

# Psychotherapy

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Deadline for nominations is  
December 15, 2024.*



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Advancement  
of Psychotherapy

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Tony Rousmaniere, PsyD  
Sentio Counseling Center  
3756 W. Avenue 40, Suite K, #478  
Los Angeles, CA 90065  
206-384-8058  
trousmaniere@sentioacc.org

#### President-Elect

Stewart Cooper, PhD  
7750 W. Desert Spirits Drive  
Tucson AZ 85743-7521  
219-242-4508  
stewart.cooper@valpo.edu

#### Secretary

Astrea Greig, PsyD, 2024-2026  
Cambridge Health Alliance  
Dept of Psychiatry  
1493 Cambridge St.  
Cambridge MA 02139  
agreig@challiance.org

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Joshua Swift, PhD, 2022-2024  
Department of Psychology  
Idaho State University  
921 S. 8th Ave, Stop 8112  
Pocatello, ID 83201  
208-282-3445  
joshua.keith.swift@gmail.com

#### Past President

Jean M. Birbilis, PhD  
University of St. Thomas  
1000 LaSalle Ave., MOH 217  
Minneapolis, Minnesota 55403  
651-962-4654  
jmbirbilis@stthomas.edu



### Domain Representatives

#### Public Interest and Social Justice

Andrés E. Pérez-Rojas, PhD, 2024-2026  
Indiana University School of Education  
201 N. Rose Avenue  
Bloomington, IN 47405-1006  
812-856-8547  
perezrae@iu.edu

#### Psychotherapy Practice

Barbara Vivino, PhD, 2022-2024  
921 The Alameda #109  
Berkeley, CA 94707  
510-303-6650  
bvivino@aol.com

#### Education and Training

Cheri Marmarosh, PhD, 2022-2024  
The George Washington University  
Professional Psychology  
Washington DC 90008  
301-728-0410  
marmaros@gwu.edu

#### Membership

Rebecca Ametrano, PhD, 2022-2024  
Office of Patient Centered Care  
VA Boston Healthcare System  
1400 VFW Parkway  
West Roxbury, MA 02132  
rametrano@gmail.com

#### Early Career

Yujia Lei, PhD, 2023-2025  
Center for Counseling &  
Psychological Services  
Washington University in St Louis  
One Brookings Drive, MSC 1201-323-100  
St. Louis, MO 63130-4899  
Office: 314-935-59551  
leiyujia@wustl.edu

#### Science and Scholarship

Patricia Spangler, PhD, 2023-2025  
Center for the Study of Traumatic Stress  
Department of Psychiatry  
Uniformed Services University  
Henry M. Jackson Foundation

*continued next column*

#### Science and Scholarship continued

6720 Rockledge Drive, Suite 550  
Bethesda, MD 20817  
240-620-4076  
patricia.spangler.CTR@usuhs.edu

#### Diversity

Susan Woodhouse, PhD, 2023-2025  
Department of Education and Human  
Services Lehigh University  
111 Research Drive  
Bethlehem, PA 18015  
610-758-3269  
Woodhouse@lehigh.edu

#### Diversity

Sheeva Mostoufi, PhD, 2022-2024  
Old Town Psychology  
1216 King Street, Suite 200  
Alexandria, VA 22314  
sheeva.mostoufi@oldtownpsychology.com

#### International Affairs

Xu Li, PhD, 2024-2026  
University of Wisconsin-Milwaukee  
789 Enderis Hall  
2400 E Hartford Ave, Milwaukee, WI 53211  
lixu.bnu@gmail.com; li342@uwm.edu

### APA Council Representative

Elizabeth Nutt Williams, PhD, 2023-2025  
enwilliams@smcm.edu

Jeffrey Younggren, PhD 2023-2025  
jyounggren@salud.unm.edu

### Student Representative

Krizia Wearing 2023-2025  
Chestnut Hill College  
Dept. of Professional Psychology  
9601 Germantown Avenue  
Philadelphia, PA 19118  
215-248-7000  
wearingk@chc.edu

## 2024 STANDING COMMITTEES

### Continuing Education

Chair: Ken Critchfield, Ph.D.  
kenneth.critchfield@yu.edu

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Chair: Wonjin Sim, Ph.D.  
wsim0930@gmail.com

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Chair: Michelle Joaquin  
michjoaquin@gmail.com

### Education & Training

Chair: Melissa Jones  
melissa\_jones@byu.edu

### Fellows

Chair: James Lichtenberg  
jlicht@ku.edu

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carlyschwartzmanphd@gmail.com

### International Affairs

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duanc@ku.edu  
Co-Chair: Dana Tzur Bitan

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nmorrison@westfield.ma.edu

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koocher@gmail.com

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jbedics@callutheran.edu  
Associate Chair : Alice Coyne, PhD

### Psychotherapy Practice

Genee Jackson, PhD  
gendeja@gmail.com

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Chair: Harold Chui, PhD  
haroldchui@CUHK.EDU.HK

### Social Justice

Chair: Linda Campbell, PhD  
lcampbel@uga.edu

**PSYCHOTHERAPY BULLETIN**

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**SOCIETY FOR  
THE ADVANCEMENT  
OF PSYCHOTHERAPY**  
American Psychological Association

6557 E. Riverdale  
Mesa, AZ 85215  
602-363-9211  
e-mail: [assnmgmt1@cox.net](mailto:assnmgmt1@cox.net)

**EDITOR**

Zoe Ross-Nash, PsyD  
[editor@societyforpsychotherapy.org](mailto:editor@societyforpsychotherapy.org)

**CONTRIBUTING EDITORS**

**Diversity**

Sheeva Mostoufi, PhD and  
Susan Woodhouse, PhD

**Education and Training**

Cheri Marmarosh, PhD and  
Melissa Jones, PhD

**Ethics in Psychotherapy**

Jeffrey E. Barnett, Psy.D. ABPP

**Psychotherapy Practice**

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**Student feature**

Krizia Wearing

**Editorial Assistants**

Kate Axford, MS and  
Sree Sinha

**STAFF**

**Central Office**

Tracey Martin  
6557 E. Riverdale St.  
Mesa, AZ. 85215  
Ofc: 602-363-9211  
[assnmgmt1@cox.net](mailto:assnmgmt1@cox.net)

**Website**

[www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org)

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Stewart Cooper, PhD, ABPP

### APA's Population Health Model and Psychology Becoming a Multi-Tiered Profession: The Emerging Opportunity for the Society for the Advancement of Psychotherapy



The Society for the Advancement of Psychotherapy (SAP) is a leading organization dedicated to the enhancement of psychotherapy practice, research, and education. Our mission is to promote mental health and well-being by supporting the professional development of psychotherapists and advancing the science of psychotherapy. Aligned with our mission, the fourth of my four 2025 Presidential Initiatives is for SAP to function as the authoritative voice in advancing psychotherapy science, practice, education, and application. There are two major movements occurring with the American Psychological Association (APA) whose confluence will produce an opportunity (and need) from Division 29. The first of the two is APA's significant buy in to advocating for and using a population health approach. The second is APA's efforts to becoming a multi-tiered profession. Having a contextual understanding of both of these is helpful for understanding the emerging opportunity for SAP.

#### Background on APA's Population Health Model:

"In most countries, physical and mental health frameworks are built around a traditional medical model which focuses on acute care for individuals. This provider-intensive approach contributes to treatment gaps resulting from an imbalance between need for services and availability of those services (Carbonell et al., 2020). A population health approach can help relieve treatment gaps and address population health needs." (APA, 2024).

The document can be viewed at <https://www.apa.org/international/networks/global-psychology-alliance/population-health>.

"Population health focuses on improving the health, health equity, safety, and well-being of entire populations, including individuals within those populations. This approach involves a multidisciplinary science base from psychology, sociology, cultural anthropology, medicine, economics, education, and other disciplines. Population health aims to address the cultural, economic, systemic, historical, environmental, relational, and occupational contexts that influence health status, well-being, and functioning across the lifespan. Its ultimate goal is to foster equitable human flourishing" (APA, 2024). Adopted from Psychology's Role in Advancing Population Health <https://www.apa.org/about/policy/population-health-statement.pdf>. This synthesis document is available in several other languages.

The Global Psychological Alliance, of which APA is a major partner, is the author of a concise synthesis article entitled "How does psychology fit within a population health framework?" The article contrasts the population health model with the traditional individual health approach and makes a strong case for the need for transformation. The piece also presents other helpful concepts and recommendations. This synopsis of the public health approach is available at <https://www.apa.org/international/networks/global-psychology-alliance/population-health-statement.pdf>

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### **Background on APA's efforts to becoming a multi-tiered profession:**

APA has been considering the role of individuals with master's degrees in the psychology profession for over 75 years. However, up until the last few years relatively little attention has been paid toward this issue. In fact, there has been significant opposition toward considering any level of training besides the doctoral degree, despite there being a number of states with master's trained health services providers. Today, 20 states either have or will have some type of license for master's in psychology trained individuals. Note that the titles and scope of practice of this group of master's psychology trained providers has and does vary greatly, something which both APA and ASPPB want to remedy. Note also that school psychology masters and Ed.S. trained professionals who worked in school settings are already accepted within APA as exceptions to the doctoral restriction.

In December of 2023, the Board of Professional Affairs (BPA) and Committee for the Advancement of Professional Practice (CAPP) Master's Workgroup produced a position paper on this topic. A decision was made to table further action or discussion at that time.\* The topic was revisited a few years later. Since that time "APA has had numerous work groups, task forces, and convenings about clinical, counseling, and school psychology—collectively known as health service psychology or HSP. In the last 5 to 6 years, general agreement has been reached on understanding the profession as multi-tiered—i.e., there is value in a unified vision that includes individuals with doctoral *and* master's degrees. In 2018, the APA Council of Representatives voted to accredit master's degree programs in health service psychology. Since then, many APA governance groups, including the Board of

Educational Affairs (BEA) and BPA have been considering what it means for psychology to become multi-tiered. BPA and BEA are in the process of developing two proposals that will be brought before the APA Council of Representatives in February 2025" (email, APA Board of Professional Affairs, 2024).

The following is a summary of APA deliberations and actions related to recognition of master's level HSPs and is taken directly from the initial draft of the Competency Framework for Master and Doctoral Degree Education and Training in Health Service Psychology developed by BPA.

- 2017: APA Council of Representatives voted to consider options for master's degree training and/or practice acknowledging current issues and developments had risen to a level that necessitated action.
- 2018: APA Council voted to proceed with accreditation of master's degree programs in HSP.
- 018: BEA Blueprint Taskforce produced a report, accepted by the Council, outlining APA accreditation plan for master's degree programs in HSP.
- 2019: The APA's Board of Educational Affairs (BEA) and Board of Professional Affairs (BPA) jointly formed a task force to delineate competencies for students completing master's degree programs in Health Service Psychology and to distinguish from individuals completing doctoral degree programs.
- 019: APA CoA began work to establish standards for accreditation of master's degree HSP programs.
- 2020: APA's Board of Directors and Council of Representatives held fo-

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cused conversations on the future of psychology practice and education.

- 2021: Master's Competencies Task Force recommended that BEA and BPA establish a separate task force to update existing APA approved Education guidelines on doctoral degree competencies which was hoped would facilitate completion of master's degree competencies.
- 2021: BEA and BPA jointly formed Task Forces to update the master's and doctoral degree competencies with the expectation that doing so would then help delineate the differences between HSP competencies for doctoral degree and master's degree students.
- 2021: APA convened an Assembly on the Value/Distinctiveness of the Doctoral Degree in Health Service Psychology.
- 2021: BPA formed a work group to recommend an appropriate master's scope of practice and title in HSP to inform upcoming updates to the APA Model Licensure Act.
- 2023: BPA received report from 2021 Master's Title and Scope Work Group.
- 2024: BEA and BPA considered the work of the Doctoral HSP Competencies Task Force.
- 2024: BPA formed APA Model Licensure Act (MLA) Work Group to begin revising and updating MLA.

### **The Emerging Opportunity for the Society for the Advancement of Psychotherapy:**

APA's endorsement and embracing of a population health approach along with its moving toward a multi-tiered profession will provide significant opportunity for and need from the SAP. Even

today, there are thousands of graduates from master's in HSP psychology-related programs each year compared to a far smaller number of doctoral level graduates. Psychotherapy will be the central skill not only for doctoral level HSP providers but also for master's level and, at a basic level, to bachelor's level and peer mental health support providers. A Presidential Task Force is focused on master's and doctoral HSP competencies, titling, and scope of practice has been formed and is active. They (Andres Perez-Rojas, Libby Williams, and James Lichtenberg) submitted a comment for SAP on the Competency Framework for Master and Doctoral Degree Education and Training in Health Service Psychology developed by BPA.

I welcome your input and ideas regarding this opportunity, i.e., what emphasis would like to see SAP take on, what support should be provided to the new members we will likely get, what advocacy positions should we take, what roles are you interested in, providing input to the Presidential workgroup, etc. Your voice is important and I value hearing from you. Please email me at [stewart.cooper@valpo.edu](mailto:stewart.cooper@valpo.edu)

President-Elect,  
Stewart Cooper

### **References**

- American Psychological Association (2024). *Population health*. Retrieved at <https://www.apa.org/international/networks/global-psychology-alliance/population-health>
- American Psychological Association (2024). *Psychology's role in advancing population Health* (PDF, 150KB).
- American Psychological Association (2024). APA Population health topic page. <https://www.apa.org/topics/population-health>

*continued on page 5*

Dodge, K. A., Prinstein, M. J., Evans, A. C., Ahuvia, I. L., Alvarez, K., Beidas, R. S., Brown, A. J., Cuijpers, P., Denton, E.-g., Hoagwood, K. E., Johnson, C., Kazdin, A. E., McDanal, R., Metzger, I. W., Rowley, S. N., Schleider, J., & Shaw, D. S. (2024). Population mental health science: Guiding principles and initial agenda. *American*

*Psychologist*, 79(6), 805–823.  
<https://doi.org/10.1037/amp0001334>  
Global Psychological Alliance (2024). *How does psychology fit within a population health framework?* Retrieved at: <https://www.apa.org/international/networks/global-psychology-alliance/population-health-statement.pdf>).



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## FALL EDITOR'S COLUMN

Zoe Ross-Nash, PsyD



Welcome to the Fall Bulletin, SAP

My oh my, what a quarter it has been for the Electronic Communications team. For the last year, we have been working on upgrading the website with Website Design Specialist, TJ Slade. It was quite the task! The previous website was established for a decade and housed over 44,000 lines of codes, news links, and articles for the division. The website not only acts as a publication, but also as a time capsule for all the amazing work our members have showcased.

While it was no small feat to transfer all our content to a new platform, I want to apologize for any inconvenience the merger may have caused. Our website was inactive for the last two weeks of August. Fortunately, due to our incredible Central Office Team Member, Tracey Martin, we had access to everything we needed, even in the absence of the website. She is truly the backbone of the division. Additionally, a special thank you to our Associate Editor, Lacy Sohn, for

navigating submissions even when our portal was inactive, and our Website Editor, Sarah Bondy, for learning how to code on a brand new website. That being said, our website is well on the way to being completely finished. Please submit any concerns, comments, or compliments at the purple banner on the top of the [website](#).

This quarter's *Psychotherapy Bulletin* has a special feature related to suicide prevention and assessment, as September was suicide prevention month. We also have great articles related to clinical work and the therapeutic process.

With three months left of the year, I invite you to take part in our monthly call for submissions if you have not already. On the first of each month, I send out the monthly topic via the listserv. If you're a planner like me, you can view 2024's monthly topics below. As always, you are welcome to submit an article outside these topics whenever you wish. Click [here](#) to write for us!

Thanks for reading!

Zoe Ross-Nash

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



## PSYCHOTHERAPY PROCESS

### Psychotherapy Practice—The Means of Addressing Negative Emotions Experienced During Psychiatric Treatment: Insights from a Psychotherapeutic Process

*Sanyukta Golaya, M.A.*



In the socio-cultural context I find myself embedded in, reaching out for support and seeking mental health services is a courageous first step. However, an aspect of receiving support that tends to take up less space in discussions pertains to issues that many individuals may encounter during the course of psychiatric treatment itself.

I have firsthand experience with the many barriers that exist in psychiatric treatment after receiving a bipolar II diagnosis nearly seven years ago and having gone through the incredibly frustrating process of learning the most effective treatment and medication regime. The frustration did not stem from the stigma I experienced, but moreso from the rigorous process of finding the appropriate medication. While studies have investigated the phenomenon of non-adherence to psychiatric medications, there is limited research on medication adherence throughout the process of discovering the most efficient dose and brand of medication for each individual (Semahegn et al., 2020). Rottman and colleagues (2016) proposed that when an individual starts taking medication, they begin to analyze the causal effects it has, particularly in terms of its perceived effectiveness. In my experience, when beneficial effects were not observed early on, a sense of distress and spiraling negative emotions overwhelmed me. Psychotherapy can and should play an impactful role during this phase of treatment by helping the indi-

vidual explore and process the feelings of frustration, anger, despair, and hopelessness that are often present. This article seeks to elaborate on how psychotherapy served as a way to help me cope with each of these emotions and may in turn serve as an important reminder for practitioners to support patients who are experiencing similar issues.

