy et al., 2018). These expectations, usually learned at a young age, may subconsciously infiltrate a male victim's thought processes, potentially warping their perception of their victimization experience. This can lead to minimization of the stalking behaviors and may create a hesitation to disclose the offense to others. Specifically for female perpetrators, Brooks et al. (2021) found that since most societies across the world perceive women as less dangerous and men as more capable of defending themselves, male victims of stalking are less likely to identify themselves as victims of crime or admit fear, which is a main component in prosecution.

Male victims of stalking often face significant psychological and systemic barriers influenced by societal expectations for masculinity. These expectations tend to discourage expressions of vulnerability and self-identification as a victim, which can affect a male's self-perception of the severity of their victimization. This experience, combined with minimized perceptions of female perpetrators, can ultimately hinder a male victim from pursuing legal action or seeking psychological treatment for this harmful offense.

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Treatment Recommendations for Male Stalking Victims

As discussed above, there are numerous systemic and psychological barriers fueled by stigmatization and gender roles that can prevent male victims of stalking from seeking justice and treatment. It's important for providers to be mindful of a male victim's reluctance toward receiving treatment for this potentially traumatizing experience because of these obstacles. This can be one of the biggest challenges in counseling a male victim of stalking as gender roles are so embedded in American culture and mind. Additionally, therapists should enter treatment with male victims with an understanding of stalking and its subsequent impact (Pathé et al., 2001), and approach treatment through a trauma- informed lens. Therapists for these clients should reflect on their personal biases toward men, male victimization, and stalking in order to recognize, acknowledge, and manage their countertransference throughout the course of treatment.

First and foremost, it's important for the therapist to establish safety and protection within the therapeutic relationship. The therapist should allow for the subjective experience of the male victim to be honored by maintaining a non-judgmental and empathetic attitude. It can be difficult to establish rapport with these clients due to potential emotional dysfunction, reluctance toward treatment, and not wanting to be perceived as a victim (Pathé et al., 2001). To help assist in rapport building, therapists should lay the groundwork for flexibility and validation in sessions. This approach can foster a supportive environment that can identify client components of emotional distress while affirming their experience.

It is essential to recognize that treatment goals for male victims of stalking should be individualized to the specific needs of the client. Generally speaking, treatment for victims of stalking should aim to alleviate distress and restore baseline functioning (Pathé et al., 2001). Therapists can create space for the client to discuss their victimization and subsequent emotions, possibly asking exploratory questions in early sessions to guide the client into disclosure while preserving an empathetic and affirming approach. Decades of trauma research has shown the significance of vocalization in trauma processing, either verbally or written (Kaminer, 2006). It allows for the victim's internal experience to become externalized, reinstating a sense of control within the victim and facilitating perception changes. However, therapists should be mindful of the client's reactions from others during this phase. Male victims of stalking might have been received with disbelief, trivialization, or blame when disclosing their experience to other people. This can reinforce the client's distrust of others and increase self-blame and further withdrawal for sharing their experience (Pathé et al., 2001). This may also become present in the therapeutic relationship, where a client may perceive the therapist's statements as judgmental or invalidating. The therapist may try to remain affirming, empathic, and supportively process the invalidation experienced from others and when it emerges in the therapy room.

The impact of stalking can heavily affect functioning in various domains of the victim's life. It is not uncommon for the stalking perpetrator to show up at the victim's home, workplace, or social gatherings. The stalking behavior can create a sense of fear and insecurity surrounding frequently visited places, which can cause the individual to withdraw from personal and professional responsibilities and to isolate from others (Pathé et al., 2001). This can be even more significant for male victims, who may experience self-blame or shame for struggling

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to continue on with their life in the same way they did prior to be victimized. Exposure should be targeted towards domains of functioning that were severely affected by the stalking behavior. Therapists can work with the client to set goals related to impaired domains of functioning and to redefine meanings of frequently visited places affected by the perpetrator to enhance comfortability.

It is important to address the role of advocacy within the therapeutic relationship as well as the challenges that arise when treating a male victim of stalking. From an ethical perspective, advocacy outside of the therapeutic relationship has the potential to blur boundaries and puts the client's rights to confidentiality and autonomy at risk. Considering the stigmatization male victims of stalking face internally and systemically, advocacy may harm the therapeutic relationship and reinforce the client's distrust of others. Therapists may struggle with the conflict of wanting to provide treatment to the client while also advocating for the rights of male victims in a broader social context. It's normal for therapists to feel this way, especially when they have an understanding of the client's victimization, emotional distress, and impairments in functioning. Therapists should engage in self-reflection throughout the therapeutic relationship, reminding themselves of their role as a therapist and actively considering how their advocacy could affect the client's overall functioning.

The release of *Baby Reindeer* (De Greef et al., 2024) has introduced the world to the experience of male victims of stalking, and the uniquely complicated psychological and systemic barriers faced by male victims when attempting to heal from subsequent trauma. This victimization is often overlooked and undermined due to deeply ingrained gender roles and stigmatization, making it difficult for victims to secure justice against their perpetrators and receive treatment from mental health therapists. Therapists must be aware of these psychological and systemic barriers to deliver empathetic and effective treatment to their clients, empowering them to reclaim their story and work to heal from perpetration. It is imperative for the field of psychology to continue to deepen its awareness of the complex psychological and systemic factors that exist within male stalking victimization and invest in expanding research in this area to develop more evidence-based practices tailored to this specific population.

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Narcissistic Personality Disorder Across Types of Therapy: Individual, Couple, and Group

Bethany Palmer, MSW, SWLC

Why is there so much talk about narcissism lately? Is it a trend, baseless hysteria, or even a problem at all? Narcissism itself is a singular personality trait; it can be protective and even beneficial, especially in Western society (Ronningstam, 2005). This may be due to the individualistic virtues and increased achievement-dependent self-esteem rates in Western cultures as compared to those from more collectivistic societies (Vater et al., 2018). Narcissistic personality disorder (NPD), on the other hand, can be much more insidious and harmful. People with NPD are not simply arrogant, vain, selfish, or empathy-impaired, as mainstream media may portray. Diagnostic criteria, ranging from entitlement to exploitation, imply destructive interactions with *other* people in their proximity.

NPD is comprised of an antagonistic personality structure, meaning relational disruption, exploitativeness, callousness, and vengefulness are standard characteristics of this presentation (Day et al., 2020). Both grandiose and vulnerable NPD variants show a preoccupation with satisfying personal needs at the expense of others (Yakeley, 2018). The prevalence of those meeting diagnostic criteria for NPD is estimated to be up to 2% of the population (Weinberg & Ronningstam, 2022), or over 6.5 million people in the United States (U.S. Census Bureau, n.d.). Moreover, rates in clinical and outpatient therapy populations may be up to 20% of the total patient population (Weinberg & Ronningstam, 2022). NPD is, therefore, inherently impactful to others in proximity and highly likely to present in a clinician's office.

Narcissistic Personality Disorder and Clinical Insight

Adults not living with NPD typically exhibit constitutional flexibility; the ability to adjust their personality features in the face of deficient interactions with themselves and/or others (Lester, 2018). People living with personality disorders have disturbances in the adjustable elements of their identity and with interpersonal (empathy and intimacy) personality traits (American Psychiatric Association, 2022). Personality disorders are not mental illnesses consistent with a symptomatic deviation from baseline functioning, but rather a complete and established state of being (Lester, 2018).

Individuals with NPD demonstrate traits of entitlement and low harm avoidance (Mitra et al., 2024), along with dysregulated self-esteem that represents a fragile ego (Ronningstam, 2005). This presents a contradiction between perfectionism and shame. Due to their additional characteristic combination of relational antagonism and fear of vulnerability, their clinical history is likely to reveal tumultuous relationships and increased isolation over time (Mitra et al., 2024).

Personality disorders are defined by the persevering of behaviors despite evidence of negative consequences (Lester, 2018). This is partly why there are few validated treatments for NPD and many studies imply that this disorder is untreatable (Mitra et al., 2024). Overall,

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NPD is a persistent condition that can gradually and slowly improve with a focus on symptom-specific interventions (Weinberg & Ronningstam, 2022).

NPD often co-occurs with other mental health conditions, such as bipolar disorders, substance use disorders, depression, and anxiety (Stinson et al., 2008). However, while other disorders may be the primary presenting problem in therapeutic settings, many of them may be misdiagnosed side effects of the isolated and emotionally dysregulated nature of NPD (Lester, 2018). Regardless, dissatisfaction in life may encourage patients with NPD to seek therapy.

Identifying the presence of NPD (or any personality disorder) is imperative to successful treatment outcomes (Lester, 2018). Due to the move to a dimensional model for diagnosis, previous personality assessment instruments are now outdated (Blüml & Doering, 2021). Appropriate assessments based on underlying themes and conflicts include the Operationalized Psychodynamic Diagnosis (OPD-2), Structured Interview for Personality Organization-Revised (STIPO-R; Blüml & Doering, 2021) or the Level of Personality Functioning Scale (LPFS; American Psychiatric Association, 2022).

Narcissistic Personality Disorder and Individual Therapy

There is a misconception that pathologically narcissistic people do not go to therapy. Dr. Craig Malkin (2024), a leading expert in NPD counseling, states that people with NPD frequently do, in fact, present in therapy. They often seek help under a grandiose victimhood mentality, primarily expressing distress about their relationships (Malkin, 2024). The presentation of grandiosity is often a defense against internal states of vulnerability (Janusz et al., 2021), which can inhibit an effective therapeutic alliance. A functional therapeutic relationship is marked by the extent to which the patient and therapist are genuine and self-reflecting with each other (Gelso, 2014), so this can be a treatment barrier for individuals with NPD.

NPD is an egosyntonic disorder, meaning a patient's understanding of themselves is poor, and accepting self-deficit is not congruent with their sense of self (Mitra et al., 2024). In therapy settings, patients with NPD often become resistant to the therapeutic process of exploring and reflecting on their inner state or learning how to better connect with others (Lester, 2018; Malkin, 2024). Many therapists feel it is difficult to work with these patients and may experience disconcerting interactions during treatment that can cause a sense of unease (Janusz et al., 2021). A therapist's confusion and recognition of a patient's disingenuousness are tell-tale signs of the presence of a personality disorder and are often contributing factors to the ineffectiveness of traditional psychotherapy (Lester, 2018). Malkin (2024) also notes that a sense of inauthenticity or lack of accountability from a patient is often the first indicator of the presence of NPD.

Studies indicate that people with NPD may be aware that they are somewhat narcissistic (Carlson et al., 2011), however, they lack an observing ego and have extreme difficulty with self-correction (Lester, 2018). Despite the ongoing struggle with sustaining meaningful and healthy relationships due to the nature of their pathology, most people with NPD are not likely to change (Lester, 2018; Mitra et al., 2024).

A formal diagnosis of NPD is associated with a 63% to 64% dropout rate from psychotherapy (Weinberg & Ronningstam, 2022). Because NPD involves increased insecurity and hypersensitivity, a more effective intervention strategy may be to

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emphasize the interpersonal cost of being seen as "potentially" narcissistic (Carlson et al., 2011). Regardless of whether a diagnosis of NPD is made, mental health professionals should be alert to the presence of pathological narcissism in their patients, as it will impact overall treatment progression and outcomes (Yakeley, 2018). Therapists may need to operate with an understanding of the diagnosis without the ability to collaborate with the patient, which is counterintuitive in traditional psychotherapeutic practice (Lester, 2018). Maintaining professional clarity and clear treatment goals are essential, and the focus should be on stabilizing functioning and reducing interpersonal conflict (Lester, 2018; Mitra et al., 2024).

NPD treatment objectives should include addressing destructive behavior patterns and increasing overall stability in identity and interpersonal dysregulation to reduce problematic interactions (Blüml & Doering, 2021; Janusz et al., 2021). Treatment modalities that are more effective for targeting personality functioning include Dialectical Behavior Therapy, Schema-Focused Therapy, Transference-Focused Psychotherapy, and Mentalization-Based Therapy (Blüml & Doering, 2021; Yakeley, 2018).

Paramount to any treatment is the need for therapists to understand the interpersonal practices of patients with NPD. Highly narcissistic patients are prone to power struggles while in therapy in an attempt to provoke and control the therapist (Janusz et al., 2021). If the therapist is not skilled or trained to work with folks with NPD, they may become lost in their countertransference or even become orchestrated by the patient (Mitra et al., 2024). Working with NPD commonly invokes feelings of shame and resentment in therapists, which may make it difficult to seek and effectively use supervision or consultation (Yakeley, 2018). Utilizing supervision and consultation while working with patients living with personality disorders is crucial for helping to regulate the therapist's emotional responses and to prevent burnout (Lester, 2018). Additionally, obtaining specialized training or referring to more qualified and skilled providers is always appropriate.

Narcissistic Personality Disorder and Couples Therapy

Many studies find that narcissistic partners are highly problematic for their significant other who frequently report basic communication problems, hostility, frequent criticisms, insults, and overall aggressive and exploitative behaviors (Janusz et al., 2021). In some cases for people with NPD, identity preservation, empathy resistance, and interpersonal malice make couples therapy contraindicated for partners. Because NPD is a pattern of malevolently influencing interactional practices, couples therapy can often be counterproductive and even harmful (Janusz et al., 2021). Those fitting criteria for NPD may use therapy in bad faith and as a form of confirmation bias; potentially misrepresenting or weaponizing therapy in an attempt to manipulate others. The patient with NPD may have difficulty containing their need for power and control over both their partner and the therapist (Janusz et al., 2021).

One common presenting quality of folks with NPD in therapy is their insistence on knowledge equality with the therapist, echoing their speech and professional lingo (Vaknin, 2008). Further, narcissists methodically distance themselves from difficult emotions, package ordinary concerns under grandiose victimhood, and seek the therapist's validation for their intellectualized problem-solving

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(Vaknin, 2008). The difficulty of engaging in good-faith collaboration with an NPD patient is amplified by their fragile ego. Researchers have noted heightened defensiveness in individuals when a narcissistic partner is witnessing a therapist's feedback. Rejection of a diagnosis, reports of unfair treatment, or premature termination from therapy are high risks when working with these couples (Janusz et al., 2021). Couples therapy can, however, provide a naturalistic setting for the interpersonal spectacle of circular, destructive communication patterns with an NPD patient. It is advised that therapists exhibit caution and organize initial sessions in an extremely gentle, unobtrusive manner to prevent defensiveness and to promote cooperation (Janusz et al., 2021).

Narcissistic Personality Disorder and Group Therapy

Patients with NPD often make flattering first impressions that deteriorate over time as people get to know them. Their reputation becomes more negative as people see them as disagreeable and low on conscientiousness, emotional stability, openness, and adjustability (Carlson et al., 2011). This phenomenon may be emphasized within the dynamics of group and family therapy.

A core presentation of most patients with personality disorders is their tendency to be surrounded by ongoing "drama," likely attributable to their resistance to problem-solve (Lester, 2018). Group therapy presents a controlled setting for identifying and potentially correcting this trend. Further, characteristic attempts by patients with NPD to maintain control in relational communication patterns may be more difficult to perpetuate in groups that are specifically monitored for their interactional quality (Janusz et al., 2021). Group facilitators and other group members have an opportunity to model real-time functional relationships and can model healthy communication behaviors to patients with NPD. Therapists can name harmful patterns in aversive behaviors that range from mundane rudeness or defensiveness to serious violations that go beyond insensitivity to cruelty and destruction (Follingstad, 2007).