According to Dollard and colleagues (1939), frustration is “an interference with the occurrence of an instigated goal-response at its proper time in the behaviour sequence” (p. 7). Further, the frustration-aggression hypothesis proposes that anger can also be an associated emotion that results from the frustration experienced at certain goals being blocked or deemed unachievable (Miller, 1941). Frustration as a state tends to be experienced when there is an intent to gratify or obtain access to a state that is desired; therefore, without intent or an inherent expectation, there can be no frustration (Dollard et al., 1939). During the process of seeking psychiatric treatment, my initial goal was to escape from my symptoms and achieve gratification in the form of relief, respite, and a return to a premorbid state of functioning. When this goal was perceived as unachievable due to an ineffective dosage or combination of medications, it often resulted in feelings of increased frustration and anger expressed through crying spells, irritated behaviour, and a reduced desire to comply with psychiatric treatment. It was through psychotherapy that I learned to modify and reframe my individual treatment goals, which was

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immensely helpful to overcome the state of frustration-aggression that I was experiencing. My initial thought transformed from, “medication is not helping me feel better” to “I am doing everything I can to help myself feel better.” This shift in perspective effectively decreased my sense of frustration as it allowed me to concentrate on behaviours that were in my control; such as, complying with psychotherapeutic treatment, adhering to medication instructions, and voicing any concerns that presented to my treatment team. I was no longer focused on being cured after realizing the value of the recovery process. As a result, I experienced an enhanced sense of autonomy and control over my journey.

In addition to feelings of frustration and aggression, I was plagued by a sense of hopelessness. Hopelessness refers to a state of being in which the individual experiences a loss of the expectation that outcomes will improve (Abramson et al., 1993). Research highlights that feelings of hopelessness are often compounded by a sense of despair where the person feels helpless to cure the self of deep emotional pain and suffering (Jeanne, 2015). In my experience with therapy, when results were not felt as I expected, there was a great sense of hopelessness and despair in my treatment journey. I convinced myself that regardless of the attempts made or the various combinations of medications I tried, my condition was doomed to remain in a static state. This was further compounded by knowing that bipolar II disorder tends to be a chronic illness with a poor prognosis (Tundo et al., 2013). Consequently, my feelings of hopelessness and despair reached to the point where I made an attempt on my life due to the belief that I would never improve or feel better. I ultimately overcame this ideation after receiving an incredible amount of support from my family and by pushing myself to persist in treatment.

Through psychotherapy, I discovered important insights that allowed me to tackle and eventually deal with the feelings of hopelessness and despair that were often present. The first insight pertained to challenging my primary cognitive distortion of predicting the future. I realized that no matter how hard I tried, I could not guarantee that any combination of medications would help with my condition, at least not before trying all of them. Instead of believing that my condition would never get better, I was led to believe that I was absolutely on the right track to figuring out which medications would eventually work well for me. The second thing that proved insightful was my therapist’s strengths-based approach. This allowed me to focus on my strengths and gave me the ability to regulate my emotions and functioning, regardless of the medication I was using. This approach was empowering as it served to highlight my strengths and reduced my perceived dependency on pharmacotherapeutic intervention. This is an important aspect to psychiatric intervention, as research demonstrates that psychotherapeutic treatments promoting medication adherence can be particularly useful for states of mania and hypomania, while cognitive coping strategies have a more pronounced benefit when it comes to depressive episodes (Miklowitz, 2008). An amalgamation of challenging faulty cognitions, adopting a perspective where I focused on the small wins and not just failures, and taking a comprehensive overview of my role in the situation helped me address the blocks and sense of hopelessness and despair I encountered.

While it is a well-established fact that psychotherapy is often a crucial aspect of treatment for a mental illness combined with psychiatric intervention, sometimes psychotherapeutic services may be required to overcome barriers

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and distress associated with psychiatric interventions themselves (Gabbard, 2009). Through the use of various cognitive and strength-based approaches, I was able to work on and process my frustration and hopelessness associated with having to try combinations of medications to keep my symptoms under control. The process, even though distressing at times, is a crucial aspect of learning how to live with and manage a chronic psychiatric illness.

The issues discussed above need to be further addressed in the field of research and should be highlighted as a legitimate concern that patients may often go through, so that more evidence-based interventions may be formulated and used for the same purpose. In terms of implications for practitioners, this article seeks to shed light on and open up a dialogue about the negative emotions that individuals may experience whilst engaging in psychiatric treatment for mental health disorders. In the case of chronic mental illness, it is essential for individuals to comply with treatment and when the process of using medication is perceived as distressing, this may result in non-adherence. Practitioners may benefit from discussing this potential obstacle with patients and to be prepared to implement techniques and interventions to support patients experiencing this type of distress. Furthermore, addressing such an issue can also help challenge the myth that pharmacotherapy is unhelpful for mental health disorders as this may be believed by various individuals, including patients (Kishore et al., 2011). This has the potential to have a profoundly positive impact on psychiatrists, mental health professionals, psychotherapists, and patients themselves.

## References

Abramson, L. Y., Metalsky, G. I., & Alloy, L. B. (1993). Hopelessness. In C. G. Costello (Ed.) *Symptoms of De-*

*pression* (pp. 181–205). John Wiley & Sons.  
Dollard, J., Doob, L., Miller, N., Mowrer, O., & Sears, R. (1939). *Frustration and aggression*. Yale University Press.

Gabbard, G. O. (2009). Psychotherapy in psychiatry. *International Review of Psychiatry*, 19(1), 5–12. <https://doi.org/10.1080/09540260601080813>

Jeanne, B. (2015). From hopelessness to despair. In S. Akhtar & M. K. O'Neil (Eds.), *Hopelessness-Developmental, Cultural, and Clinical Realms* (pp. 139–152). Routledge. <https://doi.org/10.4324/9780429475573>

Kishore, J., Gupta, A., Jiloha, R., & Bantman, P. (2011). Myths, beliefs and perceptions about mental disorders and health-seeking behavior in Delhi, India. *Indian Journal of Psychiatry*, 53(4), 324–329. <https://doi.org/10.4103/0019-5545.91906>

Miklowitz, D. J. (2008). Adjunctive psychotherapy for bipolar disorder: State of the evidence. *The American Journal of Psychiatry*, 165(11), 1408–1419. <https://doi.org/10.1176/appi.ajp.2008.08040488>

Miller, N. E. (1941). The frustration-aggression hypothesis. *Psychological Review*, 48(4), 337–342. <https://doi.org/10.1037/h0055861>

Rottman, B. M., Marcum, Z. A., Thorpe, C. T., & Gellad, W. F. (2016). Medication adherence as a learning process: Insights from cognitive psychology. *Health Psychology Review*, 11(1), 17–32. <https://doi.org/10.1080/17437199.2016.1240624>

Semahegn, A., Torpey, K., Manu, A., Assefa, N., Tesfaye, G., & Ankomah, A. (2020). Psychotropic medication non-adherence and its associated factors among patients with major psychiatric disorders: A systematic review and meta-analysis. *Systematic Reviews*, 9(17), 1274–1283. <https://doi.org/10.1186/s13643-020-1274-3>

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F., Dell'Osso, L., Proietti, L., & Filippis, R. D. (2013). Continuous circular cycling in bipolar disorder as a predictor of poor outcome. *Journal of*

*Affective Disorders*, 150(3), 823–828.  
<https://doi.org/10.1016/j.jad.2013.03.006>



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# PSYCHOTHERAPY PROCESS

## International Affairs—What to Expect When Therapying: Understanding Change Process Expectations

*Dana Elberg, M.A.*

*Pragya Sharma, Ph.D*

*Javier Fernández-Álvarez, Ph.D*

*Agostino Brugnera, Ph.D*



When patients walk into the first therapeutic session, meet their therapist for the first time, and sit (perhaps comfortably, perhaps uncomfortably) on the sofa, we would say therapy has begun. But did the therapy actually begin even before this moment? With their thoughts about their therapy, their fears about how it will be, their expectations of what will happen?



The concept of treatment expectations refers to what the patient anticipates will happen during therapy. For instance, a patient may expect a certain behavior from the therapist (role expectations), a certain length of the treatment (duration expectations) or might expect to experience something specific during therapy (process expectations; Constantino et al., 2011). Patients might also expect a specific process to take place during therapy in order for the treatment to achieve its goals (change process expectations). Surprisingly, to date, research assessing change process expectations effects is understudied. It clearly indicates a need for more research to bridge the gap between clinical work and empirical research.



Change process expectations deal with the question, when a patient enters the therapy room, what do they expect to happen that will likely result in a beneficial change? Consider this clinical encounter as an example: a teenage girl arrives for an intake meeting in the outpatient unit because she feels outcasted and depressed. During meetings with her parents, they repeatedly stated their expectation that the therapist will provide them with practical tools to help their daughter. However, the therapist saw the importance of creating a relationship and building trust as the most crucial part of therapy. These gaps could have been bridged, but after a few meetings they decided to end the therapy, maybe due to the therapist's lack of ability to meet their expectations.



In another clinical encounter, a patient with emotionally unstable relations, dependent behaviors, and an ongoing eating disorder expresses her desire to engage in therapy in order to “have a place to share her experience without judgment of friends or my parents” After a few months it was apparent that she has made some progress in therapy and even expressed satisfaction, but what has the therapist done that met her expectations? Did she indeed feel that she had a place to share her experiences without judgment? What processes made her feel that she was moving in the right direction and which processes made her feel that something was off?

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To allow an in-depth investigation of these processes, a self-report tool, named the Expectations of Active Processes in Psychotherapy Scale (EAPPS), was recently developed to tap into potential therapeutic change processes. The items in the EAPPS were derived from measures of change mechanisms previously described in the literature, such as the working alliance (Horvath & Greenberg, 1989), transference interpretations (Bøgwald et al., 1999), and measures of active participation (O'Malley et al., 1983). It asks to rate different sentences which describe potential processes of change, such as "Learn from emotions," "Understand therapist's feelings towards me," "Cope with stresses" etc. The factor analysis, which was performed to identify the most common factors, found seven ingredients: establishment of positive therapist-patient relations, verbal processing of therapist-patient relations, exploration of unexpressed contents, the ability to share sensitive contents openly and secretly, working through specific emotional problems, therapy fosters resilience, and therapy provides tools for cognitive control (Tzur Bitan et al., 2018).

How can these factors be interpreted and transformed into real-life clinical experiences? Well, it is apparent that the parents of the teenager who was struggling with feelings of alienation expected therapy to include the provision of specific tools, such as helping their daughter reconstruct her automatic thoughts, or view reality in a slightly more positive way. On the other hand, the therapist may have believed it would be more beneficial to form a therapeutic bond, listen to unconscious contents, or explore transference processes through her projected emotions. Clearly, the parents and the therapist had significant gaps in what they expected to be beneficial at this stage of therapy. In-

deed, gaps in change process expectations are common in psychotherapy. For example, in a dyadic study exploring patients and their therapists during the first three months of therapy, patients and their own therapists differed in what they perceived as the therapeutic change process. As therapy was initiated, patients expected therapy to focus on providing cognitive tools, whereas their therapists perceive the mechanism of change to be the verbal processing patient-therapist relationship. Surprisingly, three months into therapy, change process expectations did not change, and patients and their therapists continued to show the same gaps regarding the expected therapeutic process (Tzur Bitan et al., 2021).

What are the implications of such gaps between patients and therapists? Patients entering therapy for the first time in their life, expecting to receive tools to handle stress, might be very surprised if the therapist will inquire about their emotions towards them. Patients can feel embarrassed, surprised, or even intruded upon. They might think - "Why do I need to speak about my feelings towards the therapist? How will it help me?" Therapists, in turn, may feel that their interventions are inadequate or may even try to find ways to repair the therapeutic bond or make more sense of their intervention. Especially in the first stages of therapy, these gaps can influence a patient's willingness to stay in therapy, and in some cases, even lead to patients dropout, as demonstrated in the clinical example above.

Having said that, gaps are not always detrimental to the therapeutic process and outcome. For example, studies demonstrate that when a therapist rates the bond with the patient lower than the patient, the therapy process can be more

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successful (Marmarosh & Kivlighan Jr., 2012). This phenomenon, previously explained as a ‘better safe than sorry’ effect, suggests that the therapist takes a safer approach in perceiving the therapeutic bond to maintain vigilance and alertness towards changes in the alliance (Atzil-Slonim et al., 2015). In this context, one might ask: what are the effects in gaps in change process expectations? are these gaps beneficial or harmful to the therapeutic process and outcome?

In a recent study, patients and therapists rated their change process expectations at baseline, while patients rated their psychological distress at baseline and three months into therapy. The results revealed different effects of change process expectations and distress level. For example, patients’ expectation that therapy will focus on sharing sensitive contents openly and securely was related to an improvement in patients’ distress, whereas the expectation that therapy will focus on the exploration of unexpressed contents showed the opposite effect. Moreover, improvement was reported when patients rated the sharing of sensitive contents openly and securely higher than their therapists (Brugnera et al., 2024). These findings suggest, somewhat like in alliance congruence, that gaps in therapy perceptions are not always associated with negative outcomes.

Another interesting question related to change process expectations is how they are formed. One potential way to form expectations about the therapeutic change process is through the media and how therapy is portrayed in movies and TV series (Orchowski et al., 2006). For example, some cinema portrayals in Eastern countries may include blurred patient-therapist boundaries or overemphasis on therapist self-disclosure (Menon, 2024), which might lead to pa-

tients’ expectations to such change processes. Expectations about therapy can also be created or influenced by an individual’s own experience as a patient. For example, people might learn about the therapeutic change through the interventions of therapists. Alternatively, expectations can be co-generated by both the patient and the therapist. According to such possibility, therapists may come with preconceived notions about the mechanism of change but may revise and revert to other mechanisms as they learn about the patient’s thoughts and wishes. Similarly, patients might not learn what therapy is about, but rather create their own expectations about therapy with the therapist. In other words, change process expectations may be dynamic and evolve as the therapeutic endeavor progresses, with both patients and therapists constantly modulating and changing their views of the right process at each stage of the therapy. These intriguing sources remain to be investigated in future research.

It is also important to understand the cultural influences affecting therapy process expectations of both the patient and the therapist. Western cultures tend to emphasize individualism and self-exploration, which might lead to the expectation to discuss and work on the patient’s goals and wishes. The therapist might also expect a collaborative process of working mutually on these goals with certain responsibility being taken by the patient. However, many Eastern cultures tend to place more focus on collectivism. In such cultures, patients may look up to the therapist as a guide (Ma, 2000) or as a savior, who will direct their life decisions and tell them what to do (Reddy, 1988). Furthermore, patient expectations might include the anticipation that therapy will incorporate their roles and responsibilities towards their

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family and community. In such cases, the patient may expect the therapist to think collectively and not just about themselves. Therapist expectations might also differ in such cultural contexts, either through their identification with cultural norms, or alternatively through their attunement with the patient's perspectives.

Beyond the Western/Eastern cleavage that influences therapy expectations, there are numerous factors, such as societal norms, cultural beliefs, prevailing attitudes, and the stigma associated with seeking psychotherapy that vary depending on the predominant theoretical approach. For instance, in cities like New York, Paris, or Buenos Aires, the psychoanalytic approach not only predominates but is also intertwined with intellectual pursuits that are highly regarded rather than stigmatized. These cultural contexts not only shape how therapy is perceived and sought but also influence the expectations patients and therapists bring to the therapeutic process. In such cities, for example, it might be more expected that patients and therapists will perceive the therapy as exploration of unconscious contents, rather than other mechanisms of change.

Clearly, there is much to be learned about how individuals perceive the therapeutic process, and how it affects their expectations. The studies performed thus far suggest that patients' and therapists' change process expectations have clinical relevance and are likely to inform the therapeutic process. In our view, therapists should be aware of patient's perceptions of the therapeutic process, what they expect will transpire during therapy, what process would be attuned to their expectations and what processes will not. Furthermore, therapists might need to be aware of cultural and social influences such as cinema-based stereotypical pro-

totypes, discuss their influence within therapy, and aim to provide accurate information to their patients (Orchowski et al., 2006). Recognizing and respecting these cultural variations can enhance therapeutic rapport and outcomes, ensuring that treatment is both respectful and relevant to the patient's cultural context. Many questions remain to be addressed by a scientific exploration, including whether therapists' expectations change from patient to patient; if therapists match their perceptions to their patient's views as time progresses; how therapists' change process expectations affect therapy outcomes, and many more. These questions may inform future clinical practice and may facilitate the improvement of psychotherapy for the benefit of our patients.