Studies note that empathy impairment associated with NPD may not be inherent but rather a conscious choice based on feelings of intolerance, self-regulatory impulses, processing difficulties, and conflicting interests (Weinberg & Ronningstam, 2022). Group facilitators can prioritize a focused approach to identifying how various exchanges are experienced and perceived by other group members. This information can educate people on the interpersonal context and impact of psychological aggression (Follingstad, 2007). Therefore, all group members can become empowered by an increased ability to discern normative interactions from harmful ones.

Narcissistic Personality Disorder Outside of Therapy

Some experts have proposed it would be appropriate to create an obverse condition, named narcissistic victim syndrome, to help treat insidious psychological damage inflicted by people with NPD (Fletcher, 2023). Indeed, partners and family members of people with NPD often feel victimized by the person's destructive relational behaviors. Interpersonal dysfunction, antagonism, and hostility are well-documented aspects of people with NPD that exact a significant toll on individuals in relations with them (Day et al., 2020).

For people who may interact with someone with NPD, whether professionally or personally, it is advised to learn about

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psychologically abusive patterns and formulaic moves. Maladaptive manipulation tactics include scapegoating, passive aggression, triangulation, silent treatment, bullying, gaslighting, intermittent reinforcement, defamation, mockery, criticism, disregard, and ridicule (Fletcher, 2023; Petric, 2022; Sackett & Saunders, 1999). People with both vulnerable and grandiose NPD have even been shown to use strategic jealousy induction, or intentionally and subtly invoking feelings of jealousy in their partners to maintain power and control (Tortoriello et al., 2017).

Destructive NPD relational patterns may be elusive to discern in the moment when attempting to engage in conflict resolution and boundary setting. Over time, navigating someone's NPD may leave people feeling disoriented and can result in psychological harm. It has been shown that ongoing verbal criticisms and sadistic patterns of interpersonal control are experienced as more disturbing and injurious than physical violence (Follingstad, 2007; Sackett & Saunders, 1999). The worst-case scenario would be a "systematically devious psychological process engendered by one person such that the partner comes to be mentally confused without the wherewithal to identify the process" (Follingstad, 2007, p. 447).

Victims of psychological violence may suffer from distinctively complex mental health consequences. Complex post-traumatic stress disorder, also referred to as C-PTSD, contains common symptoms of this particular type of interpersonal trauma, such as, disruption of a sense of self, dissociation, depression, anxiety, suicidality, sleep disturbance, and substance abuse (Dokkedahl et al., 2019). Further, a history of interpersonal trauma is the most consistent predictor of subsequent trauma exposure (Jaffe et al., 2019). Alarmingly, research repeatedly notes that anger outbursts are intrinsic to the narcissistic personality (Green & Charles, 2019). Unfortunately, outbursts and rage are not evaluated as part of current diagnostic criteria for NPD. These tantrums, even in those who do not meet full criteria for NPD, more often than not lead to physical violence (Green & Charles, 2019).

Awareness of the characteristics of NPD is worthwhile to prevent and heal from potential entanglements and victimization. Specific interventions for narcissistic abuse should provide nervous system regulation, targeted deprogramming, psychoeducation, and development of protective factors that promote self-worth, autonomous identity, and post-traumatic growth to heal and prevent future harm.

NPD is an unfortunate conditional state, however, compassion must be held with discernment. Kindness at the expense of one's boundaries and sense of self could become kindness exploited and weaponized. Therapists should be attuned to the prevalence rates, clinical presentation, treatment implications, and potential destructive effects of NPD. Whether in person or in close proximity, distress related to this disorder will likely walk through the office door.

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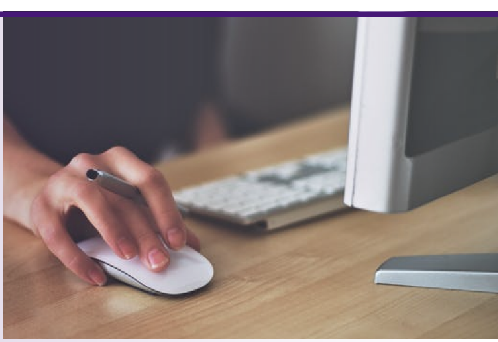

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FEATURE

Shame and Other Self-Devaluing Schemas in Suicidal Persons

Samuel Knapp, EdD, ABPP

Clinical Impact Statement: Suicidal patients often have self-devaluing schemas, such as shame, self-disgust, and perfectionism, which may lead to social isolation and reinforce or drive their suicidal thoughts. This article describes how psychologists can identify and address these schemas in psychotherapy.

Those who treat suicidal patients are often startled by the depth and intensity of the anger patients express toward themselves. When asked to list their reasons for wanting to die, many respondents listed negative self-appraisals, such as "I'm worthless, "I'm a piece of crap," or "I don't deserve to live" (Madsen & Harris, 2021, p. 5).

These negative trans-diagnostic self-appraisals appear in depressive, anxiety, and other disorders and could reflect shame, self-disgust, or perfectionism. Although distinct in some ways, these schemas, or enduring ways of thinking about oneself, have the common feature of disapproving or devaluing oneself (see Table 1 for a brief description of these patterns). These ways of viewing oneself can become entrenched and automatic ways that patients view themselves or interpret their life experiences. Psychotherapists can better help their suicidal patients if they understand these self-disapproving schemas, their accompanying emotions, and healthy alternatives.

Shame versus Guilt

Shame and guilt may both arise when an individual believes they have violated a rule of social behavior. However, they differ in how individuals respond to their perceived transgressions. Those who feel guilty feel motivated to apologize, repair the harmed relationship, or make amends for their behavior. In contrast, those who feel shame believe that their offensive actions represent something intrinsically wrong with themselves and that they are so defective that they can never sufficiently apologize or make amends for their behavior. Shame is concerned with the individual's totality and perceptions of their worth. It involves a global and stable negative belief about themselves and concentrates on their deficiencies and shortcomings. Those who feel shame tend to withdraw, escape, or otherwise avoid others (Swee et al., 2021).

Table 1

Manifestations of Self-Devaluation

Schemas	Expression	Healthier Alternatives
Shame	Condemnation of self for violating a social norm	Guilt
Self-disgust	Self-disapproval with physiological features	Self-Acceptance
Perfectionism	Self-anger and intolerance of imperfection	Conscientiousness

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Those who feel guilt have some self-compassion, while those who feel shame lack this tendency. A person with guilt, for example, may believe it is only human to make mistakes, that forgiving oneself is healthy, and that it is unproductive to be consumed by negative emotions. In contrast, a person with shame is likelier to ruminate and show cognitive inflexibility (Cenker et al., 2023). Shame causes or increases the emotional burden on suicidal patients, discourages them from seeking support from others, and increases their overall risk of suicide. Patients who feel shame may have difficulty sharing their feelings with others. Even when they do enter psychotherapy, they may be less likely to disclose the behaviors that led to shame, including the shame of having suicidal thoughts (Knapp, 2023).

Self-stigma may occur as a result of shame. In addition to having shame over past behaviors, patients may also feel ashamed of having suicidal thoughts in general. Society often stigmatizes people with suicidal thoughts as weak, cowardly, or selfish (Joiner, 2010), and some suicidal persons may have internalized these beliefs. This self-punishment tends to increase the frequency of suicidal thoughts (Tucker et al., 2017) and the risk of suicide (Mayer et al., 2020). As stated by O'Connor, "When stigma increases, help-seeking declines, ignorance flourishes, and deaths soar" (2021, p. 79).

Self-Disgust versus Self-Compassion

Disgust can be adaptive because individuals want to avoid obnoxious, smelly, offensive, and potentially harmful objects or substances, such as spoiled fruit or rotten carcasses. Self-disgust is a maladaptive variant of disgust. Self-disgust is not defined consistently and could refer to an emotional state or an enduring way of thinking about oneself (Clarke et al., 2019). It overlaps with shame but involves unique physiological reactions. As one research participant stated, "I'm feeling depressed, you feel that cramp in your stomach, and it feels like I'm about to throw up or something" (Mason et al., 2021, p. 584).

Those who feel self-disgust tend to distance themselves from others (Schienle et al., 2020). Self-disgust appears to have a reciprocal relationship with self-harm, with self-disgust preceding acts of self-harm and acts of self-harm contributing to a feeling of self-disgust (Clarke et al., 2019). This finding makes sense because those who feel self-disgust and want to avoid others may easily develop perceived burdensomeness or a sense that others would be better off if they died (Mason et al., 2021).

Perfectionism versus Conscientiousness

Perfectionism is the "combination of excessively high personal standards and overly critical self-evaluation" (Curran & Hill, 2019, p. 410). Perfectionism is a maladaptive expression of conscientiousness. Being conscientious means being responsible, diligent, or careful. Perfectionism differs from conscientiousness because it involves the continual, unfair, unforgiving, and unrelenting negative evaluations of one's behavior. The standards are so high that one can never reach them. Whereas conscientiousness prompts people to reach higher levels of achievement or virtue, perfectionism may inhibit their ability to reach these goals. High standards only uplift if they are combined with self-compassion. High standards without self-compassion predispose a person to feelings of failure and inadequacy. As stated by Barcaccia et al. (2019), "The more you judge the worse you feel" (p. 33).

Perfectionism can take different forms, such as *self-oriented perfectionism* or hold-

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ing oneself to unreasonably high standards. However, *socially prescribed perfectionism*—"the tendency to believe others have high or unrealistic expectations as well as a belief that one has failed to meet these high expectations" (Moscardini et al., 2023, p. 268)—is the form of perfectionism that is most strongly linked to suicidal thoughts.

It is easy to see how socially prescribed perfectionism could impair one's relationship with others. Suppose one sees others as a source of continuing and unfair criticism. In this case, it is reasonable to believe that those with socially prescribed perfectionism are at risk of strained interactions with others and would be less likely to seek emotional support due to feeling inhibited about sharing their self-doubts, fears, or concerns.

Intervention Options

Often, patients attempt to regulate the feelings caused by self-devaluing schemas by avoiding others or through emotional suppression. Neither of these strategies is effective, and emotional suppression may even heighten negative emotions in the long run (Tucker et al., 2017). The psychotherapist's goal is to help patients develop better strategies for managing their emotions, often through cognitive reappraisals or rethinking their assumptions about themselves.

Some universal elements of good psychotherapy appear to address these harmful schemas. For example, psychotherapists who present themselves as caring and nonjudgmental may convey to patients that whatever they did—or think they did—never negates their intrinsic worth as a person. This includes the process of validation. This does not mean that the psychotherapist agrees with their patient's ideas of killing themselves but rather understands how—given their patient's life experiences and assumptions—their patient concluded that suicide should be an option for them (Schecter & Goldblatt, 2011). Of course, interventions are best when they are tailored to individual needs (Norcross & Cooper, 2021), and psychotherapists may need to tailor their interventions to address their patient's unique, harmful self-devaluing schemas.

The informed consent process can be utilized as an initial intervention strategy containing psychotherapeutic elements. This can include expressing patients' involvement in as much of the clinical decision-making as possible, relying on them as experts on their own experience, and expecting feedback from them concerning their perceptions of the nature of psychotherapy and their progress (Knapp, 2024).

Although cognitive reappraisals may occur in many forms of psychotherapy, interventions that focus on self-compassion or mindfulness appear especially appropriate for patients with self-devaluing schemas (Flett et al., 2021; Stynes et al., 2022). These may increase patients' self-acceptance and psychological flexibility and reduce their isolation from others. Some elements of self-compassion include avoiding strong identification with any emotion, accepting that some aspects of life are universal (e.g., everyone may feel self-disgust at some point), and striving for self-forgiveness. Mindfulness-based interventions, such as compassionate mind training, mindfulness-based stress reduction, or mindfulness-based cognitive therapy, may increase psychological flexibility by helping patients identify thoughts and feelings in the present and consider alternative ways of dealing with them (Flett et al., 2021; Stynes et al., 2022).

Finally, self-devaluing schemas are intrapersonal events with interpersonal

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consequences. Reducing their negative impact may help patients become more open in their relationships with others, decrease social isolation and avoidance, and help them develop meaningful social relationships that will enrich their lives and provide a buffer against suicide attempts.

Practice Pointers

- Psychotherapists should be aware of the self-disapproving schemas (shame, self-disgust, and socially prescribed perfectionism) when treating suicidal patients.
- Shame and other self-devaluing schemas may create barriers between patients and others, including a reluctance to be open with their psychotherapists.
- Psychotherapists can reduce the impact of shame by approaching their patients with a caring, nonjudgmental, and curious attitude and using interventions that focus on self-compassion or mindfulness.

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FEATURE

Fostering Global Collaboration in Psychotherapy: Treatment of Suicidality in Adolescents with a History of Concussions

Kayela Malewitz, BA
Stephanie Bono, JD, PhD

According to the Centers for Disease Control and Prevention (CDC), suicide is the third leading cause of death among adolescents 15-19 years of age (Centers for Disease Control and Prevention, 2024a). A concussion or mild traumatic brain injury (mTBI) is a risk factor for suicide in adolescents as this type of injury can increase depressive symptoms, which is a significant risk factor for attempting and completing suicide (Chrisman et al., 2021; Kay et al., 2023; McCory et al., 2013; Miller et al., 2021). According to the CDC, the current definition of a concussion is, "a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move rapidly back and forth" (Centers for Disease Control and Prevention, 2024b, para. 1). As previously mentioned, concussions can increase suicidality due to an increased likelihood of experiencing depression (Awan et al., 2021), which could be related to isolating from peers because of said concussion (Broscheck et al., 2015 as cited in Chrisman et al., 2021). As a result, it is imperative for clinicians to screen for depression after a client experiences a concussion. When treating adolescents with a presenting concern of suicidality or suicide attempts who have a concussion history, intervention approaches, such as dialectical behavior therapy (DBT) and neurocognitive rehabilitation, are more beneficial during treatment (Adrian et al., 2019; Collins et al., 2023; Tracey et al., 2023).

High school students who have had at least one concussion are shown to be at higher risk of suicide and suicidal ideation compared to peers who have not experienced a concussion (Kay et al., 2023). This could be due to an increase in depressive symptoms and feelings of hopelessness among this particular population of adolescents. Additionally, having multiple concussions is related to increased mental health problems, such as depression, anxiety, and suicide attempts. Other stressors, such as missing class and not being able to play the sport they participate in, may also contribute to the subsequent mental health problems following a concussion (Brosheck et al., 2015, as cited in Chrisman & Richardson, 2013). Specifically, those with a concussion history are over three times more likely to have depression than their non-concussed peers and the depression is more likely to linger over time, which can be an additional risk factor for future suicide attempts (Awan et al., 2021; Hellewell et al., 2020). Because of this, it is recommended there be a screening process for depression when an adolescent is in treatment for a concussion, no matter the setting they're in (Chrisman & Richardson, 2013). This way, based on the results of the screening, they can be referred to a

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therapist to address and treat any symptoms of depression they are endorsing (Master et al., 2024; O'Neil et al., 2024).