## References

- Atzil-Slonim, D., Bar-Kalifa, E., Rafaeli, E., Lutz, W., Rubel, J., Schiefele, A. K., & Peri, T. (2015). Therapeutic bond judgments: Congruence and incongruence. *Journal of Consulting and Clinical Psychology, 83*(4), 773-784.  
<https://doi.org/10.1037/ccp0000015>
- Bøgwald, K.-P., Høglend, P., & Sørbye, Ø. (1999). Measurement of transference interpretations. *The Journal of Psychotherapy Practice and Research, 8*(4), 264-273.
- Brugnera, A., Constantino, M. J., Grossman-Giron, A., Ben David, T., & Tzur Bitan, D. (2024). Patient and therapist change process expectations: Independent and dyadic associations with psychotherapy outcomes. *Psychotherapy Res, 1-10*.<https://doi.org/10.1080/10503307.2024.2328302>
- Constantino, M. J., Arnkoff, D. B., Glass, C. R., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. *Journal of Clinical Psychology, 67*(2), 184-192 <https://doi.org/10.1002/jclp.20754>

*continued on page 15*

- 
- Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*(2), 223. <https://doi.org/http://dx.doi.org/10.1037/0022-0167.36.2.223>
- Ma, J. L. C. (2000). Treatment expectations and treatment experience of Chinese families towards family therapy: Appraisal of a common belief. *Journal of Family Therapy, 22*(3), 296-307. <https://doi.org/10.1111/1467-6427.00153>
- Marmarosh, C. L., & Kivlighan Jr, D. M. (2012). Relationships among client and counselor agreement about the working alliance, session evaluations, and change in client symptoms using response surface analysis. *Journal of Counseling Psychology, 59*(3), 352. <https://doi.org/http://doi-org.ezproxy.haifa.ac.il/10.1037/a0028907>
- Menon, A. M. (2024). Representation of therapy and therapists in Indian Movies and TV Series: An examination of accuracy, influence, and perception. *Indian Journal of Mass Communication and Journalism (IJMCJ), 3*(4), 13-19. <https://doi.org/10.54105/ijmcj.D1075.03040624>
- O'Malley, S. S., Suh, C. S., & Strupp, H. H. (1983). The Vanderbilt Psychotherapy Process Scale: A report on the scale development and a process-outcome study. *Journal of Consulting and Clinical Psychology, 51*(4), 581. <http://dx.doi.org/10.1037/0022-006X.51.4.581>
- Orchowski, L. M., Spickard, B. A., & McNamara, J. R. (2006). Cinema and the valuing of psychotherapy: Implications for clinical practice. *Professional Psychology: Research and Practice, 37*(5), 506-514. <https://doi.org/10.1037/0735-7028.37.5.506>
- Reddy, K. R. (1988). Cultural beliefs and expectations of the patients: A consideration of the customer's viewpoint. *Indian Journal of Psychological Medicine, 11*(2), 93-100. <https://doi.org/10.1177/09751564198802>
- Tzur Bitan, D., Ben David, T., Moshe-Cohen, R., & Kivity, Y. (2021). Patient-therapist congruence and incongruence of process expectations during psychotherapy. *Psychotherapy, 58*(4), 493-498. <https://doi.org/10.1037/pst0000410>
- Tzur Bitan, D., Lazar, A., & Siton, B. (2018). Development of a scale quantifying expectations regarding active processes in therapy: The Expectations of Active Processes in Psychotherapy Scale (EAPPS). *Psychiatry Research, 267*, 131-139. <https://doi.org/10.1016/j.psychres.2018.05.040>
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# PSYCHOTHERAPY PROCESS

## Psychotherapy Practice—Inside the Head of a Therapist

Richard Makover, MD



My third book on psychotherapy is *Annotated Psychotherapy, A Session by Session Look at How a Therapist Thinks*, published by Routledge, Taylor & Francis Group, 2024.

After a brief review of some fundamental principles, *Annotated Psychotherapy* employs a unique format to demonstrate how effective psychotherapy works. It uses a “script” to present session transcripts for eight different clients/patients. In each session every statement by the therapist is followed by an explanation of her thoughts and the reason for her chosen response. These annotations show the reader how the psychotherapist balances support for the therapeutic alliance with her interventions to help clients/patients reach their treatment goals. Discussion sections after each transcript and a glossary provide helpful explanatory material for the key ideas and concepts.

Why add *Annotated Psychotherapy* to the extensive library of books on psychotherapy? I believe it fills an unmet need.

Training health care providers in most specialties follows the apprentice model. Close observation of senior members of the profession provides extensive opportunities for hands-on learning. A surgeon-in-training assists at operations. An experienced physical therapist demonstrates procedures to a beginning physical therapist. A student nurse shadows the duties of a registered nurse. Medical students watch residents and attendings perform hands-on treatment.

In all these teaching opportunities, the apprentice is physically present as the care is provided, hears the expert explain the treatment as it takes place, sees first-hand what is being done as it happens, and is able to question the proficient mentor in real time. With these advantages, trainees learn from an experienced practitioner not only what to do and how to do it but when and why it is done.

The prospects for apprentice learning in behavioral health training, however, are quite different. In many programs, opportunities to discover how experienced therapists think and how they interact with their clients are often limited. Because of time constraints in a crowded curriculum, exercises, such as case discussions with supervisors, allow coverage of just a few main topics. As silent observers watching a senior therapist’s interview through a one-way glass or on video, trainees cannot access and thus appreciate the internal judgments and reasoning behind what they see happening.

Even though limited, these valuable clinical exercises allow trainees to model themselves after an admired teacher, providing examples of their style and techniques. They may pick up and store a particular approach, a turn of phrase or an effective interview technique. What these learning exercises lack, however, is the ongoing, moment-to-moment knowledge of the therapist’s internal rationale for what the observers see; in other words, they are unable to monitor the therapist’s cognitive process.

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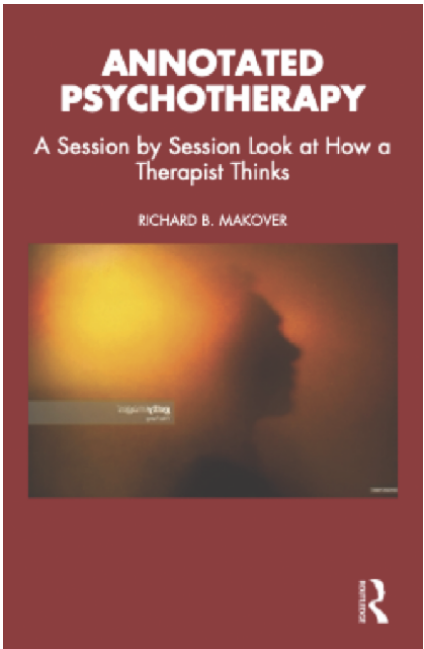
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Even with an opportunity afterwards to discuss the interview, the instructor will be able to provide only a partial and general explanation for their responses and not the detailed relevant ideas that underlie each of them. As useful as these exercises are, most training programs can only allot time for infrequent demonstrations. After graduation, even these few eyewitness opportunities are usually lost.

*Annotated Psychotherapy* attempts to offer the missing element of the therapist's

cognitive process. It documents the most detailed and instructive information about the therapist's handling of a variety of clinical cases. The therapy transcripts provide immediate commentary and allow the reader full access to the therapist's ongoing assessment and decision process. While it attempts to supplement a limitation found in some training programs, the result should be of interest to therapists at every level of experience and regardless of their professional disciplines.

*Annotated Psychotherapy* and earlier books by Richard Makover are available on Amazon and can be found on [www.richardmakover.com](http://www.richardmakover.com).



## My “Best Practices” in Psychotherapy: Part I

Steven Hendlin, PhD



As I write this, I am 75½ years old, doing psychotherapy part-time, and coming off the highest practice income month *ever* in the history of my 50-year career. I continue to find the work captivating and meaningful. As one of my graduate school professors, the renowned psychiatrist Viktor Frankl, M.D., used to remind us, “We’re all looking for meaning.” He believed it was the primary motivating force in life. I still have the paper I wrote for his seminar on Logotherapy, comparing it to Gestalt Therapy. He liked the paper and wrote positive comments on it. So, I guess for now, money and meaning triumph over retirement. Since I have a measure of life-wisdom and five decades of experience to offer, I continue to be effective with patients.

What policies, modalities, and techniques have I found most useful? In this article, I want to recommend some of my “best practices” that, once employed, were good enough for me to keep in place no matter how much time passed, social norms changed, or psychotherapeutic theories or techniques were abandoned or updated to fit the times.

Allow me to preface what follows: I understand that different patient populations and ethnicities, locations, psychotherapist personality, experience, personal preference, economic conditions, and training models may mean that what works for me may not be right for all. I had the interest and good fortune to be trained in a number of psycho-spiritual modalities that have allowed me to mix and match from a

wide basket of resources. Due to time, cost, and interest constraints, I assume that most who have been more recently trained are not necessarily going to be so motivated to explore widely from diverse theoretical orientations. Being taught by and practicing from step-by-step manuals is a very different model than the psychotherapy tools we learned during the creative heyday during the ‘60s, ‘70s and ‘80s.

What I am offering are powerful enough in their impact that I would like colleagues to at least consider these elements, if not implement them into their practice. They are powerful in the sense that they immediately get the patient interested and involved in the process of self-discovery, rather than waiting for the therapist to do the work for them. In my work, these tools help set the frame of the work and unlock new self-awareness and psychodynamic insights that may free patients to make changes in their thinking and behavior. Some of these elements are related to policies and the frame in which the work is done, and some are directly related to techniques.

### **Policies: Initial Inquiry for Services**

I require a brief phone conversation with any prospective new patient. It is not enough for someone to simply fill out a form online and be granted an initial intake consultation. I want to hear the voice of new prospects and how they frame their concerns. I want to know who referred them or how they found my name. Since I do not accept insurance payments directly, I want them to know how much they will be

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charged and make sure they can afford treatment. If desired by the person, I do provide a statement at the end of each month for those who wish to file insurance themselves.

I want to get a sense of their motivation for engaging in treatment, as well as learn whether they have previously received counseling or psychotherapy. I am not looking to get a detailed history, rather I just want to know if they have had it. All this information is obtained within a few minutes.

I purposely refrain from engaging in an extended phone conversation with prospects—no matter how anxious they sound or how much they may plead. If they are in a true emergency, I refer them to an appropriate resource. This is not only to save time but to also prevent them from mistakenly assuming I am accepting them as a patient. I keep in mind that I am putting myself in potential ethical and legal jeopardy if I become a misguided sympathetic listener, as the caller may assume that listening or giving advice on the phone means we are working together. While some colleagues may offer an initial phone consultation of 15 or more minutes at no charge, I never did this. Again, I am concerned about legal issues of responsibility and do not want to inadvertently lead the prospective patient to believe we have contracted to work together.

If a spouse or other family member is calling to make an appointment for a designated patient, I ask, “Why are you calling for your husband?” Sometimes I will be told that the designated patient is too disturbed or disabled to call for himself. In my experience, more often, however, a spouse calling is an indicator that the patient does not really want treatment but is going along with a demand of the calling spouse. Not surprisingly, in my practice, there is a higher

percentage of cancellations when this is the case. To be fair, if not given a referral by a friend or professional, some spouses like to do online research to evaluate a potential psychotherapist and then follow through with a call, in hopes of finding the best person for their spouse.

### **Intake Session and Frame**

From the psychoanalytic/psychodynamic tradition (Langs, 1981), I have made it standard practice to begin and end all sessions on time. Patients can count on my opening the door or admitting them to the Zoom screen on time. I do not begin a session even a few minutes late. While this requires a requisite ability to manage one’s time carefully and a measure of positive compulsivity, beginning and ending on time demonstrates to patients that their time is valued. It encourages them to value literally “every minute” of their expensive session time and to manage their own time carefully, either in planning to be in my consulting room or beginning the teletherapy session on time. It also allows me to keep a precise and orderly schedule. A doctor of any kind admitting a patient on time is a new experience for many, as even the relatively wealthy patients with high expectations that I typically see have been conditioned to sit in a waiting room for up to a half-hour or more before they see the doctor.

Additionally, I do not extend the session when a patient is late; they simply lose the time. Nor do I allow sessions to extend past the end time, even when patients are emotionally distraught. I charge for late cancellations and no-shows if it is not a bona-fide emergency and require a 48-hour notice for cancellations. Since the pandemic, a recent exception to this strict time limit is when there is a digital connection problem on my end, I will offer a few minutes to make up for the interruption.

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I encourage new patients to meet for the intake session in the physical office rather than using teletherapy. I have found that the interaction is deeper in the consulting room than online—not just for the intake session but for all sessions. The myriad distractions that may occur for the patient when doing online therapy are much more limited in the consulting room. I also want to see the patient’s full body, observe how they move and shift, see their eye contact, watch for any physical symptoms of anxiety, and any other non-verbal expressions that may be displayed. I ask all patients to turn off their cell phones, so they will not be distracted. I gather basic history during the session, using an intake form that covers the biographical information I want to obtain. And I do this all the old-fashioned way, with pen and paper.

Unlike many practicing psychotherapists and clinical psychologists in general, I no longer administer any inventories, checklists, or formal assessments in the first session or subsequent sessions. Everything I need to know comes from patients telling their history, my clinical questions, observations, my experience with the patient, and our interaction. I gave up doing periodic standard intelligence testing and diagnostic batteries decades ago. For some years, I periodically did what used to be called “projective testing,” where psychodynamic interpretation was required. I went so far as to focus my doctoral dissertation on using the Rorschach Ink Blots. Projective testing is no longer taught in most United States graduate or professional schools or practiced, having become a relic of an earlier era (Piotrowski, 2015). It went out of fashion in step with the psychoanalytic theory and practice from which it arose.

Fairly often, prospective patients have completed their “homework” before we

meet for the intake session by going to our website and reading about my theoretical orientation, specializations, and publication history. I tell them they can expect me to be active and that I do not just sit back and listen without much response. I tell them this because some who have never been in psychotherapy have an outdated and stereotyped notion of the psychoanalytic frame that a psychotherapist listens passively with occasional comments. I want them to know they can expect a dialogue between us, even though the focus will always be on what is of interest or concern to them, not me.

At the beginning of the intake session, I have new patients sign a Consent to Treatment form. I assure them everything they tell me is confidential, aside from the legal limits of being a danger to themselves or others and the other mandated exceptions. I hand them a printed copy of my office policies to take with them. I suggest that in the same way I must honor confidentiality and cannot tell anyone I know them without their express written and verbal permission, they should be careful what they tell anyone, including a spouse, about the contents of the session. I want patients to have the mental freedom to ponder what we discuss without having to tell anyone or solicit others’ opinions.

I invite prospective patients to ask any questions they may have as we go, as I want them to make an informed decision as to whether they think I can help them. I tell them we will not go too deeply into their concerns the first session but gather information and then together make a decision at the end as to whether we want to continue.

Unless they make it clear during the inquiry call that they only want a consul-

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tation, I do not take on anyone new who will not commit to weekly sessions, as I have found over the years that I cannot have my greatest impact with less than this frequency. I will, however, cut back with patients after a lengthy period of treatment by dropping the frequency to every other week or less when they request. If we decide to engage, I tell patients we will take a few sessions to see how it goes and then evaluate. I do not want them to feel locked into ongoing treatment when they do not know what they are signing up for. I also want to reserve the right to end the treatment if for whatever reason, I don't think I can be helpful to them or it is not a good therapeutic fit.

### **Boundaries**

I have always maintained a strict policy of not engaging in any kind of socializing with patients. I do not go to patient weddings, out for coffee, attend special occasions or funeral/memorial services. My refusal to socialize outside the office may not be initially understood but makes sense after I explain how I am bound by professional and ethical guidelines that have been put in place for a good reason. This policy extends to patients who have terminated. Since they may choose to return for further treatment in the future, I make it clear that socializing is not possible. I will accept relatively inexpensive holiday gifts from long-term patients who I know would feel offended if I refused their gift, as it is a way to thank me for my help beyond payment for services.

With a few exceptions over the years, I have refrained from engaging in any kind of bartering for services. It is too easy for there to be disappointment in weighing the exchange of my services for whatever they may be offering. In addition, it is possible with bartering for it to turn into a dual relationship, which I want to avoid, even though dual rela-

tionships are not considered unethical.

I require payment for services at the time they are rendered. Pre-COVID, this meant a check or cash was handed to me by all patients as I do not accept credit card payment. During COVID and beyond, payment has been almost one hundred percent direct bank-to-bank transfer through Zelle or a similar application, like Pay It Now. This method is not only fast and efficient for all parties but also provides a measure of privacy that cannot be matched when a third party has access to the patient's information. I should note that I am able to use these applications because I am not filing any insurance claims or doing anything online related to patient record-keeping. If you are accepting and filing insurance claims online, you should use a HIPAA compliant alternative, like Stripe.

A "best practice" is to refrain from ever allowing an outstanding balance to accumulate. It can quickly ruin the therapeutic relationship should the patient be unable to pay it off. At worst, it may result in the patient angrily terminating and then the psychotherapist having to file a complaint in small claims court. This is a waste of time and money and too often results in never receiving the balance due even when you may win the case, as you may be forced to garnish the wages of the patient in order to get paid. Ethics experts have always warned against filing a small claims case against patients for unpaid balances because it can trigger the patient retaliating with a formal complaint to the state board. That is why it is in your interest to make sure your compassion for patients does not sway you toward allowing outstanding balances to accumulate or any other behaviors that may compromise a professional relationship.

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Being firm in boundary setting has contributed to my never having had an ethics complaint filed against me by any patient over the course of my career. Now that we have identified some of my best practices related to policies, intake procedures and the initial session, let me move on to some techniques as they related to psychotherapy interaction. See part II of this article (see next page).

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### References

- Langs, R. (1981). *The technique of psychoanalytic psychotherapy. 1*. New York: Jason Aronson.
- Piotrowski, C. (2015). On the decline of projective techniques in professional psychology training. *North American Journal of Psychology, 17*(2), 259.



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## My “Best Practices” in Psychotherapy: Part II

Steven Hendlin, PhD



### Techniques: Weaving and Blending Surface and Depth

I have found it a powerful combination to utilize both pointing out and working with surface behaviors as they occur and alternatively, interpreting unconscious dynamics as appropriate. The surface—what is happening in the present as the patient presents themself—blended with making conscious what has been unconscious, may work in tandem to increase awareness of what they are doing and how they are doing it, along with how they are being influenced or even controlled by what is outside of awareness. For example, helping an adult realize how unconscious resentment toward a parent for an incident that took place years ago continues to shape his thinking and behavior toward that parent can be an illuminating insight that frees up negative emotion and cognitive rumination.

I conceptualize the work as pointing out what is on the surface and probing it to go deeper into what is outside awareness combined with examining the past and making unconscious interpretations that move depth to the surface. I focus on the process by pointing out the surface as it unfolds and content, by probing stories and details, finding their meaning.

The theoretical models deeply embedded in my work include existential-humanistic with emphasis in Gestalt Therapy, Psychodynamic, and life-long exploration of various Eastern philosophies and meditative practices. “Life-long” means going back as far as high school, when I was using mala beads

and chanting with a group in the Nichiren sect of Buddhism.

### Undervaluing Past Experiences

In the early years of practice, I noticed how many clients did not value the impact of their past experience—even traumatic experience—on their present behavior and the issues that they were presenting. They had trouble seeing any relationship between their past and present difficulties. At first, I attributed this to their lack of psychological knowledge. Later, I revised my thinking to include not only a lack of knowledge but also the resistance to accept that they could possibly be so heavily influenced by events in the past. Some clients held an overly optimistic view of their ability to purposely choose to act unencumbered by past trauma. While certain adaptive defenses blot out some of the past and may be useful in allowing the person to move forward in life and not become fixated on past negative events, this does not mean these events don’t continue to have an impact, whether they are aware of them or not. Their defenses are continuing to influence their thinking, emotional reactions, and decision-making.

By undervaluing past experiences, some individuals prefer to look for current, short-term causes to their problems and instead need to understand how their current and long-term challenges have been conditioned by earlier relationships and events. This realization of connecting their past to their present is typically an “ah-ha!” insight moment, in which they finally see why they have been unable to let go of their negative

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programs. It is said that becoming more psychologically minded by connecting past to present is one of the primary self-growth goals for everyone—not just those in treatment.

### **The Unconscious Mind**

Some patients, even those with some psychology background, do not understand or honor the power of unconscious dynamics influencing their conscious thinking and behavior. In addition, it is my belief that for many clinicians who do not receive specialized training beyond their academic classes and clinical internships, psychotherapy training no longer focuses on unconscious dynamics as it did in previous generations when its influence was more mainstream. While cognitive-behavior theory understands the importance of identifying and altering internal dialogue, it does not go far enough in helping patients understand how they may be motivated by deeper psychic forces of which they are totally unaware.

Whether it be psychological or spiritual growth, one of the best metaphors to describe this experience is that of “waking up.” Waking up from what is unconscious to the light of consciousness and waking up to parts of ourselves that transcend our ego identifications, beliefs, and the body. We wake up to a higher level of consciousness, always from the slumber of what is unknown to what is now known.

At a certain level of having awoken, we say someone is “enlightened.” Socio-cultural history provides us with numerous examples of how even enlightened beings typically continue to be dragged down by unconscious or conscious, uncontrolled aspects of themselves that are not fully integrated, and may interfere with putting their best teaching foot forward. If this were not so, we likely would not hear the far too frequent cau-

tionary stories of gurus, priests, and teachers from all religions and philosophies taking advantage of their authority or abusing their students.

As a clinician, I have come to the understanding that no one wants to believe that the motivation for their behavior may be out of their conscious awareness and control.

Because of this, it goes against the grain for some to accept the notion of an “unconscious mind.” Accepting the power of unconscious motivation is one sign during treatment that a patient is growing in their psychological self-knowledge. It may also help them understand and be more sympathetic to others’ behavior. For example, if you can accept that your sister does not necessarily remember or cannot identify her resentments from growing up together, it is easier to take the burden of blame off her today and see that she is not purposely trying to emotionally injure you. She is simply reacting to you on “auto-pilot” today as she may have long ago, and you may be doing the same with her.

One way the unconscious motivation may be revealed is through strong emotional reactions. As a “best practice,” whenever you observe a patient expressing a clearly out-of-proportion reaction, you want to ask, “Where do you think that emotion is coming from?”

For example, a woman in her 40’s tells me she sees signs of hair loss and is taking a product to address the problem. She laments, “This morning, I stared in the mirror and began crying. I looked hideous. All I see now is my hair, skin and body beginning to fall apart. I couldn’t stop crying. I felt such a strong reaction, as if someone had died.” I respond, “Yes, that’s a strong reaction.” I pause, look her in the eyes, and gently ask,

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“Who died?” She is startled by my question. Then after a half-minute of deliberation, she answers, “You know, what died is the part of me that has always felt that my body, my looks, were what I had to offer and now, I’m losing it.” This led to a productive dialogue on how she was always told by her mother that her physical beauty was her primary asset.

In working with the unconscious, I have found there are two obvious obstacles that must be confronted:

1. Patients must understand and accept that they may be motivated by events and reactions of which they are unaware
2. Have them accept the specific interpretation presented when it is totally dependent on the knowledge and ability of the psychotherapist to bridge the gap between unconscious and conscious behavior.

This requires knowing the patient’s history and defenses well enough to connect past to present. The interpretation is presented as a possibility, not as a certainty, even when I may be certain.

For example, I may say, “Do you think your unwillingness to speak to your mother for the last month may be related to your anger at her when she forgot your anniversary?” The patient makes the decision to accept or reject the interpretation. To be accepted, it must, at some point, resonate with the patient. Sometimes patients will have a knee-jerk reaction to reject, however, after allowing time for consideration and softening, they later report resonating with the suggestion I provided. Those who stay in treatment develop the ability to ask, first, “What is my motivation for my behavior?” and, later, “What may be my unconscious motivation for this decision?”

### **Working with Unconscious Interpretation**

An interpretation of the unconscious may be followed by having the patient express whatever the mental or emotional material may be. Using resentment as an example, a patient may speak to me directly as their parent or perhaps in an “empty chair” dialogue, in which they switch roles back and forth with the parent. If the patient chooses, and with sufficient preparation, they may talk to the parent directly. This is an option the patient needs to prepare and feel ready for, not something that I expect of them or push them to execute. I notice this usually takes them weeks to months before they feel ready to face a parent if they decide to go this route.

I have observed over the decades that those who choose to speak directly to their parent, sibling, friend, or lover about their current or past feelings tend to experience a more complete resolution. In my opinion, speaking directly means having an in-person meeting with the individual and the patient. It does not mean communicating by text, email, or phone. Since part of the reluctance to expressing emotion is the fear of the other’s response, I want them to see that they can face the other directly and handle whatever reaction they may receive without it having to threaten the relationship. If it is not possible to speak to the person directly because they may no longer be living or it is not safe to meet with them, I have them express their feelings to me as a substitute for the person in question.

### **Defense Mechanisms**

While the purpose of treatment is not ostensibly to teach patients psychology, in my experience, that is what indirectly takes place in the service of understanding their behavior. What is projection?

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What is rationalization? Or retroflection? A quick perusal of online lists of primary mechanisms confirms that retroflection is a defense not typically listed. But it is considered significant in Gestalt therapy. Those who have a basic understanding of various defense mechanisms are armed with an advantage to gain insight into themselves and others. Ideally, patients become curious about defense mechanisms and do some research on their own.

### **Addressing Here-and-Now Behavior**

One tool I have found effective in the early sessions and as an ongoing tool throughout treatment is pointing out something in the here and now that gives some insight into their self-presentation. I do this partly to capture their interest and show them that I can offer them something of value in the early sessions without having to know them well. I also do it because I know that in the early phase of treatment, patients are more open to my statements. The freshness of our interaction heightens their receptivity to any comments I may make. I take advantage of this novelty phase of the relationship by making observations and/or interpretations that have a higher chance of making an impact and being remembered. Examples of observations include:

- “I notice each time you mention your husband, you tighten your lips. What are you feeling when you think of him?”
- “Are you aware that you’re smiling while talking about your mother’s cancer? How does your smile relate to her disease?”
- “I see you grimacing as you tell me about your lack of sexual interest in your wife.”
- “You are avoiding eye contact with me now. What do you think makes it difficult to look at me?”
- “I notice your voice goes down when you mention your new boss. How do you feel about her?”

Having been steeped in Gestalt therapy training and practice long ago, it has become second nature for me to make comments on behavior being presented as we interact. For most patients, it is not the norm in their everyday life for someone to point out what they are seeing and hearing as it is happening. Nor is this a common tool for most psychotherapists to learn in their clinical training. But in my opinion, it is one of the most powerful and penetrating “best practice” tools a psychotherapist has available.

One way to work with what is pointed out on the surface is to ask the patient to keep doing what they are doing or even exaggerate what they are doing. This helps connect the behavior to the emotion that accompanies it. For example, “Could you tighten your lips even more? What do you feel when you tighten?” Other examples of commenting on what the patient is doing include:

- “I noticed you were just talking about your disappointment with your son and then shifted to your wife. What made you think of her right then?” Or: “What were you feeling about your son when you shifted to your wife?”
- “You are opening and closing your hand in a fist. Is there someone you’d like to hit?”
- “You keep glancing at the clock. Are you anxious for the session to end?”
- “Your voice just lowered when you mentioned your girlfriend’s handling of her finances. What would you like to say to her about it?”

One of my tasks is to discern which behaviors being displayed are deserving

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of being called out. This means I need to believe it is worth our time to focus on the surface and process because it will take the patient deeper into cognitive or emotional understanding. In essence, I use the surface as the gateway to deeper insight.

### **Truth-Telling**

Patients are paying for and deserve the truth about what I think is happening. I give my opinion sooner and more directly than many others might. This means believing that ultimately, they can handle hearing the truth, as well as believing that the truth paves the way toward greater integrity. I was told early in my graduate training by a psychoanalyst something to the effect of, “patients can handle hearing more than you think they can. Their defenses will protect them from what they aren’t ready to hear. Act as if this is true.” I have this in the back of my mind when I consider what someone is ready to hear. If I assess that they have the ego strength to handle hearing something they may not like and we have developed a level of trust, I take the slight risk to present it to them.

For those psychotherapists in the early phases of building a practice, it is easy to be overly careful about saying anything that may upset patients and make them terminate treatment, even when it may be just what the patient needs to hear. They may be focused on the threat of loss of income and may not take risks that could upset the patient. While this is a normal cautionary reaction while building a practice, it can be at odds with doing your best work through taking chances. “Best practice” is to resist the temptation to be overly careful and conservative in experimenting, keeping in mind you are bounded by good professional and ethical practice.

One truth that most psychotherapists learn along the way is that patients will

purposely and unconsciously lie to them. They will deliberately withhold or “forget” crucial pieces of information that would give a more accurate and complete clinical picture. And when asked, “Are you telling me the whole story?”, they will assure you they are, when, of course, they are not. They are lying about not lying. Sometimes they come in the next session and tell me they withheld. They fear being judged or disliked by me, which is how they are feeling about themselves. I handle the revelation of withheld information by asking, “What did you imagine would happen if you told me that?” Confronting lying may lead to a discussion about other areas and facts of their life they are lying about out of fear, shame, embarrassment, or to impress the other.

### **Asking Good Questions**

A “best practice” is to learn how to ask good questions. Good questions keep the flow of the session moving, take the dialogue deeper, and immediately get the interest of the patient. They are often met with the immediate response of, “That’s a good question.” This means, “I haven’t thought about that before and have no easy answer but see how it’s relevant to our topic.” Good questions may also take the patient deeper into connecting various elements that may not initially seem relevant. It is easier to ask good questions when you know the patient well and can connect elements yourself that the patient has not yet realized. Your questions may help them make those connections.

### **Having a Sharp Memory**

Besides an unconscious insight that brings an “aha” moment, I believe the most impressive feat from the patient’s point of view is their therapist’s ability to remember their history in detail. It shows them in no uncertain terms that

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you have listened well enough to their history to remember it accurately. It also demonstrates your ability to recall it in the moment, helping them connect past to present. If you can combine asking good questions with a sharp memory, you will gain the trust of patients, as likely, they will not be used to anyone listening to them so closely.

### **Being Comfortable with Silence**

I believe one of the skills that differentiates an experienced and skilled psychotherapist from one that is not is the ability to allow empty spaces or pauses, in the dialogue without filling them. There are crucial moments when it is important for the patient to reflect on what they or the therapist has just said. These spaces are often filled with internal dialogue, imagery, or emotion by the patient. What I call “pregnant pauses” allow room for internal reflection, rather than quickly moving on. The therapist needs to allow these spaces and understand they are necessary for the patient to have to integrate the material being discussed.

One of the values of meditative practice by the therapist is that it makes them more comfortable with these silences. Sometimes there is a natural break in the dialogue because a topic has been exhausted. I am silent during these times, comfortable in waiting for the patient to begin again when ready. One way to practice staying silent outside the consulting room is simply noticing in conversations the pauses, sitting with them, and not feeling compelled to say anything. I believe “best practice” is to resist the temptation to fill the empty spaces with words to save the patient and yourself from a moment of awkward discomfort.

### **Laughter as Connection**

Much of what transpires in the consulting room is heavy in content and serious in tone. When natural moments of lightness result in laughter, it helps connect

the patient and the therapist. I view these moments as a “meeting of the emotions,” in which we can view something as humorous and respond to it together. Pay attention to those patients who are never able to find humor in anything they say, or you may say. Sometimes, in a moment of shared humor and laughter, truisms arise that may only be acceptable if they are followed by laughter. While all psychotherapists are taught how to bracket their own emotions when accompanying the patient into the depths of pain and suffering, some are not taught how to find the meaning that is possible in a moment of shared laughter.

### **Sharing Personal Information**

Disclosure may be conditioned by one’s theoretical orientation. From the existential-humanistic perspective, some sharing of personal information by the therapist is viewed as positive to building a solid bond (Bracke, & Bugental, 2002; Mahrer, 1978). It is also in line with the “I-Thou” relationship, in which both people meet each other authentically (Katz, 1975; Kramer, 2003). I will share something personal only when it is clear to me that the patient can learn from hearing my experience by gaining a different perspective or reinforcing their own. I never share any personal problems, as I am there for the patient, not for them to hear about how I may have the same or related issue. My sharing is circumscribed to things like, “Be sure to take the train to Lake Como when you’re in Milan” or “Try Nick’s Swedish-style Light Ice Cream if you want one that is lower in sugar and tastes good.” Refrain from ever burdening patients with your own personal issues. When you work with some patients over years, it is unavoidable that they will learn certain facts of your life just from observation and inference. If in doubt, it is usually better to

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refrain from sharing any personal information that could elicit envy or negative self-evaluation by patients.