As for the treatment of suicidal ideation and attempts in adolescents with concussions, research shows that DBT and neurocognitive rehabilitation are the best courses of treatment (Adrian et al., 2019; Collins et al., 2023; Tracey et al., 2023). DBT is a type of psychotherapy that utilizes acceptance of one's experiences and circumstances and then helps the client to learn ways to change their behaviors. This can include regulating emotions and finding ways to decrease engagement in dysfunctional behaviors by utilizing coping skills (American Psychological Association, 2018a). Because of its emphasis on skills training, DBT can help adolescents regulate their emotions and cope with the symptoms of depression and feelings of hopelessness that may be present (Berk et al., 2024). There is also research suggesting that those using maladaptive coping strategies do not recover as well as those who use effective coping strategies following a concussion (Sandel et al., 2017). If one was participating in a sport, this may have been the coping strategy they utilized prior to their concussion, eliminating a once effective coping mechanism and leaving a gap in their coping skillset. Therefore, varied and effective coping strategies to combat mental health issues are paramount during the time after the injury because a lack of healthy coping strategies could lead to increased engagement in maladaptive behaviors (Sandel et al., 2017). After completing a meta-analysis regarding the treatment of suicidal ideation in adolescents, Berk et al. (2024), found that those treated with DBT were more likely to continue progressing in treatment compared to other individual or group therapy modalities.

One treatment that has been promising for those with a history of suicidal ideation and concussions is neurocognitive rehabilitation. Neurocognitive rehabilitation or cognitive rehabilitation therapy (CRT) "focuses on restoring cognitive function through interventions or tools designed to improve memory, focus, and other cognitive skills" (National Academies, 2022, p. 116). In a meta-analysis completed by Tracey et al. (2023), they found this treatment to be more beneficial than other therapies, such as cognitive behavioral therapy (CBT) and acceptance and commitment therapy (ACT), for improving mental health symptoms after a concussion. In the meta-analysis, mindfulness-based stress reduction (MBSR) was used as a treatment intervention for mental health symptoms post-concussion, which is classified as a form of CRT. One reason mindfulness may work for those with mental health issues after a concussion is that it helps one focus on the present moment (American Psychological Association, 2018b; Sandel et al., 2017). For example, a student may experience increased stress after a concussion due to missing class or missing out on their sport, which can contribute to depressive symptoms (Brosheck et al., 2015, as cited in Chrisman & Richardson, 2013). MBSR can help with these negative feelings and stress as it teaches one to focus on the present moment. Therefore, it can help the student focus on what they can control instead of worrying about grades, their sport, or ruminations about the past and wondering what they could have done differently to not have sustained the concussion in the first place. By focusing on the present moment, they may be less impulsive, experience a decrease in depressive symptoms and, therefore, be at a lower risk for suicidal ideation and suicide attempts.

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Key Takeaways

1. Concussions can increase suicidality in adolescents.
2. Screen for depression when an adolescent comes into any sort of treatment for a concussion, whether that be from a medical doctor, psychologist, or therapist.
3. Utilize dialectical behavior therapy and/or cognitive rehabilitation therapy, like mindfulness-based stress reduction when treating suicidality and depression in adolescents who have a history of concussions.

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Society for the Advancement of Psychotherapy

"The Breakers Breaking. The Seagulls Squawking"

Pat DeLeon, PhD, MPH, JD

During the Closing Hours of 2024: The last time the Republican Party (GOP) controlled the Senate, House, and Presidency was from January 20, 2017 to January 3, 2019, during which time Donald Trump was President of the United States having being inaugurated on January 20, 2017. With this historical context in mind, the 118th Congress struggled with their ***Appropriations*** decisions for the coming year. Although it was not ultimately adopted, the initially crafted bipartisan Continuing Resolution (CR) provided a glimpse into the thinking of several of the authorization committees. Whether these provisions will ultimately become public law is yet to be determined. Nevertheless, there was clear evidence of the growing recognition by both parties in Congress of the applicability and benefits of telehealth care. For example, included in the proposals were express authorities for Expanding Telehealth Services for Federally Qualified Health Centers and Rural Health Clinics with the costs associated with the furnishing of these services to be considered allowable costs for the purposes of the prospective payment system. Delaying the In-person Requirements Under Medicare for Mental Health Services Furnished Through Telehealth and Telecommunications Technology; and, Allowing for the Furnishing of Audio-Only Telehealth Services. Also included was authority for Extending the Use of Telehealth to Conduct Face-to-Face Encounters Prior to Recertification of Eligibility for Hospice Care.

Also in the proffered CR was a provision, which another committee proposed, for the establishment of an Older Americans Tribal Advisory Committee—"In addition to other methods of government-to-government consultation between the Administration and Indian Tribes and conferring with organizations representing Native Hawaiians, the Assistant Secretary shall establish an advisory committee, to be known as the 'Older Americans Tribal Advisory Committee' to provide advice and guidance… on matters relating to the needs of older individuals who are Native Americans and implementation of related programs and activities under this Act." This new Committee would be composed of 11 voting, non-Federal members, including geographically diverse individuals with expertise on the range of issues affecting Indian Tribes, organizations representing Native Hawaiians, and older individuals who are Native Americans. Not less than one Alaskan Native and one Native Hawaiian would be appointed to the Committee.

On December 23, 2024, President Biden signed the Servicemember Quality of Life Improvement and National Defense ***Authorization*** Act for FY 2025. This was the 64th consecutive year in which the Defense authorization legislation was signed into public law, notwithstanding bipartisan concerns expressed after the Speaker of the House of Representatives included a particularly controversial provision after the conferees had come to an agreement. Although the authorization legislation did not include any specific

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provisions that would appear to be directly targeted towards the behavioral/mental health professions, there were a number of relevant issues which were addressed in the final conference report.

For example, in exploring Psychological Performance Training for high-stress environments, the conferees noted: "We understand that long-term exposure to high-stress environments can leave servicemembers in suboptimal performance states—possibly leading to compromised performance abilities and negative behaviors. The Air Force trains on the development of proactive psychological performance skills and strategies for psychological flexibility and mental strengths. We recognize potential benefits to training to develop and maintain psychological performance skills and mental resilience. We, therefore, direct the Secretary of the Air Force to provide a briefing, not later than April 1, 2025, to the Committees on Armed Services of the Senate and the House of Representatives on the following: (1) Efforts conducted previously or currently at Air Force Global Strike Command and Air Force Air Mobility Command to train airmen in psychological health and performance; (2) Outcomes of such training efforts – to include any relevant airmen feedback; (3) Costs associated with providing such training services; (4) Efforts, if any, to budget and plan for expanding psychological performance skill training; and (5) Any other relevant matters that the Secretary determines appropriate."

The conference agreement further included a provision which would require the Secretary of Defense to monitor access standards for specialty behavioral health care. And, in the event that the Secretary determines that behavioral health care access in a state does not meet or exceed prescribed access standards for more than 12 consecutive months, the Secretary would be required to expand health care accreditation standards in that state to include credentials issued by state-level organizations. Although the conferees did not include a House proposed provision that would have required the Secretaries of the military departments to review and certify suicide prevention policies each year as well as update online contact information, they did expressly note that the conference report for the previous year directed the Secretary of Defense to review publicized information on suicide prevention and behavioral health and to provide a briefing, not later than June 1, 2025, to the Committees on the results of such review.

Impressively, the conferees also noted that in August, 2022, the Armed Services Committees had received a report from the Department that "demonstrated consistent high quality of perinatal health care services in the direct care component of the military health system. According to the report, the pregnancy-related mortality ratio in such component was 2.91 deaths per 100,000 live births as compared to 23.80 deaths per 100,000 live births in civilian hospitals. Furthermore, we note that the military health system collaborates with external organizations, such as the Leapfrog Group, to adopt leading practices to decrease maternal mortality further."

Pleasant Reflections: Over the years, one of the most impressive *interprofessional* training and clinical initiatives that we have seen, has been the Medical-Legal Partnership for Children in Hawaii (MLPC-HI) directed by Dina Shek. As APA CEO Arthur Evans steadily moves organized psychology towards systematically embracing a population-based, public health orientation, Dina's underlying vision captures the essence of a comprehensive and

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truly holistic, patient (client-) oriented health system aggressively addressing the psychosocial-cultural elements of quality health care.

Highlights of Dina's annual report: "We are pleased to share some year-end highlights from an exciting 2024 at the MLPC-HI, a project of the University of Hawaii's William S. Richardson School of Law (WSRSL). As we take this moment of reflection and gratitude, we also brace ourselves for more hard work to come. We invite you to join us and support the team as we enter 2025 committed to realizing our core values by centering racial justice, acting collaboratively, and uplifting community power.

"We launched a new MLPC-HI site with the Kapi'olani Medical Center for Women and Children, Hawaii's only pediatric specialty hospital! Our staff attorney Ashley Kaono (WSRSL '20) is embedded with the hospital social work team, and together they have already maintained critical benefits, improved housing conditions, and reduced hospital stays for children with disabilities. The University of Hawaii *News* featured our celebration. We completed our 15th year of partnership with our anchor site at Kokua Kalihi Valley (KKV), now staffed by our staff attorney Fernando Cosio (WSRSL '18). To date, we have handled about 2,000 legal case matters at KKV, supporting housing, financial, and family stability. We also support public housing residents, Micronesian communities, and other migrant/immigrant communities through extensive systemic advocacy work. [Earlier, when Mary Wakefield arranged for KKV CEO David Derauf to attend a special Obama Administration White House event, Dina reflected that they were truly having a national impact.]

"Our Community & Policy Advocate Philios Uruman organized and led our staff and law students in Micronesian community advocacy work including Maui outreach for Micronesian survivors of the Lahaina wildfires; co-hosting a COFA [Compacts of Free Association] Benefits Update Town Hall with the Hawai'i Coalition for Immigrant Rights that featured Meghan O'Connor from the Office of Senator Mazie Hirono (D-HI); and meeting with His Excellency Wesley W. Simina (WSRSL '88), President of the Federated States of Micronesia. Deja Ostrowski (WSRSL '10) was elevated to Managing Attorney with support from a new Medical-Legal Partnership Plus federal grant program. With the support of Aimee Grace, Director of the UH Office of Strategic Health Initiatives, we were one of eight grantees selected for this national grant and in February we hosted a site visit with the Director of the Office of Community Services under the Administration For Families & Children, HHS.

"Personally, I recently co-authored an essay in the *Yale Law Journal Forum* titled 'Bind Us Together: Coalition Public Policy Advocacy in Medical-legal Partnerships' Our team also collaborated with a University of Hawaii librarian to publish an article in the *Journal of Law, Medicine & Ethics* titled 'Quantifying 'Community Power' and 'Racial Justice' in the Medical-Legal Partnership Literature' which was published online earlier this year.

"As we head into the new year, our MLPC-HI team remains committed to ensuring a safe and just future for all. Rebecca Solnit reminds us in the moment. 'Remember what you love. Remember what loves you. Remember in this tide of hate what love is. The pain you feel is because of what you love.' We are so grateful to all of you for your partnership and support of our work. Many thanks and Happy Holidays!" [For in-

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formation regarding Dina's MLPC-HI program, see:
[https://law.hawaii.edu/academics/medical-legal-partnership/]
and for information about the MLP national organization see:
[https://medical-legalpartnership.org].

Steady Maturation: The waves heralding steady movement away from our traditional symptom-oriented, individual patient/silo-based health care system continue to expand, as constantly urged by the National Academy of Medicine and other health policy think tanks. What is envisioned at the conceptual level is a considerably broader and more comprehensive approach which takes into account historical structural racial, economic, and environmental barriers, that unfortunately have led to demonstrable and highly significant Health Disparities. From the warm beaches of Hawaii and its Medical-Legal Partnership for Children to the rugged coasts of Maine, the growing signs of change are evident. In October, Maine Psychological Association CEO Randy Moser urged his membership to attend their annual convention and "Explore how integrating behavioral health and primary care can revolutionize treatment for rural communities. Hear from national experts like Arthur C. Evans and Maine's own Diana Prescott as they share cutting-edge strategies for addressing mental health and substance use disorders, tailored specifically for rural populations. Don't miss this chance to learn how integrated care can improve patient outcomes and build healthier communities!" "To the seaside, whoa-oh. By the beautiful sea" (From *Sweeney Todd*)."

Aloha,
Pat DeLeon, former APA President – Division 29 – January, 2025

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Rayna D. Markin, PhD

I am honored to be nominated for President-Elect of the Society for the Advancement of Psychotherapy. Over my 10 plus years serving on the board of this division, I had the privilege of serving as the Early Career Psychologist (ECP) Chair, ECP Domain Representative, and Education and Training Chair. In these roles, I planned and organized various mentoring programs and events, chaired or participated in numerous committees, reviewed award proposals, contributed articles to the *Psychotherapy Bulletin*, and planned and hosted an on-line video series for the Division's website, consisting of interviews with experts on how to apply psychotherapy relationship research to training and supervision. I was fortunate to receive both the Charles J. Gelso Psychotherapy Research Grant and the APF/Division 29 ECP Award.

I have been intricately involved with the journal *Psychotherapy* for almost twenty years, first serving as a reviewer, then an editorial board member, and finally in my current role as associate editor. Because of my varied experiences with the journal, I believe I am in a good position to support its continued success.

As a psychotherapy clinician and researcher, I have developed a relational-attachment psychotherapy approach to treating the psychological effects of pregnancy loss and other reproductive traumas, as highlighted in my recent book, *Psychotherapy for Pregnancy Loss: Applying Relationship Science to Clinical Practice* and APA live therapy demonstration video, *Pregnancy Loss*. With students and colleagues, I have published over 40 articles, books, or book chapters on psychotherapy for pregnancy loss and on the therapy relationship more broadly.

If elected president, I would see my role primarily as supportive of other members, board members, and committee chairs ideas and initiatives. My experience as a board member of this division was largely about building relationships with friends and colleagues. As president, I would focus on maintaining and strengthening relationships within the division, collaborating together to work toward the goal of promoting psychotherapy research, practice, and training. I would also use this role as a platform for education and training on psychotherapy for pregnancy loss and other related reproductive traumas, an area of increasing importance and relevance and for which there is little training and resources. Thank you for considering me for this position. ■

Patricia Spangler

I am deeply honored to be a candidate for President of APA Division 29/ Society for the Advancement of Psychotherapy. I am a research psychologist with the Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc., and a research assistant professor at Uniformed Services University as well as a licensed psychologist with a small private practice.

Division 29 has been a professional home since I joined as a graduate student, and I strongly believe in our mission of advancing the science, teaching, and prac-

Candidate Statements for President-elect continued on page 88

tice of psychotherapy. I have served in SAP governance since 2014, first as a Professional Practice committee member and, since 2020, as Domain Representative for Science and Scholarship. As Domain Representative I have administered the Norine Johnson Grant and Charles J. Gelso Grant, worked to increase grant funding for Division 29 researchers, reviewed abstracts for Division 29 presentations for the APA convention, written articles for *Psychotherapy Bulletin,* and supported the initiatives of previous SAP presidents.

As I write this in February 2025, the national political and societal tumult has brought uncertainty and fear about our future as researchers, as practitioners, and as teachers. Now, more than ever, we need the society of colleagues to exchange scientific knowledge, provide support for one another, and strive to maintain the excellence of the resources we offer. If elected, I would focus my presidential initiative on maintaining and promoting resources such as our journal *Psychotherapy*, our website, and our growing variety of continuing education courses. I would promote efforts to increase membership by continuing the efforts of recent presidents to prioritize national and international outreach and expand the public face of the society. Finally, in the current climate, I believe Division 29 must serve a vital role by continuing its longstanding support of diversity, equity, and inclusion in research, practice, and teaching. ■

Joel Jin, PhD

I am honored to be considered for the Early Career Domain Representative position. As a clinician, educator, and researcher, I am committed to advancing the field of psychology through innovative training, culturally responsive care, and evidence-based practice.