**Summary**

In summary, I have offered some of my “best practices” in psychotherapy. All of these are worthy of more in-depth attention. My intent was only to identify them with a short description and examples. My hope is that you will find them worthy of your consideration and incorporate those that are consistent with your own theoretical orientation, patient population, and style of practice.

*Steven Hendlin, Ph.D., is in independent practice in Newport Beach, California.*

**References**

Bracke, P. E., & Bugental, J. T. (2002). Existential/humanistic psychotherapy. *Comprehensive handbook of psychotherapy: Interpersonal/humanistic/existential*, 3, 255-277.

Katz, R. L. (1975). Martin Buber and Psychotherapy. *Hebrew Union College Journal*, 46, 413-431.

Kramer, K. (2003). *Martin Buber’s I and Thou: Practicing living dialogue*. New Jersey: Paulist Press.

Mahrer, A. R. (1978). *Experiencing: A humanistic theory of psychology and psychiatry*. New York: Brunner/Mazel.

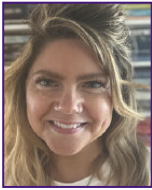


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## TRAINEE SUPPORT

### Education and Training—A First Year Doctoral Student's Introduction to Evidence-Based Practice in Psychotherapy: What I'm Taking with me Into Sessions as a New Therapist

Ahrianna Keefe, BA  
Jill D. Paquin, PhD



**Clinical Impact Statement:** This manuscript provides a synthesis of recent findings related to psychotherapy skills and methods that work, including meta-analytic findings across approaches, multicultural orientation, strengths-based approaches and positive regard, diversity considerations in using empirically supported techniques (i.e., cognitive restructuring), and gathering practice-based evidence. This manuscript provides other trainees and trainers with an example of a research-informed framework for becoming an evidence-based practitioner from the perspective of a first year counseling psychology doctoral student working closely with her mentor (a psychotherapy clinician-researcher) to help develop her approach. This paper provides a synthesis and analysis of recent articles reviewing psychotherapy research from the perspective of a first-year counseling psychology doctoral student about to begin practicum. Specific themes discussed include: research support for particular transtheoretical skills and methods; the multicultural orientation; strengths-based approaches and positive regard, diversity considerations in using empirically supported techniques, such as cognitive restructuring, and gathering practice-based evidence.

As a first year doctoral student in counseling psychology, I have been im-

mersed in scholarship surrounding the topic of how to be a successful therapist. Now, as I am approaching the start of practica, I am beginning to consider how I will integrate what I have learned into my own client sessions in a more concrete way. In other words, the task in front of me is to shift from thinking about the research evidence from a more abstract level to a more practical one. To this end, we have provided a synthesis of recent articles reviewing psychotherapy research and some key take-aways for use in clinical practice for trainees (and therapists of all levels) for evidence-based therapy practice. Our hope is that it might be useful to others wishing to update their knowledge regarding psychotherapy research findings and their practical application.

#### **Skills and Methods That Work: An Evidence-Based Overview for Trainees**

In their concluding chapter in a special issue of *Psychotherapy* devoted to meta-analytic reviews examining effective therapy skills and methods, Hill and Norcross (2023) provide a helpful overview of the research supporting a wide range of therapy skills. This offers a valuable starting place for examining what might be beneficial (or harmful) for clients during therapy. The researchers divide these skills into several subcategories and rate the research evidence for their level of effectiveness in terms of immediate in-session, intermediate between session, and distal client

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outcomes. Specifically, I learned from this work that certain techniques, such as therapist affirmation and validation, were shown to be demonstrably effective in terms of achieving beneficial client outcomes (Hill & Norcross, 2023). In addition, being able to identify and repair a rupture can be used to maintain or even restore the therapeutic alliance following challenging interactions. Restoring the therapeutic alliance following a rupture is related to positive outcomes from treatment (Eubanks et al., 2018) and this skill is worthy of developing for trainees. The authors also provide a list of techniques gathered from the research that have mixed results, including approaches that could negatively impact clients. For example, the researchers note that while homework assignments were “probably effective” between sessions, homework appears to sometimes lead to therapeutic ruptures (Hill & Norcross, 2023). In addition, the authors note that metaphors were found to be less effective for clients with schizophrenia (McMullen & Tay, 2023; as cited in Hill & Norcross, 2023). Neither of these actions should be eliminated from therapy practice but knowing that some commonly used skills/techniques could have unintended negative outcomes for some clients offers a reminder about the importance of considering a client’s unique presentation. This is especially important given some of the gaps highlighted by the authors. In particular, the researchers describe that immediacy as a skill does not have clear support regarding its impact on client outcomes. They also discuss how very few studies have examined the impact of the culture or identity of the therapist or the client on outcomes (Hill & Norcross, 2023). This is a significant gap in research on skills and methods, especially since multicultural competence (MC)—something intertwined with cultural identity—is

recognized as a core clinical competency (Tao et al., 2015). Other studies have found that therapist MC has a significant effect on many different aspects of the therapeutic relationship and therapy process, such as client satisfaction, session impact, and overall treatment outcome (Tao et al., 2015).

### **Multicultural Orientation Framework: A Useful Therapeutic Tool for Trainees**

Having positive regard for our clients appears to be significantly related to client outcomes and this may be more complex (and even more vital) in cross-cultural counseling and/or in providing therapy to clients from historically marginalized groups (Clauss-Ehlers et al., 2019; Farber et al., 2018). Carl Rogers (1957) may have been among the first to suggest that how a client interprets our positive regard is the most important aspect of positive regard (Farber et al., 2018). Conflict in any relationship, including the therapeutic relationship, is unavoidable. For instance, microaggressions and missed opportunities to discuss a client’s social identit(ies) and/or identity-based experiences can be places where ruptures occur in therapy (Davis et al., 2018). In their meta-analysis exploring the Multicultural Orientation (MCO) Framework, Davis and colleagues (2018) explored how using this framework can impact the therapeutic relationship. The MCO Framework focuses on incorporating cultural awareness and humility into therapy. While researchers have shown that microaggressions occur frequently in therapy, clients often do not bring up microaggressions until they are leaving therapy. This demonstrates the importance of therapists’ ability to notice opportunities to discuss culture when they arise in therapy, grow their comfort level with discussing culture, and do so within a

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framework of cultural humility (Davis et al., 2018). Specifically, cultural humility was found to play a role in repairing ruptures in the therapeutic alliance and lessening the negative impact of missed opportunities. Davis and colleagues point to many areas where the MCO can be incorporated into therapeutic work, such as during intake, case conceptualization, and throughout therapy sessions (2018). The MCO and its component parts would be a helpful set of skills/techniques to include in a future review of psychotherapy skills and methods that work. Until then, I find the MCO to be a highly valuable framework for thinking about my upcoming clinical work.

### **Remember to Focus on Client Strengths as an Evidence-Based Approach**

In his book, *Therapeutic Communication*, Paul Wachtel notes the importance of centering a client's strengths during the therapy process, rather than making diagnosis and psychopathology the focus of therapy (Wachtel, 2011). Furthermore, strengths-based methods are research supported for in-session and post-treatment client outcomes (Hill & Norcross, 2023). At this stage of my training, it feels easy to make diagnosis or psychopathology the focus of sessions, since generally, when individuals go to therapy, they have a problem in their life that they want to discuss. It can seem instinctual, Wachtel writes, to focus on what needs to be different, rather than what is already going well; and having significant concerns can sometimes drown out strengths or positive aspects of an individual's daily life. This makes it vital to draw attention to a client's strengths and sources of resilience. Furthermore, there is an "assumption that the sicker the patient appears to be through the lens of the therapist's diagnosis the more profound and acute must be her clinical perceptions" (Wachtel,

2011, p. 191). This statement contains an important reminder that it can be easy to err on the side of over-pathologizing a client's behavior, yet this does not necessarily benefit the patient, and in some cases can even cause harm (Paris, 2013).

A strengths-based approach is intertwined with the therapist's positive regard for the client. Positive regard involves centering a client's experiences and accepting them without judgement (Rogers, 1957). Viewing a client this way could help with the cultivation of a strengths-based approach. For instance, it might be challenging for a therapist to see a client's strengths if they lack positive feelings about that client (or about themselves, for that matter). Research has demonstrated that using positive regard also appears to help create a therapeutic environment where clients feel accepted by their therapist and are then consequently better able to accept themselves, although the exact mechanism through which positive regard impacts client outcomes is likely complex. At any rate, positive regard likely helps clients see their own sources of strength and better understand their positive attributes (Farber et al., 2018).

In addition, positive regard is something that is largely communicated to clients through therapists' words: "...words are [also] the medium of relationships" (Wachtel, 2011, p. 3). Training for therapists, according to Wachtel, often focuses on what clients are saying, and that what the therapist should say will follow naturally (Wachtel, 2011). This could easily seem discouraging to trainees who are constantly encountering new situations. Knowing the perfect thing to say in response to a client sharing something very personal or challenging seems, in fact, the opposite of natural or automatic. Related to this,

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researchers have found that 53 to 81% of clients have experienced a microaggression while they were in therapy. This implies that relying on instinct or automatic responses when deciding how to respond to what a client is saying could be harmful (Tao et al., 2015).

### **Our Words Matter: The Example of Cognitive Restructuring**

Focusing on the specific words that therapists say may help trainees avoid automatic responding and instead engage in some of the more challenging techniques that have demonstrated research support (Hill & Norcross, 2023; Wachtel, 2011). In particular, Wachtel describes how some of his trainees were hesitant to challenge their clients and feared that their words would offend them; a fear to which I could easily relate (Wachtel, 2011). And apparently, some research has demonstrated that this may be a concern for other therapists as well, specifically when using techniques such as cognitive restructuring (CR). CR, in some form, is an integral aspect of nearly all treatment approaches, including cognitive behavioral therapy. However, as demonstrated in their review, Ezawa and Hollon (2023) demonstrated that CR implemented poorly can lead to significant therapeutic ruptures.

In addition, hesitance to use CR has been shown to have disproportionate impacts on some groups of clients. Specifically, researchers found that therapists used fewer cognitive techniques when working with Black/African American clients than they did when working with White clients (Ezawa & Strunk, 2022). Generally, CR has been shown to have a positive impact on therapy outcomes and can also lead to longer term changes. CR gives clients skills they can continue to use to assess and change their behavior even after their therapeutic journey has ended. If

some groups of clients are systematically not getting to experience these same evidence-based benefits, this is a health-care disparity that warrants further examination as to why this happening so it can be addressed. The researchers hypothesized that the mostly White sample of therapists were afraid of engaging in microaggressions, offending a client, and/or their underuse indicated an overall lack of cultural sensitivity. To me, this warrants further investigation as this indicates a need for increased multicultural competence training for therapists and further education surrounding the implementation of CR in ways that feel positive and constructive to clients and therapists. CR as an impactful technology is about language and communication; it may be that simple changes to a sentence or better attending to tone and nonverbals can dramatically impact how a client will interpret the message they are getting from their therapist (Wachtel, 2011).

### **Practice-Based Evidence: Being a Local Clinical Scientist**

While exploring this research, I did not find any simple answers as to what I should and should not include in my own therapeutic approach, yet the above research provided a valuable starting point. Significant gaps still remain, specifically with regard to MC and cultural adaptations (Hill & Norcross, 2023). With this in mind, it is vital for therapists to consider each individual patient with whom we are working—rather than the average client upon which research data are based—within our daily practice. Practice-based evidence is the process of gathering process and outcome data in our own practice with clients and can help each of us better understand what is working well and what is not working well for our individual (or group) clients (Paquin,

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2017). This approach highlights the importance of collaboration via asking clients for feedback. Giving clients a chance to say what is working well and if they feel like there is a good therapeutic alliance could help elucidate areas where adjustments or changes might be necessary. Combining my new knowledge about what methods and techniques have empirical support, focusing on client strengths, remembering the power of positive regard, using a multicultural orientation, inviting client collaboration and engaging in practice-based evidence will help me account for the unique experiences and needs of each client I work with. These are concrete practices that will ground me when I feel lost and that I know that I can carry with me well beyond my years as a trainee.

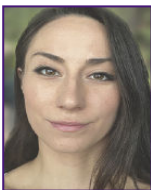
## References

- Clauss-Ehlers, C. S., Chiriboga, D. A., Hunter, S. J., Roysircar, G., & Tum-mala-Narra, P. (2019). APA multicultural guidelines executive summary: Ecological approach to context, identity, and intersectionality. *American Psychologist, 74*(2), 232–244. <https://doi.org/10.1037/amp0000382>
- Davis, D. E., DeBlare, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., Van Tongeren, D. R., Worthington, E. L., & Placeres, V. (2018). The multicultural orientation framework: A narrative review. *Psychotherapy, 55*(1), 89–100. <https://doi.org/10.1037/pst0000160>
- Eubanks, C. F., Muran, J. C., & Safran, J. D. (2018). Alliance rupture repair: A meta-analysis. *Psychotherapy, 55*(4), 508–519. <https://doi.org/10.1037/pst0000185>
- Ezawa, I. D., & Hollon, S. D. (2023). Cognitive restructuring and psychotherapy outcome: A meta-analytic review. *Psychotherapy, 60*(3), 396–406. <https://doi.org/10.1037/pst0000474>
- Ezawa, I. D., & Strunk, D. R. (2022). Working with Black vs. White patients: An experimental test of therapist decision-making in cognitive behavioral therapy for depression. *Cognitive Behaviour Therapy, 51*(3), 229–242. <https://doi.org/10.1080/16506073.2021.1970799>
- Farber, B. A., Suzuki, J. Y., & Lynch, D. A. (2018). Positive regard and psychotherapy outcome: A meta-analytic review. *Psychotherapy, 55*(4), 411–423. <https://doi.org/10.1037/pst0000171>
- Hill, C. E., & Norcross, J. C. (2023). Skills and methods that work in psychotherapy: Observations and conclusions from the special issue. *Psychotherapy, 60*(3), 407–416. <https://doi.org/10.1037/pst0000487>
- Paris, J. (2013). *The intelligent clinician's guide to the DSM-5*. Oxford University Press.
- Paquin, J. D. (2017). Introduction to a special issue on clinician–researchers: A career engaged in both therapy research and practice. *Counselling Psychology Quarterly, 30*(3), 225–233.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103. <http://dx.doi.org/10.1037/h0045357>
- Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology, 62*(3), 337–350. <https://doi.org/10.1037/cou0000086>
- Wachtel, P. L. (2011). *Therapeutic communication: Knowing what to say when* (2nd ed). Guilford Press.



### Moving Away for Internship: Helpful Takeaways and Lessons Learned

Deanna Young, M.A.



As November approaches, some of us may be preparing for family get-togethers, thinking about holiday décor, or enjoying the change of the season. For many psychology graduate students, November's hasty approach signifies application deadlines and match-day anxieties. No matter where you are in this process, internship is an exciting time where students take a significant step forward in their careers. I focused my internship applications on training sites that were most appealing to me, however, it wasn't until I got matched that I realized the immense journey it would be to move cross-country from California to Florida. Some of my colleagues shared the stress of big moves and we learned a lot from each other. This article provides some of the tips, tricks, and lessons learned from these experiences.

*Note: these ideas come from the experience of moving as a single or coupled person. They may not represent the experience of those moving with a family. For tips and suggestions on moving as a family for internship, please see [this article](#) from the American Psychological Association.*

**Preparing for the Move: Sell, Sell, Sell**  
Thinking about how to prepare for a move is overwhelming in itself, let alone actually doing it. This can be minimized by having fewer items to pack and move. Sell or give away as many of your material possessions as possible and start this process in the earliest phases of the move. We often forget how many possessions we truly have until we have to

do something with them. I had planned a schedule on what to sell and when, with goal sell-by dates to stay on top of advertising and cost-reduction per item. I found this helped with decision fatigue and overall anxiety. It also helped me identify which pieces were most important to me. My colleagues and I used the app OfferUp and Facebook Marketplace to sell our items and found that OfferUp yielded the best results.

It was helpful to recognize that everything you take will cost money due to shipping costs, especially if you're moving a long distance. Consider the following questions when assessing your items:

- What will this item provide me?
- Would it be more cost-effective to buy this item later?
- Will this item be important for my training and professional goals?
- How much joy will this item provide me?
- How is keeping or getting rid of this item aligned with my values and goals?

I saw this as an opportunity to reset, live minimally, and release myself from the burden of material possessions. It may feel terrible to let go of so many things all at once but recognizing that pain and discomfort may help you make more intentional decisions when buying possessions. Lastly, considering where you move to, it may be less expensive to buy all new furniture at your new location (especially if you intend to live minimally). If you find yourself alone in a

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new place and need help with moving your new furniture, the on-demand movers company, Lugg, is an incredible resource. They are a fast, friendly, and affordable option.