Currently, I serve as an Acting Assistant Professor and Behavioral Health Consultant at the University of Washington School of Medicine, where I provide integrated behavioral health services and teach family medicine residents. Previously, as an Assistant Professor at Seattle Pacific University, I taught skill-based clinical psychology courses, mentored graduate students in research, and helped produce six peer-reviewed journal articles and over 20 conference presentations. My scholarship focuses on deliberate practice in psychotherapy training and adapting psychological interventions for chronic pain among ethnic minority populations.

Beyond academia, I have contributed to the field through my writing, including co-authoring *Deliberate Practice in Multicultural Therapy* (APA, 2023) and leading publications on anti-racist psychology and spiritual competencies in clinical practice.

If elected, I will advocate for early career psychologists by promoting professional development opportunities, supporting mentorship initiatives, and fostering inclusive spaces for interdisciplinary collaboration. I believe our field thrives when we engage in intentional practice, continuous learning, and community-driven growth.

I appreciate your consideration and would be grateful for your support. ■

Yujia Lei

I am deeply honored and humbled to be nominated once again for the Early Career Psychologist (ECP) Domain Representative position for APA Division 29. Over the past six years, I have served as a staff psychologist at the Center for Counseling & Psychological Services at Washington University in St. Louis, where I specialize in supporting diverse college students, particularly those from historically marginalized and international backgrounds. As a first-generation immigrant woman, I am committed to integrating multiculturalism and social justice into psychotherapy. Beyond clinical work, my passion extends to culturally informed supervision, teaching, training, and research in both the U.S. and China. Grounded in the scientist-practitioner model, my research explores the role of cultural values in psychotherapy processes and outcomes, as well as the development of culturally responsive interventions to advance mental health equity.

Serving as the ECP representative has been both a privilege and a deeply meaningful experience. During my first

Domain Representative for Early Career, continued on page 90

term, I formed a dedicated ECP committee that met regularly and successfully organized multiple high-impact events each year. These included panels on private practice development, suicide risk assessment, family planning for psychologists, and *Gab with Greats* discussions on critical topics related to multiculturalism and diversity.

If re-elected, I will continue advocating for ECP representation within Division 29's leadership while strengthening connections among ECPs and the broader division membership. I am committed to fostering opportunities for mentorship, networking, professional development, advocacy, and grant support. Additionally, I will work to enhance collaboration in psychotherapy research and practice, ensuring that Division 29 remains a vital resource for ECPs at every stage of their professional journey. I would be truly honored to continue serving in this role and contributing to a strong, supportive community for early-career psychologists in Division 29. ■

CANDIDATE STATEMENTS
Domain Representative For Science and Scholarship

Jamie Bedics

My name is Jamie Bedics, and I am a Professor and Director in the Graduate School of Psychology at California Lutheran University in Thousand Oaks, CA. I am a licensed clinical psychologist and board-certified in Behavioral and Cognitive Psychology by the American Board of Professional Psychology. I teach courses in statistics, exploratory data analysis and visualization using R, dialectical behavior therapy, clinical behavioral methods, and suicide assessment and risk management.

Over the years, I have had the privilege of contributing to Division 29 as a member, program reviewer, grant reviewer, and most recently, as program co-chair for the convention. Additionally, I have served as a reviewer and associate editor for *Psychotherapy*.

I am honored to be on the ballot for the Science and Scholarship Domain Representative. As a past recipient of the Gelso Grant awarded by Division 29, I greatly value the division's role in supporting research and scholarship that advances the scientific study of psychotherapy. Psychotherapy research is one of the most complex fields of scientific investigation. Addressing its intricate statistical and methodological challenges while ensuring findings remain pragmatic, clinically relevant, and culturally sensitive requires both rigor and humility. In addition to what we study, I believe it is equally important to consider how we conduct our research. Considering this, I am a strong proponent of open science initiatives to improve transparency, replicability, and integrity in psychotherapy research. Thank you for your consideration for this position. ■

Wilson Trusty, PhD

I am honored to be considered for Division 29's Science and Scholarship domain representative position. I am a licensed psychologist and research psychologist at Penn State's Center for Collegiate Mental Health, which is an international practice-research network of university counseling centers. I have been involved in the Division since the beginning of my psychology career, including being awarded the Gelso psychotherapy research grant and publishing in the Division's journal and bulletin. I am thrilled at the possibility of contributing to the Division's mission in a domain representative capacity.

I believe a central function of psychotherapy science and scholarship is to advocate for the needs of clients/patients, clinicians, clinical systems, and those involved in training. My priorities as domain representative would be to (1) encourage members to submit applications for the Division's grants on topics that are responsive to current sociocultural and other contextual factors, (2) leverage psychotherapy research to advocate for public policies that serve the needs of key stakeholders, and (3) disseminate psychotherapy research findings to pro-

Domain Representative for Science and Scholarship, continued on page 92

fessionals and the public. I would accomplish these objectives through actions such as tailoring calls for grant submissions to emphasize timely issues (broadly defined) in psychotherapy, inviting Division members to lend expertise in crafting and disseminating accessible summaries of research findings that can contribute to informed public dialog on mental health treatment, and collaborating with other domains (e.g., Social Justice and Public Policy) to identify ways to use psychotherapy research in public advocacy efforts.

Thank you for your consideration! ■

CANDIDATE STATEMENTS

Domain Representative For Diversity

Michelle Joaquin, PsyD

As a proud Latina cisgender Dominican psychologist, I happily announce my candidacy for the Diversity Domain Representative at the American Psychological Association (APA). My journey has been profoundly shaped by my background, and I have witnessed the impact of diversity and inclusion on mental health and well-being.

I completed a trauma psychology specialization internship at the University of Southern California's Children's Hospital and underwent a year of postdoctoral training in trauma psychology at USC. I was an APA Division 29 Advocacy and Mentoring Program for Diversity (AMPD) scholar and I served two years as an Early Career Committee Chair. I co-facilitated Crawford Bias Reduction Theory and Training (CBRT) groups and organized an APA symposium on "Addressing Microaggressions and Racist Comments in Psychotherapy." And I facilitated Diversity Equity and Inclusion (DEI) faculty process groups at Yale University and currently run my own psychotherapy practice in California and New York.

As your Diversity Domain Representative, I would work tirelessly to foster collaboration, understanding, and respect within the division. I aim to enhance access to mental health resources, support diversity training events, and create mentorship opportunities for emerging psychologists. This is especially crucial in our current political climate that threatens to dismantle diversity, equity, and inclusion initiatives. Together, we can build a psychological community that values diversity as a strength. I invite you to join me in this important mission to promote a culture of inclusion, empowerment, and equity in our field. Thank you for your support! ■

Wonjin Sim

I am deeply honored to be nominated as the Diversity Domain Representative of Division 29. I am an associate professor and program director at Towson University and maintain a private practice specializing in the mental health of immigrants and Asian Americans. My research centers on multicultural counseling and making psychotherapy more accessible for Asian Americans, immigrants, and international students. Within Division 29, I have served as the Diversity Committee Chair since 2022 and held multiple leadership roles in Division 17. My time on the Division 29 board has deepened my appreciation for the dedication and collaboration of its talented members, all working toward advancing psychotherapy practice, research, and training. The meaningful interactions I've had with many Division 29 members have reinforced my commitment to this incredible community.

If elected, I will leverage my clinical and scholarly expertise, along with my experience as the Diversity Committee Chair to foster a more inclusive and supportive professional community. I am eager to

Domain Representative for Diversity, continued on page 94

strengthen and expand Division 29's mentorship and training programs, such as the Advocacy and Mentoring for Diversity (AMPD) program, which provides crucial support for minority students. Furthermore, I hope to collaborate with the Social Justice and Professional Practice Domains to develop practical resources, including comprehensive toolkits and create ongoing supportive spaces such as virtual conversation hours for members with marginalized identities and those working with diverse clients. I also aim to partner with the Membership Domain to enhance diversity within Division 29 and its board.