### **Moving Large Possessions: To Ship or Not to Ship**

One consideration I often forgot about is how I would move my car from one coast to another. I had originally planned to drive cross-country but was told the West-Coast-East-Coast drive gets old fast. Two of my friends shipped their cars with glowing appreciation and I found the experience to be phenomenally simple, easy, and surprisingly cost-effective. The cost of shipping your car will depend on the supply and demand of the market, so get several quotes if you can. Each company is different, so be mindful of reviews. A colleague of mine had to ship her two cars on different occasions due to a poor experience with the first company she chose, but she had glowing reviews for the other company. She recommended Sherpa Auto Transport, as she found them extremely professional and communicative. I used ShipaCarDirect.com after a colleague suggested it and I found them to be incredibly reliable, fast, and affordable.

Additionally, we all were able to pack our cars with as much stuff as possible, leaving room in the driver's seat and keeping the back window free from obstruction. However, make sure you check with the agency's policy first on packing items in your car as each agency may operate differently. I planned to pack my heaviest, most cumbersome items in my car, such as books, my printer, my coffee maker, etc. There was still plenty of space left in my 4-door sedan after these items were loaded. It's surprising how much can fit into a car, so don't forget about that resource if you have it! I also used my flight to Florida to transport my goods. I brought the rest of my clothes, essentials, and most meaningful items in two suit-

cases, a carry-on, and a backpack. Additionally, my colleague, who was also moving coast-to-coast, found that adding an additional suitcase to her flight was more cost-effective than shipping the items through FedEx or UPS. So, if you find yourself needing more space, add the suitcase!

If the car transport isn't an option or if you have more items than would fit, shipping boxes and containers are another helpful option to consider. With this option, the company will deliver a big container to your place of residence for you to load your possessions that you want shipped and they will then pick up the container and deliver it to the desired address. One company that provides this service and that I have heard positive reviews on is U-Box by U-Haul. If you choose to use U-Haul's U-Box, they have storage options as well, which is very helpful when you're not exactly sure where you'll land. Professional movers are also an option, and likely the most stress-free but expensive. Consider all of the options and resources you have available to make the best decision for your specific circumstance.

### **Finding Your New Home: Book One-way**

If you've never been to the city, let alone the state you're now moving to, the experience can seem overwhelmingly daunting. When you don't have a frame of reference for the different neighborhoods, their culture, and what they offer, it can feel scary trying to decipher where you're going to root yourself. My fellow big-move colleagues and I came to a consensus on this conclusion: If you can, book temporary housing (e.g., Air BNB, Extended Stay) in the area for 2-weeks to a month to explore the city and identify the neighborhood and housing arrangement that best suits your needs.

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This will give you the flexibility and security of choice. Additionally, if you used U-Box to ship your possessions, you can take advantage of their storage options as well.

Alternatively, two colleagues and I took a week-long trip to our internship area to secure a home. We were all disoriented with the number of apartments we looked at and felt pressured to decide. In the end, we were all satisfied with our choices, as life is what you make it, but we wish we had the flexibility to explore the area and see what other options we had. For example, due to time constraints, I could only explore one area of one city. I had the chance to explore different neighborhoods but was so busy traveling to back-to-back viewings that it was challenging to stay present and really take in each option. Additionally, many of the apartment complexes are only open Monday through Friday from 9-5 PM and require appointments. It was extremely helpful to keep an excel sheet of which apartments I planned to see, when they were open, pros and cons of each, various costs, and other important factors. Organization was key in curating my options. In the end, my advice is to go with your gut on which home will best suit you.

**The Important Stuff**

While internship only lasts one year, that year can be a painfully long time away from loved ones and valued spaces. Moving to a new state or a new place often means losing a big part of your support system and self-care practices. You're a stranger in a strange land, the air is wet and there are lizards instead of squirrels everywhere—at least this was the case for me.

Before the big move, it is essential to schedule intentional time to spend with loved ones and doing valued activities. These memories will carry you through the challenging times and ground you in who you are when everything seems foreign. We experience the world through relationships, and those relationships continue to be with you and support you no matter the distance or time apart. In the weeks leading up to my move, I scheduled a lot of hangouts with friends and family. We didn't have a big celebration or long goodbye, just business as usual. However, I entered each experience with the understanding and intention of appreciating every moment and being as present as I could be. As a result, those memories exist so vibrantly in my memory, I'm filled with warmth and joy every time I call upon them. When I'm homesick, I remember these moments and the people close to me, the memories we made, and the plans we intend to fulfill. It encompasses a valued past and a hopeful future, which allows me to embrace the present with gratitude and strength. Above all, this has been the most helpful in making this experience meaningful for me.

**In Conclusion**

Moving anywhere is an enormous effort and when combined with preparing for internship and managing academic responsibilities, the move can be even harder. However, it can also be an adventure; one that paves the way for incredible growth and self-discovery. With careful planning, intention, and a few leaps of faith, it can be more manageable than you may have expected. Regardless, congratulations on your internship! I hope you enjoy the ride!



# SUICIDE ASSESSMENT

## A Brief Synopsis of the Third Part of the Suicide Prevention Triangle: Detailed Documentation

Stewart Cooper, Ph.D.



Effective patient suicide prevention is composed of three interrelated facets: assessment, intervention, and documentation. Examples of free assessments include the Columbia-Suicide Severity Rating Scale (C-SSRS; available at <http://cssrs.columbia.edu/>) and the Substance Abuse and Mental Health Services Administration (SAMHSA) SAFE-T Suicide Assessment Five-step Evaluation and Triage (available at <https://store.samhsa.gov/sites/default/files/sma09-4432.pdf>). Two examples of suicide intervention programs are the Collaborative Assessment and Management of Suicidality (CAMS), a therapeutic framework in which clini-

cians work collaboratively with patients to develop a treatment plan that directly targets suicidal thoughts and behaviors (Jobes, 2016) and Dialectical Behavior Therapy (DBT), originally developed for individuals with borderline personality disorder. DBT has been effective in reducing suicidal behavior and self-harm in high-risk populations (Lanehan, 1993). Use of suicide safety planning is also recommended. A free version is available at [https://dbhds.virginia.gov/assets/doc/bh/msmvf/brown\\_stanleysafetyplantemplate.pdf](https://dbhds.virginia.gov/assets/doc/bh/msmvf/brown_stanleysafetyplantemplate.pdf)

The table below lays out the recommended documentation for suicide assessment and prevention. The material is taken from Simpson and Stacy (2004).

**Suicide Risk Assessment Documentation**

<b>Suicide Ideation (wish to die and thoughts about attempting suicide)</b>	Endorsement or denial
<b>Suicide Attempt Plan</b>	The plan details All suicide attempt methods How the attempt methods could/would be accessed.
<b>Suicidal Intent</b>	Endorsement or denial
<b>Recent Suicide Attempts and Attempt History</b>	Endorsement or denial of a nonfatal suicide attempt that occurred at some point within the past year. Number of attempts Precipitating events Attempt methods used (and how access was obtained) The patient's attitude toward being alive following the attempt.
<b>Risk and Protective Factors</b>	Endorsement or denial of any suicide risk or protective factors that are discussed. Also note the risk and/or protective factors.
<b>Safety Planning</b>	Was a safety plan created? What did the patient/client agree to do?

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<b>Clinical Judgment</b>	Your risk formulation with a justification informed by the patient's history and any relevant information obtained from the risk assessment.
<b>Recommendations/ Next Steps</b>	What are the recommendations (e.g., hospitalization) and the specific plan moving forward for the patient/client (e.g., treatment plan)?
<b>Responses from the patient and informants</b>	Document all attempts to contact informants. Include patient responses to assessment, formulation, and recommendation.

Simpson and Stacy (2004) posit that thorough and careful documentation of suicide risk assessments is simultaneously a best practice as well as a best defense against malpractice claims. The latter is related to legal implications of inadequate documentation, that poorly documented assessments and interventions can be seen as negligent in a court of law. They add that clear and comprehensive documentation provides some of the best evidence that clinicians have acted with appropriate care and consideration in their assessments and initial interventions.

Their guidance table [see above] covers the essential categories to consider with specific suggestions as to the related content to address. Of note, Simpson

and Stacy (2004) highlight that of equal importance of what to include in suicide assessment and intervention documentation is what to avoid, for example vague or incomplete notes, failure to document follow-up plans, and neglecting to record the patient's own statements about their suicidal thoughts.

#### References

- Jobes, D. A. (2016). *Managing suicidal risk: A collaborative approach* (2nd ed.). The Guilford Press.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. The Guilford Press.
- Simpson, S., & Stacy, M. (2004). Avoiding the malpractice snare: Documenting suicide risk assessment. *Journal of Psychiatric Practice*, 10(3), 1-5.





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# SUICIDE ASSESSMENT

## Suicide Prevention Using Artificial Intelligence: Collaborative Support Approach

*Caleb Onah, M.S.*



The World Health Organization (WHO) asserts that suicide is a significant global health problem. In 2016, the suicide rate was estimated to be 10.6 per 100,000 individuals, with 80% of these cases occurring in low-income and middle-income countries (Fazel et al., 2020). Often, individuals at risk of suicide do not seek help from their clinicians or communities due to fear of stigmatization and the possibility of forced medical treatment. Furthermore, individuals with mental illnesses—who represent a majority of suicide cases—may have limited awareness of their mental condition and may not recognize themselves as being at risk of suicide (Picardo et al., 2020). This situation is further complicated by the difficulty clinicians or psychotherapists face in accurately identifying those at risk of suicide when they do seek medical care (Walsh et al., 2018).

Epidemiological studies have also shown that young adults' ages 15 to 21 years have the highest prevalence of mental illness leading to suicide, with a rate of 39% (Eisenberg et al., 2007). Psychiatric conditions that are often associated with suicidal ideation and behavior include depression, anxiety, substance use disorders and eating disorders (Bradyik, 2018). Warning signs of suicidal ideation may include a prior suicide attempt or intentional self-harm behaviors, such as cutting or burning oneself (Ryan & Oquendo, 2020).

In an effort to mitigate the impact of suicide, there is a growing interest in lever-

aging artificial intelligence (AI), data science, and other analytical techniques to enhance suicide prediction and risk identification. Broadly, these tools fall into two categories: medical suicide prediction tools and social suicide prediction tools. Medical suicide prediction tools involve clinicians and psychotherapists using AI techniques (i.e., natural language processing and machine learning) to identify patterns of information and behavior indicative of suicide risk, and to utilize data from electronic medical records and potentially other government data sources (Nugent et al., 2019). These tools are typically employed in hospital settings or general practitioner clinics to support clinicians or psychotherapists with assessing patient suicide risk. Social suicide prediction tools, on the other hand, involve AI and data tools that analyze information from social media and browsing habits to assess suicide risk. Platforms like Facebook, Google, and Apple, for example, may use data to identify users at risk of suicide and then provide appropriate interventions, such as offering free information and counseling services (Coppersmith et al., 2018; Muriello et al., 2018).

While it may not be possible to completely eradicate suicide, enhancing predictive and preventative measures through advanced analytical tools may offer the best potential for improved outcomes. However, predicting suicide risk remains challenging for traditional epidemiological studies and healthcare providers due to the complex factors involved and the difficulties with identi-

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fyng a small number of at-risk individuals within a large population of individual who share similar risk factors. Lejeune et al. (2022) conducted a review to evaluate the potential of AI in identifying patients at-risk of attempting suicide. They performed a systematic review of literatures using the PubMed, EMBASE, and SCOPUS databases, with relevant keywords. Out of 296 studies identified, 17 studies published between 2014 and 2020 met the inclusion criteria and were deemed relevant. These studies focused on predicting individual suicide risk or identifying at-risk individuals within specific populations. Overall, the performance of AI was found to be good, though it varied across different algorithms and application settings. The review concluded that AI holds significant promise for identifying patients at-risk of suicide; however, the exact application of these algorithms in clinical practice, along with the ethical issues they raise, still needs further clarification and research evidence.

### **Approaching Suicide Prevention Using AI as a Clinician**

A landmark meta-analysis by Franklin et al. (2017), which examined 365 studies over a 50-year span, revealed that suicide prediction is only slightly better than chance for all outcomes and this predictive ability has not improved over the last five decades. This review found that psychotherapists are challenged by the fact that many individuals who die by suicide never disclose their suicidal thoughts to a healthcare provider. Those experiencing suicidal ideation often fear discussing their thoughts with friends or family due to concerns about being judged, hospitalized, or medicated (Franklin et al., 2017).

Despite these challenges, a longitudinal study found that 83% of individuals who die by suicide had contact with

health services within the year preceding their death, and 45% had contact within the month before (Sheehan et al., 2017). This indicates a significant opportunity for medical prediction tools to assist clinicians in assessing suicide risk when these patients seek care. Consequently, these prediction tools should move away from focusing solely on risk factors and instead utilize machine learning algorithms and data science to predict suicide risk using innovative analytical methods.

For instance, Kessler et al. (2017) applied machine learning protocols—such as Naive Bayes, random forests, and support vector regression—to predict suicide deaths among military veterans within 26-weeks of an outpatient mental health visit. The study reported an area under the curve (AUC) of 0.72 for those with a prior psychiatric hospitalization, 0.61 for those without such hospitalization, and 0.66 when both groups were combined. This implies that there was a 72% chance that the model would correctly rank a randomly chosen patient who completed suicide higher than a randomly chosen person who did not. Further, the model had only a 61% chance of correctly ranking a patient who completed suicide higher than someone who did not. However, the model was able to correctly rank suicide death cases over non-suicide cases 66% of the time. This moderate AUC reflects an overall better performance than random guessing but suggests that the model's predictive accuracy is still limited, particularly when both groups (hospitalized and non-hospitalized) are considered together. Overall, the model performed better in predicting suicide deaths for patients with a prior psychiatric hospitalization (AUC of 0.72) than for those without (AUC of 0.61). When considering both groups together, the

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model's predictive ability averaged out to an AUC of 0.66, indicating moderate performance with room for improvement. Relevant factors included suicidality, depression, bipolar disorder, and non-affective psychosis (Kessler et al., 2017). Interestingly, the AUC improved to 0.75 when predicting suicide death within five weeks of the outpatient visit.

Similarly, a study by DelPozo-Banos et al. (2018) utilized artificial neural networks, a type of machine learning technique, to analyze routinely collected data in electronic medical records (EMRs) to assess suicide risk in patients visiting health services for any reason. By analyzing EMR and hospital data from the 5 years prior to a patient's suicide, the model accurately distinguished between control patients and those who died by suicide, achieving an accuracy of over 73%. However, it is important to note that more complex models incorporating additional data points could likely yield even better results, and the researchers plan to develop such a model in the next phase of their research (DelPozo-Banos et al., 2018).

Artificial intelligence has also demonstrated high accuracy in predicting suicide attempts. By applying machine learning to electronic health records (EHRs), Walsh et al. (2017) developed machine-learning algorithms (random forest and logistic regression) that achieved AUC values of 0.80 and 0.84 when predicting the likelihood of a suicide attempt within the next 2 years and within the next week, respectively. Important predictors in both long- and short-term predictions included depression with psychosis, schizophrenia, and a history of prior suicide attempts. In the study conducted by Walsh and colleagues (2017), they analyzed patient data from the records of 5,167 adults treated at Vanderbilt University Medical Center. The study reported the accuracy of their suicide prediction models in terms of area under the

curve (AUC), where an AUC of 0.5 indicates "accuracy no better than chance," and an AUC of 1.0 represents perfect accuracy (Centers for Disease Control and Prevention, 2018). Given that traditional suicide prediction methods may be only slightly more accurate than a coin flip (approximately 50% or 0.50 probability), the study's findings are noteworthy. For patients attempting suicide for the first time, Walsh and colleagues (2017) reported AUC values ranging from 0.82 at 7 days prior to suicide attempts to 0.75 at 720 days prior to suicide attempts (VA Releases National Suicide Data Report, 2018).

Ryu et al. (2019) also employed a machine learning technique (random forest) to predict suicide attempts among individuals with suicidal ideation. Their prediction model achieved impressive results, with an AUC of 0.947 and an accuracy of 88.9%. While the clinical applicability of these tools in real-world settings has yet to be fully proven, the initial results are highly promising.

In all, an important question that arises is what actions should be taken when individuals are identified as being at-risk of suicide? For some patients, hospitalization may be the appropriate step, but for others, hospitalization could potentially cause more harm than good. Additionally, forcibly detaining patients in a hospital or other medical setting could lead to significant psychological distress and may even hasten future suicide attempts (Jackman & Kanerva, 2017).

### **Suicide Prevention Using Social Evidence Approach of AI**

In a study, Gaur et al. (2019) analyzed Reddit posts for signs of suicidal language to assess suicide risk. They compared different clinical classification schemes against machine learning techniques, including random forest and convolutional neural networks. Convo-

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lutional neural networks outperformed the others, achieving an overall precision of 70%, which was 40% better than baseline approaches that relied solely on medical classification systems (Gaur et al., 2019).

Earlier, on April 2, 2018, Zuckerberg revealed that Facebook's AI scans the content of users' private messages, suggesting that both public and private user-generated content may be monitored for signs of suicidal intent (Meyer, 2014). On September 10, 2018, Facebook provided additional details about its suicide prediction algorithms. Using an AI tool called random forests, Facebook analyzes user-generated content and assigns a risk rating to specific words, word pairs, and phrases in each post. Hypothetical examples provided by the company include terms like "sadness," "much sadness," and "so much sadness." Unlike medical suicide prediction, being primarily experimental, requiring approval from Institutional Review Boards (IRB), and resulting in peer-reviewed publications in academic journals, Facebook's suicide prediction program does not undergo independent ethics reviews (Muriello et al., 2018). Additionally, Facebook's methods and results are not published or made publicly available, raising concerns about safety, accountability, and transparency. Instead of consulting an IRB, Facebook will use an internal ethics board. Unlike mandatory IRB approval at a hospital or university, however, the review of Facebook's projects by its ethics board occurs at the company's discretion. This lack of transparency and accountability is troubling, given Facebook's history of monitoring users' emotional states and conducting experiments on users without their knowledge or consent (Muriello et al., 2018).

Coppersmith et al. (2018) utilized natural language processing, along with supervised and unsupervised machine

learning methods, to analyze social media data from various platforms, including Instagram, Facebook, Twitter/X, Strava, Fitbit, Reddit, and Tumblr, with permission from the test subjects, to assess the risk of suicide attempts. The model achieved an AUC of 0.89–0.93 for time frames ranging from 1 to 6 months. According to Coppersmith et al. (2018), if a false alarm rate of 1–2% is assumed, this model could be up to 10 times more accurate in predicting suicide attempts compared to clinician averages (40–60% vs. 4–6%).

Lissak et al. (2024) employed AI methodologies to uncover hidden risk factors that contribute to or exacerbate suicidal behaviors. The primary dataset comprised 228,052 Facebook posts from 1,006 users who completed the Columbia Suicide Severity Rating Scale. The secondary dataset included responses from 1,062 participants who completed the same suicide scale, along with well-validated scales measuring depression and boredom. The results revealed that an almost fully automated, AI-guided research pipeline identified four Facebook topics that predicted suicide risk, with boredom emerging as the strongest predictor (Lissak et al., 2024). Interestingly, a comprehensive literature review using APA PsycInfo indicated that boredom is rarely considered a unique risk factor for suicide. Analysis of the secondary dataset revealed an indirect relationship between boredom and suicide, mediated by depression (Parsapoor et al., 2023). A similar mediated relationship was observed in the primary Facebook dataset, where a direct relationship between boredom and suicide risk was also found. The integration of AI methods enabled the discovery of an under-researched risk factor for suicide: boredom. This study highlights boredom as a potentially maladaptive factor that

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could trigger suicidal behaviors, independent of depression. Further research is recommended to draw clinicians' attention to this burdensome and sometimes existential experience.

### **Future of Using Artificial Intelligence in Suicide Prevention**

Study results consistently demonstrate that AI can outperform doctors in predicting both suicide completion and suicide attempts, underscoring the potential of AI-based medical suicide prediction. The research indicates a promising clinical application for AI in identifying the risk of suicide completion.

**Implement Natural Language Processing (NLP) tools:** It is more important for all clinicians and healthcare settings to begin utilizing NLP to analyze patient communications, such as journal entries or therapy session transcripts, for signs of suicidal ideation. This technology can identify risk factors that may not be captured in traditional screening tools like the PHQ-9 (Zaubler, 2024). For instance, studies have shown that NLP can detect suicidal thoughts in over half of patients who might otherwise go unnoticed, allowing clinicians to intervene more effectively (Gliadkovskaya, 2024). By integrating clinical data, social determinants, and behavioral indicators, these models can provide timely alerts to clinicians about patients at-risk, facilitating early intervention. This approach has been successfully implemented in youth suicide prevention, demonstrating its potential to save lives (Pediatric Health Advances, 2023).

**Enhance clinical decision support systems:** It is crucial to integrate AI into clinical decision support systems to assist clinicians and psychotherapists in assessing suicide risk. AI can analyze vocal biomarkers and speech patterns to provide real-time feedback during ther-

apy sessions, helping clinicians make informed decisions about patient care (Thompson, 2023). Such systems can alert providers when a patient exhibits concerning signs, ensuring a quick response that is central to the intervention process (Gliadkovskaya, 2024).

**Foster collaborative care models:** Health institutions should encourage collaboration between AI systems and human clinicians to create a holistic care approach. AI can handle data analysis and risk assessment, while clinicians can focus on building therapeutic relationships and providing personalized care. This partnership can enhance the overall effectiveness of suicide prevention strategies, as clinicians are better equipped with actionable insights from AI.

**Utilize AI for resource allocation:** Employing AI to optimize the allocation of mental health resources, particularly in underserved communities, is very important. By analyzing data on suicide rates and mental health service availability, AI can help identify areas with the greatest need for intervention. This targeted approach ensures that resources are directed to where they have the most impact, addressing disparities in mental health care access (Gliadkovskaya, 2024).

**Ensure ethical and secure data usage:** Establish strict ethical guidelines and robust cybersecurity measures for using AI in suicide prevention (Onah et al., 2024). As AI relies on sensitive patient data, it's crucial to protect this information and maintain patient confidentiality (European Parliament, 2023). Clear legal frameworks should be developed to guide the responsible use of AI in clinical settings, ensuring that ethical considerations are prioritized alongside technological advancements. Further,

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population-wide suicide prediction may offer an ethical and effective application for AI, helping policymakers and medical professionals allocate healthcare resources more efficiently.

While AI in suicide prevention may be much more advanced than traditional methods, current medical suicide prediction models still yield a considerable number of false positives and false negatives. Consequently, these tools are primarily used for research purposes and are not yet fully employed to guide clinical decision-making in most healthcare settings. Although advances in AI present significant opportunities for developing novel tools to predict suicide, further evidence suggests that the combined medical and social suicide prediction tools could enhance our ability to identify individuals at-risk of suicide and potentially save lives. By implementing these strategies, the integration of AI into suicide prevention efforts can enhance the ability of clinicians to identify at-risk individuals and provide timely, effective, life-saving interventions.

## References

- Bradyik, L. (2018). Suicide risk and mental disorders. *International Journal of Environmental Research and Public Health*, 15(9), 20-28. <https://doi.org/10.3390/ijerph15092028>
- Centers for Disease Control and Prevention (2018). Suicide rising across the United State. [Web article]. Retrieved from <https://stacks.cdc.gov/view/cdc/55609>
- Coppersmith, G., Leary, R., Crutchley, P., & Fine, A. (2018). Natural language processing of social media as screening for suicide risk. *Biomedical Informatics Insights*, 10. <https://doi.org/10.1177%2F1178222618792860>
- DelPozo-Banos, M., John, A., Petkov, N., Berridge, D. M., Southern, K., Lloyd, K., Jones, C., Spencer, S., & Travieso, C. M. (2018). Using neural networks with routine health records to identify suicide risk: Feasibility study. *Journal of Medical Internet Research in Mental Health*, 5(2), e10144. <https://mental.jmir.org/2018/2/e10144/>
- Department of Veterans Affairs (2017, April). VA REACH VET Initiative helps save veterans lives: program signals when more help is needed for at-risk veterans. [Web article]. <https://news.va.gov/press-room/va-reach-vet-initiative-helps-save-veterans-lives-program-signals-when-more-help-is-needed-for-at-risk-veterans/>
- Eisenberg, D., Gollust, S. E., Golberstein, E., & Hefner, J. L. (2007). Prevalence and correlates of depression, anxiety, and suicidality among university students. *American Journal of Orthopsychiatry*, 77(4), 534-542. <https://doi.org/10.1037/0002-9432.77.4.534>
- Fazel, S., Runeson, B., & Ropper, A. H. (2020). Suicide. *New England Journal of Medicine*, 382, 266-274. <https://doi.org/10.1056/nejmra1902944>
- Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., Musacchio K. M., Jaroszewski, A. C., Chang, B. P., & Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin*, 143(2), 187-232. <https://doi.org/10.1037/bul0000084>
- Gaur, M., Alambo, A., Sain, J. P., Kuru-suncu, U., Thirunarayan, K., Kavuluru, R., Sheth, A., Welton, R. S., & Pathak, J. (2019). Knowledge-aware assessment of severity of suicide risk for early intervention. *Proceedings of the WWW '19: The World Wide Web Conference*, 514-525. <https://doi.org/10.1145/3308558.3313698>

*continued on page 46*

- Gliadkovskaya, A. (2024). AI in action: Enhancing suicide risk detection in behavioral health. [Web article]. Retrieved from <https://www.fiercehealthcare.com/ai-and-machine-learning/ai-action-enhancing-suicide-risk-detection-behavioral-health>
- Jackman, M., & Kanerva, L. (2017). Evolving the IRB: Building robust review for industry research. *Washington & Lee Review Online*, 72(3), 442-457. <https://scholarlycommons.law.wlu.edu/wlur-online/vol72/iss3/8>
- Kessler, R. C., Stein, M. B., Petukhova, M. V., Bliese, P., Bossarte, R. M., Bromet, E. J., Fullerton C. S., Gilman, S. E., Ivany, C., Lewandowski-Romps, L., Millikan, B. A., Naifeh, J. A., Nock, M. K., Reis, B. Y., Rosellini, A. J., Sampson, N. A., Zaslavsky, A. M., Ursano, R. J., & Army STARRS Collaborators (2017). Predicting suicides after outpatient mental health visits in the army study to assess risk and resilience in service members (Army STARRS). *Molecular Psychiatry*, 22, 544-551. <https://doi.org/10.1038/mp.2016.110>
- Lejeune, A., Le Glaz, A., Perron, P. A., Sebt, J., Baca-Garcia, E., Walter, M., Lemey, C., & Berrouguet, S. (2022). Artificial intelligence and suicide prevention: A systematic review. *European Psychiatry*, 65(1), 1-22. <https://doi.org/10.1192%2Fj.eurpsy.2022.8>
- Lissak, S., Ophir, Y., Tikochinski, R., Brunstein Klomek, A., Sisso, I., Fruchter, E., & Reichart, R. (2024). Bored to death: Artificial intelligence research reveals the role of boredom in suicide behavior. *Frontiers in Psychiatry*, 15(1), 01-08. <https://doi.org/10.3389/fpsy.2024.1328122>
- Meyer, R. (2014). Everything we know about Facebook's secret mood manipulation experiment. [Web article]. Retrieved from <https://www.theatlantic.com/technology/archive/2014/06/everything-we-know-about-facebooks-secret-mood-manipulation-experiment/373648/>
- Muriello, D., Donahue, L., Ben-David, D., Ozertem, U., & Shilon, R. (2018). Under the hood: Suicide prevention tools powered by AI, Facebook code. [Web article]. Retrieved from <https://engineering.fb.com/2018/02/21/ml-applications/under-the-hood-suicide-prevention-tools-powered-by-ai/>
- Nugent, A. C., Ballard, E. D., Park, L. T., & Zarate, C. A. (2019). Research on the pathophysiology, treatment, and prevention of suicide: Practical and ethical issues. *BMC Psychiatry*, 19(1), 332. <https://doi.org/10.1186/s12888-019-2301-6>
- Onah, C., Ogwuche, C., & Sohn, L. (2024). Treatment procedures for behavioral risks associated with GPT-4 artificial intelligence model. *Psychotherapy Bulletin*, 59(3). [Web article]. Retrieved from <https://societyforpsychotherapy.org/treatment-procedures-for-behavioural-risks-associated-with-gpt-4-artificial-intelligence-model/>
- Parsapoor, M., Koudys, J. W., & Ruocco, A. C. (2023). Suicide risk detection using artificial intelligence: The promise of creating a benchmark dataset for research on the detection of suicide risk. *Frontiers in Psychiatry*, 14, 01-06. <https://doi.org/10.3389/fpsy.2023.1186569>
- Pediatric Health Advances (2023). Revolutionizing Suicide Prevention with AI Revolutionizing Suicide Prevention with AI. [Web article]. <https://www.childrencolorado.org/advances-answers/recent-articles/suicide-prevention-with-ai/>
- Picardo, J., McKenzie, S. K., Collings, S., & Jenkin, G. (2020). Suicide and self-harm content on Instagram: A systematic scoping review. *PLoS One*. *continued on page 47*

- 
- 15(9), 1-16. <https://doi.org/10.1371/journal.pone.0238603>
- Ryan, E. P., & Oquendo, M. A. (2020). Suicide risk assessment and prevention: Challenges and opportunities. *Focus, 18*(2), 88–99. <https://doi.org/10.1176/appi.focus.20200011>
- Ryu, S., Lee, H., Lee, D. K., Kim, S. W., & Kim, C. E. (2019). Detection of suicide attempters among suicide ideators using machine learning. *Psychiatry Investigation, 16*(8), 588–593. <https://doi.org/10.30773/pi.2019.06.19>
- Sheehan, L., Dubke, R., & Corrigan, P. W. (2017). The specificity of public stigma: A comparison of suicide and depression-related stigma. *Psychiatry Research, 256*, 40–45. <https://doi.org/10.1016/j.psychres.2017.06.015>
- Thompson, K. (2023,). Artificial intelligence in behavioral health and suicide prevention: Opportunities and challenges. [Web article]. Retrieved from <https://www.communitysolutions.com/resources/artificial-intelligence-in-behavioral-health-and-suicide-prevention-opportunities-and-challenges>
- VA Releases National Suicide Data Report for 2005-2016 (2018, September). US department of veterans affairs, 2018. [Web article]. Retrieved from <https://www.va.gov/opa/press-rel/includes/viewPDF.cfm?id=5114>
- Walsh, C. G., Ribeiro, J. D., & Franklin, J. C. (2017). Predicting risk of suicide attempts over time through machine learning. *Clinical Psychological Science, 5*(2), 457–469. <https://doi.org/10.1177/2167702617691560>
- Walsh, C. G., Ribeiro, J. D., & Franklin, J. C. (2018). Predicting suicide attempts in adolescents with longitudinal clinical data and machine learning. *Journal of Child Psychology and Psychiatry, 59*(12), 1261–1270. <https://doi.org/10.1111/jcpp.12916>
- Zaubler, T. (2024, March). AI and suicide prevention in primary care: A Q&A. [Web article]. <https://www.medscape.com/viewarticle/1000468?form=fpf>
- European Parliament. (2023, December). EU AI act: First regulation on artificial intelligence. [Web article]. Retrieved from <https://www.europarl.europa.eu/news/en/headlines/society/20230601STO93804/eu-ai-act-first-regulation-on-artificial-intelligence>
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# SUICIDE ASSESSMENT

## The Psychotherapeutic Benefits of Informed Consent with Suicidal Patients

*Samuel Knapp, EdD, ABPP*



Clinical Impact Statement: The informed consent process does more than help patients decide whether or not to enter psychotherapy; it is also the first step in effective psychotherapy.

Informed consent has three dimensions: legal, ethical, and psychotherapeutic, and it is often considered a precursor to the intervention. However, there is no clear break between when the informed consent process ends and when psychotherapy begins because the informed consent process can also contain psychotherapeutic elements. By giving more attention to the psychotherapeutic aspects of informed consent, psychotherapists can significantly enhance the quality of their outcomes. This article delineates the essential elements of informed consent in psychotherapy and how psychotherapists can use the informed consent process to initiate psychotherapeutic movement in suicidal patients.

### Elements of Informed Consent

Informed consent is a legal requirement. State boards of psychology, when they incorporate the American Psychological Associations' (APA) Ethics Code or a version of it in their regulations, and other state or federal laws, mandate informed consent. Standard 10.01 of the APA Ethics Code stipulates that psychologists must inform patients "about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality, and provide sufficient opportunity for the client/patient to ask questions and receive answers" (Ameri-

can Psychological Association, 2017, Standard 10.01). The informed consent process should occur "as early as feasible." This allows for delaying some or all informed consent elements to help patients in immediate crisis. Informed consent may also require complying with the Health Insurance Portability and Accountability Act (HIPAA) or the federal Cures Act, if applicable. Depending on the circumstances, other laws may apply, such as special requirements when delivering telehealth services as required in some states.

In addition to information about fees, limits of confidentiality, and potential involvement of third parties, Standard 10.01 of the APA Ethics Code (2017) requires a discussion of the "nature and anticipated course of psychotherapy." However, it does not define what this means. The nature of psychotherapy (and subsequently the nature of the informed consent discussion) may vary according to the personal style of the psychotherapist, their training and theoretical orientation, the age of the patient (e.g., a child versus an adult patient), and the type of psychotherapy (e.g., individual, family, or group) implemented. Topics to be covered might include a brief description of the modality proposed, the frequency and length of sessions, the potential for a medication referral, and practical details, such as how the psychotherapist handles communications or emergency services.