Thank you for your consideration. ■

CANDIDATE STATEMENTS

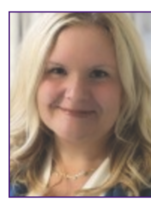
Domain Representative For Council

Jean M. Birbilis, PhD, LP, BCB

I'm honored to have been approved by the SAP Board to run for one of our two Council Representative positions. In 2023, when I served as the president of the Society for the Advancement of Psychotherapy, I focused on improving the communication among Board members and between the Board and membership, including formalizing the orientation process for new Board members that Tracey Martin designed and conducts, reconfiguring the Publications and Communications Committee and initiating revisions and updates of all SAP publications and communications under the leadership of Dr. Amy Ellis, and formalizing the process for proposing and offering CEs with the guidance and contributions of Dr. Melissa Jones. I continued the efforts of the previous SAP president (Dr. Clara Hill) to strengthen connections with SEPI and SPR. I proposed and created the foundation for an SAP archive, which I continue to work on with the assistance of Tracey Martin and Simone Droge.

Those efforts have paid off in enhanced communication and benefits for SAP members. Meanwhile, I watched and learned about the importance of our relationship with APA as Division 29 through our two Council Reps during my presidential year, Dr. Libby Williams and Dr. Jeff Younggren. I would appreciate having the opportunity to continue the process of SAP being part of the governance of APA and of increasing the influence of psychotherapy practice, research, and education on the mission and vision of APA. Thank you for reading my statement; I would appreciate your support. ■

Melissa Goates Jones



I am honored to be considered for the Society for the Advancement of Psychotherapy (SAP; Div 29) representative for the APA Council of Representatives. I graduated with my PhD in Counseling Psychology from the University of Maryland and have spent 20 years working in private practice, DEI consulting, and teaching. Currently, I am an Associate Professor of Psychology and Associate Director of Clinical Training of the Clinical Psychology doctoral program at Brigham Young University, where I also serve on our Faculty Advisory Council, Department Diversity Committee, and the Global Women's Studies Executive Committee—roles that reflect my dedication to leadership, advocacy, and inclusion.

My current work focuses on three core areas (1) using psychology and social justice to center anti-racism, diversity, equity, and inclusion in workplaces, (2) training and supervising ethical and competent psychotherapists, and (3) conducting and supporting research surrounding the inclusion of sexual and gender minorities in institutions of higher learning.

Within Division 29, I have served on the Education and Training Committee and later as its chair, as well as a member of the 2021 Presidential Task Force. In each of

Domain Representative for Council, continued on page 96

these roles, my focus has been on enhancing organizational efficiency while advancing SAP's mission—preserving and expanding psychotherapy, strengthening the evidence base for psychotherapy and therapeutic relationships, and ensuring that its benefits are accessible to all.

I commit to bringing my advocacy and leadership skills to fearlessly initiate and advocate for council business that will support the present values of the Society for the Advancement of Psychotherapy. ■

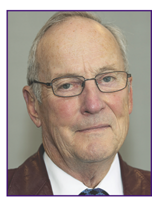
Elizabeth Nutt Williams, PhD

I would be honored to continue as your Council Representative. I have been active in Council, including being a mover of a recent new business item that Division 29 unanimously endorsed. There is more to do, and I would like to serve the Division for another three years. I believe it is critical that we continue to have a strong voice for psychotherapy practice, research, and advocacy at Council.

I have worked with Division 29 governance for over 20 years, first as the Early Career representative to the Board of Directors in 2005, then as the Membership Domain Representative (2008-2010), and as President of the Division in 2011. I received my bachelor's degree in psychology from Stanford University and my doctorate in Counseling Psychology from the University of Maryland. I have been a professor for 28 years. I am a Fellow of the APA (Divisions 2, 17, 29, and 35), have served on several editorial boards (e.g., Psychotherapy, Psychotherapy Research), and study both the science and practice of psychotherapy.

Why should you vote for me? I care deeply about the Society. I have consistently focused on highlighting the effectiveness of psychotherapy, strengthening the link between psychotherapy science and practice, promoting our commitment to diversity, and advocating on behalf of the profession. I am invested in collaborative, solution-oriented processes. I will continue to work to ensure that our members' voices are heard within APA and that APA remains a strong membership organization. Thank you so much for your consideration. ■

Jeffrey N. Younggren, PhD, ABPP



If elected to another term on the APA Council of Representatives I will continue to work on two primary issues among others. First, I will continue to advocate for the return of APA's identity as a membership-controlled organization consistent with its charter. APA has gradually moved away from a focus on membership control to one where staff and administration decide the direction of the association with very little input from membership. This needs to change. Second, I will focus on fiscal responsibility and the need for APA to address the serious problems it is facing with negative budgets. APA needs to return to a balanced budget and stop excessive spending of reserves to balance the budget. Of course, I will also support policies that further focus on the value of psychotherapy and emphasize the importance of this to leadership I hope you will support me in this by returning me to Council for another 3 years. ■

2025 CHARLES J. GELSO PSYCHOTHERAPY RESEARCH GRANT

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

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

Submission Deadline: May 1, 2025

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

Description
The program for 2025 will award one grant for a research project in the area of psychotherapy process and/or outcome.

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

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

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

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Evaluation Criteria

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

Requirements Components for All Proposals

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

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

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

Additional Information

- After the project is complete, a full accounting of the project's income and expenses must be submitted within six months of completion.
- Grant recipients are expected to write a brief article on their project for SAP's Psychotherapy Bulletin within 2 years of receiving funding.
- Grant funds that are not spent on the project within two years must be returned.

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- When the resulting research is published, the grant must be acknowledged.
- All individuals who directly receive funds from SAP will be required to complete an IRS W-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31)

Submission Process and Deadline

- All materials must be submitted electronically.
- All applicants must complete the grant application form, in MSWord or other text format.
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file.
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email).
- All required materials for proposal should be submitted to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received; please resubmit.
- Deadline: May 1, 2025

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

2025 NORINE JOHNSON PSYCHOTHERAPY RESEARCH GRANT FOR EARLY CAREER PSYCHOLOGISTS

Brief Statement about the Grant:
The Norine Johnson, Ph.D., Psychotherapy Research Grant, offered annually by the Society for the Advancement of Psychotherapy to Early Career Psychologists (within 10 years post earning the doctoral degree), provides $15,000 toward the advancement of research on psychotherapy. All aspects of psychotherapy research can be supported, including the psychotherapy relationship, psychotherapy process, or psychotherapy outcomes.

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

Submission Deadline: May 1, 2025

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

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

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

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

Eligibility Requirements
- Early Career (within 10 years post earning the doctoral degree), Doctoral-level researchers
- Demonstrated competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The selection committee may elect to award the grant to the same individual or research team up to two consecutive years
- The selection committee may choose not to award the grant if no suitable nominations are received

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

Evaluation Criteria

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

Requirements Components for All Proposals

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

Additional Information

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

Submission Process and Deadline

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

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- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received. Please resubmit.
- Deadline: May 1, 2025

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

Society For The Advancement Of Psychotherapy

THE ONLY APA DIVISION SOLELY DEDICATED TO ADVANCING PSYCHOTHERAPY

Society for the Advancement of Psychotherapy

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

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

Name ____ Degree ____________________

Address ____

City ____ State ________ ZIP________________

Phone __________________________________ FAX __________________________________

Email ____

If APA member, please provide membership #

Member Type: ❑ Regular ❑ Fellow ❑ Associate

❑ Non-APA Psychologist Affiliate ❑ Student ($29)

❑ Check ❑ Visa ❑ MasterCard

Card # ____ Exp Date _____/_____

Signature ____

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

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

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

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PSYCHOTHERAPY BULLETIN

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

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

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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.

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We'd love to hear from you!