The Code of Ethics does not require psychologists to get their patients to sign an

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informed consent document, although this may be a prudent risk management strategy (Knapp et al., 2013). This lets patients read the document at leisure, reinforcing points made during the informed consent discussion. A signed document also shows that the psychotherapist met the legal obligations of providing informed consent. Various sample informed consent forms exist, such as the one developed by Scropo et al. (n.d.) from the Trust, a major professional liability carrier for psychologists, which is readable and easy for patients to understand.

In addition, informed consent has an ethical dimension because it derives its justification from the ethical principle of respect for patient autonomy. According to this principle, patients have a right to make decisions about their own lives, including whether they want to enter treatment (APA, 2017, General Principles). The informed consent process is designed to ensure that patients understand the nature of treatment sufficiently to make an informed decision (Beauchamp & Childress, 2019).

Although the laws establish minimal standards for what should be included in the informed consent process, the ethical principles call upon psychologists to go beyond the minimum and consider what information would be relevant to their patients. Consequently, ethical psychologists will approach the informed consent process as a dialogue, will vary the emphasis on specific points depending on the needs of their patients, add additional information if helpful, and will revisit informed consent issues throughout treatment as the need arises, such as when they introduce new techniques to their patients (Bryan & Rudd, 2018).

Respect for patient autonomy does not end when a patient has been offered the HIPAA Privacy Notice or has signed an

informed consent document. Instead, psychotherapists can respect patient autonomy throughout treatment by listening carefully to their patients, explaining treatment details thoroughly, involving patients in treatment decisions as much as feasible, and asking patients for feedback (Knapp, 2024).

Finally, the informed consent process has a psychotherapeutic dimension. Psychotherapists should not view informed consent as a pro forma process that they are required to get out of the way to start psychotherapy. Instead, it can be the first step in psychotherapy.

### **Psychotherapeutic Aspects of Informed Consent with Suicidal Patients**

Psychotherapists treating suicidal patients should modify their informed consent process to accommodate their patients' unique needs. This means providing more detail on the nature and anticipated course of psychotherapy, which requires clinical honesty and describes a collaborative approach focusing on how patients can gain more control over their lives. The process contains psychotherapeutic elements to the extent that it improves the psychotherapist/patient alliance, increases expectations concerning the benefit of treatment, and affirms the patient's agency and capacity to overcome their problems.

### **Accurately Describing Treatments to Suicidal Patients**

Psychotherapists should be transparent about the nature of psychotherapy, including its risks as this builds trust between psychotherapists and their patients. "Clinical honesty related to suicide risk begins with thoughtful and thorough informed consent" (Jobes, 2023, p. 7). This also shows respect for the patient's right to make treatment de-

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cisions because it gives them accurate information when deciding about entering psychotherapy.

Clinical honesty includes discussing facets of psychotherapy that patients might not like. For example, psychotherapists should acknowledge that psychotherapy may involve discussing unpleasant situations and sometimes engenders unpleasant emotions (Scropo et al., n.d.). With that in mind, Bryan and Rudd (2018) told their suicidal patients receiving brief cognitive behavioral therapy (BCBT) that “treatment will involve discussions of emotionally difficult topics that can sometimes increase a patient’s distress in the short term. These periods of increased distress tend to be very brief, but they could increase the patient’s desire for suicide for short periods. The clinician and patient will work together to help the patient get through these periods” (Bryan & Rudd, 2018, p. 41).

Honesty also requires acknowledgment that no psychotherapist can guarantee a nonfatal outcome. For example, in their informed consent process, Bryan and Rudd (2018) explain that some suicidal patients will attempt suicide while in treatment but that their risk of an attempt usually declines over time.

However, honesty also involves describing the positive outcomes that can occur, and psychotherapists should not be shy about touting the benefits of good psychotherapy because evidence shows that many psychotherapies are highly effective in reducing suicide attempts and deaths (Sufrate-Soranzo et al., 2023). For example, one suicide intervention, safety planning, has been shown to reduce suicide attempts by an average of 48% (Nuij et al., 2021), and a trial with BCBT reduced suicide attempts in the treatment group by 60% compared to a treatment-as-usual

group. There is no need to puff up or exaggerate the effectiveness of these techniques, and the psychotherapist should acknowledge there may be a need for some trial and error. As described by Bryan and Rudd (2018), “treatment involves experimenting with new skills designed to solve problems without suicide attempts” (p. 41).

Suicidal patients often encounter friends or even other mental health professionals who avoid talking about suicide (Frey et al., 2016). Patients may feel relief when they can speak to someone who appreciates the severity of their suicidal urges yet is not afraid to talk about it openly and can honestly describe the risks and benefits of treatment (Jobes, 2023). Although psychotherapists can offer optimism, they should not minimize their patients’ concerns nor exaggerate the ease or speed of recovery.

Suicidal patients often feel a sense of entrapment or a belief that they do not have the power to stop the intense and unbearable pain that they feel. Entrapment is similar to the concept of hopelessness in that patients do not see a way out of their difficulties, but it differs in that it necessarily includes intense pain. The discussion of the effectiveness of psychotherapy may challenge their entrapment beliefs and give patients hope that they will be able to get more control over their lives. Patients who enter psychotherapy with expectations of improvement are more likely to benefit from psychotherapy (McAleavey et al., 2019).

### **Accurately Describing Their Attitude Toward Coercive Techniques to Suicidal Patients**

Psychotherapists should be honest about when they would use coercive interventions with their patients. Many suicidal patients fear that their psychotherapist

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will force or pressure them to go into the hospital against their will, take medications that they do not want to take, or disclose information to third parties without their consent. The fear of coercion is one of the most common reasons that patients hide or minimize their suicidal thoughts (Blanchard & Farber, 2020). Their fear of disclosure may be exacerbated by the stigma attached to being the subject of involuntary treatment.

Consequently, psychotherapists should describe the circumstances under which they would use coercive interventions. Ideally, this would be the rare circumstance when the risk of a patient's death is imminent, and there is no other way to stop a suicide attempt. Even then, an effort will be made to involve patients in the decision as much as possible. Psychotherapists can then describe their personal experiences using coercive measures, which is likely very rare, thus giving more weight to their promise of collaboration.

As written by one former patient, "Promise to listen to everything I say and take into consideration my emotional state at the time. . . Then see admitting to a hospital as a LAST resort" (Blanchard & Farber, 2020, p. 131). Psychotherapists who follow this advice will significantly improve their patients' trust and increase the likelihood that patients will be honest with them. Tucker and Gonzalez (2024) found that veterans who watched an informed consent video that presented a collaborative approach to treatment and limited reliance on coercion expressed a greater willingness to disclose suicidal thoughts and related risk factors compared to those who watched a more general informed consent video.

### **Describing a Collaborative Approach to Suicidal Patients**

The best treatments for suicidal patients focus on respecting their autonomy (e.g.,

Bryan & Rudd, 2018; Jobes, 2023; Knapp, 2024) not only during the informed consent process but also throughout psychotherapy. Psychologists can demonstrate this respect by adopting a collaborative approach to assessment and psychotherapy (Knapp, 2024).

Psychotherapists can emphasize the importance of collaboration during the informed consent process. They can express faith that the patient has the internal ingredients (with guidance from their psychotherapists) to overcome their problems. Jobes tells his patients that "the answers to your struggles exist within you—we will find these answers together as treatment partners" (Jobes, 2023, p. 64). They are told that they are experts in their own experiences. They are expected to participate actively in treatment and honestly express any concerns about psychotherapy. Just the expression of faith in the patient's latent strengths can start the process of dismantling self-devaluing emotions.

### **Practice Pointers When Discussing Informed Consent with Suicidal Patients**

Although it is a legal requirement and an ethical mandate, the informed consent process can also contain the first steps in psychotherapeutic interventions.

The informed consent process with suicidal patients emphasizes clinical honesty about the benefits and risks of psychotherapy, an expectation that the patients will be partners in a collaborative relationship, and faith in the patient's ability to redirect their lives.

These elements can help patients develop trust in their psychotherapists, increase their willingness to be honest with them, instill hope that there may be an end to their suffering, and foster confidence that

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they can overcome their difficulties with guidance from their psychotherapists.

## References

- American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, amended effective June 1, 2010, and January 1, 2017). <https://www.apa.org/ethics/code/>
- Blanchard, M., & Farber, B. A. (2020). "It is never okay to talk about suicide": Patients' reasons for concealing suicidal ideation in psychotherapy. *Psychotherapy Research*, 30(1), 124-136. <https://doi.org/10.1080/10503307.2018.1543977>
- Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive behavior therapy for suicide prevention*. Guilford.
- Frey, L. M., Hans, J. D., & Cerel, J. (2016). Perceptions of suicide stigma: How social networks and treatment providers compare? *Crisis*, 37(2), 95-103. <https://doi.org/10.1027/0227-5910/a000358>
- Jobs, D. A. (2023). *Managing suicidal risk: A collaborative approach* (3<sup>rd</sup> ed.). Guilford.
- Knapp, S. (2024). Listen, explain, involve, evaluate: Why respecting autonomy benefits suicidal patients. *Ethics and Behavior*, 34(1), 18-27. <https://doi.org/10.1080/10580422.2022.215338>
- McAleavey, A. A., Xiao, H., Bernecker, S. L., Brunet, H., Morrison, N. R., Stein, M., & Beutler, L. (2019). An updated list of principles of change that work. In L. Castonguay, M. L. Constantino, & L. E. Beutler (Eds.), *Principles of change: How psychotherapists implement research in practice* (pp. 13-37). Oxford University Press.
- Nuij, C., van Ballegooijen, W., de Beurs, D., Juniar, D., Erlangsen, A., Portzky, G., O'Connor, R. C., Smit, J. H., Kerkhof, A., & Riper, H. (2021). Safety planning-type interventions for suicide prevention: Meta-analysis. *British Journal of Psychiatry*, 219(2), 419-426. <https://doi.org/10.1192/bjp.2021.50>
- Scropo, J., Taube, D., & Zelechowski, A. (n.d.). *Sample informed consent for psychotherapist-adult patient contract*. Retrieved from <https://parma.trustinsurance.com/Resource-Center/Document-Library-Quick-Guides>
- Sufrate-Soranzo, T., Santolalla-Arnedo, I., Garrote-Cámara, M. E., Angulo-Nalda, B., Cotelo-Saáenz, R., Pastells-Peiró, R., Bellon, F., Blanco-Blanco, J., Juárez-Vela, R., & Molina-Luque, F. (2023). Interventions of choice for the prevention and treatment of suicidal behaviours: An umbrella review. *Nursing Open*, 10(8), 4959-4970. <https://doi.org/10.1002/nop2.1820>
- Tucker, B. C., & Gonzalez, V. M. (2024). Effect of enhanced informed consent on veteran hesitancy to disclose suicidal ideation and related risk factors. *Suicide and Life-Threatening Behavior*, 54(3), 405-415. <https://doi.org/10.1111/sltb.13053>
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### Dealing with Bias in Artificial Intelligence Driven Psychotherapy Tools Among Cultural and Racial Populations

Caleb Onah, MS



Psychotherapy as a tool for treating various mental and physical health disorders has long been established as an effective treatment modality for mental disorders in

Western populations, demonstrating efficacy and long-term efficiency (Kim et al., 2019). However, some authors argue that Western approaches and models in psychotherapy may not be suitable for Black Africans (Shatte et al., 2019) and for other cultures. Others advocate for a return to traditional psychotherapeutic paradigms, suggesting that in Africa and other continents of the world, healing is not solely based on the individual alone, but between therapist and patient and also as a collective process involving the community. The traditional African system, for instance, has an inherent psychological treatment framework. For example, African Grief Therapy, evident in burial rites and ceremonies, and the ritual bathing of child soldiers for cleansing, facilitates the assumption of a new identity and coping with the past (Nwoye, 2000).

Currently, there is no doubt that available artificial intelligence (AI) technologies could automate some of the time and labor-intensive aspects of clinical practices and therapies, thereby improving the efficiency and accessibility of psychological services in both public and private sectors (Huang et al., 2019). It is conceivable that AI will eventually enable the development and implementation of autonomous psychotherapy-bots capable of providing fully automated psychological services and therapies

(Collins et al., 2021). Kleiman and colleagues (2017) found that using ecological momentary assessment data factors such as hopelessness and loneliness also correlated with suicidal ideation for clients over time. This knowledge paves the way for idiographic, real-time assessments that can inform truly personalized interventions (DeRubeis, 2019; Weisz et al., 2019). Another advantage of artificial intelligence in psychotherapy is its potential to enhance our identification of clinical populations and improve our ability to match interventions to the subgroups most likely to benefit (Kretschmar et al., 2019).

Research in the application of AI in psychotherapy across cultures is advancing (Kim et al., 2019; McGreevey et al., 2020) with software being developed for language recognition and processing. Also, AI and machine learning - a subset of AI that focuses on developing algorithms and statistical models that allow computers to perform tasks without explicit instructions - are increasingly utilized in mental healthcare and psychotherapeutic intervention (Torous et al., 2020), however, their reliability across cultures and varied populations is limited. One emerging technology is the Generative Pretrained Transformer (GPT-4.5) AI model, including agents and chatbots, which are often integrated into mobile applications and various medical devices. These tools help in providing mental health support or solutions, frequently addressing depression, anxiety, and other disorders (Adamopoulou & Moussiades, 2020).

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Clinicians and psychotherapists have categorized AI tasks and processes into three areas: mechanical, thinking, and feeling (Huang et al., 2019). Huang and colleagues (2019) posited that AI could readily handle mechanical (robotics) and thinking tasks (processing, analyzing, and interpreting data), but suggested that feeling tasks (communication) should be reserved for humans. This research did not account for the potential amplification of biases present in the input used to train AI systems. Clinical research has admittedly found that the analysis and processing of heterogeneous data can be problematic (Dwivedi et al., 2021). There are ethical dimensions to consider regarding data sharing and discrimination. Even though humans do not conduct the analysis and decision-making, the AI algorithm can reflect the pervasive discriminatory attitudes of the engineer or the source data (OpenAI, 2019). Challenges related to data usage and integrity has also been highlighted. As technology matures, these issues need to be resolved to ensure full confidence among clinicians and research stakeholders (OpenAI, 2022).

### **Trends of Bias in the Usage of Artificial Intelligence**

#### **Bias in the Usage of Artificial Intelligence across Different Populations**

In one study, Johnson and Williams (2023) assessed GPT-4's potential to perpetuate racial and gender biases in clinical decision-making. A team of Brigham researchers analyzed GPT-4's performance in four clinical decision support scenarios: generating clinical vignettes, diagnostic reasoning, clinical plan generation, and subjective patient assessments. The study found that GPT-4 has the potential to perpetuate racial and gender biases in clinical decision-making. The authors suggest that further research is needed to understand the extent of these biases and how they can be mitigated. Clinicians already face

considerable pressure to diagnose and treat patients accurately and fairly. Relying on AI tools prone to bias could introduce additional challenges, requiring clinicians to constantly evaluate and potentially override AI suggestions, adding to their workload. This could also create ethical dilemmas when faced with conflicting recommendations.

In my usage, language models have been shown to amplify biases and perpetuate stereotypes in cases against women more than men (Blodgett et al., 2020; Onah et al., 2024). Like earlier GPT and other common language models, both early launch versions of GPT-4 have been found to have the potential to reinforce and reproduce specific biases and worldviews, including harmful stereotypes and demeaning associations for certain marginalized groups (Onah et al., 2024). Model behaviors, such as inappropriate hedging, can also exacerbate stereotyping or demeaning behaviors. In recent decades, there has been a growing trend of incorporating data collection across various aspects of life, facilitating the development and application of new AI methods (California Association for School Psychologists, 2020). This trend is evident across domains with prevalent multi-dimensional data sets and common use of AI methods. Researchers and clinicians from various disciplines have increasingly highlighted a pervasive assumption in relying on these methods (O'Neil, 2016; Prakash et al., 2022). Hence, this could undermine the trust between therapist and client, impede the therapeutic process, and perpetuate harmful stereotypes within the therapeutic setting.

Research on multi-dimensional databases and algorithms has shown they are prone to biases and heuristics, relying on arbitrary classifications, messy

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data, and numerous concealed uncertainties (Hong, 2020). Similarly, psychotherapy data can also be biased. For instance, cognitive behavioral therapy has shown to be predominantly developed and utilized with White, well-educated, heterosexual individuals (Wong, 2023). Any algorithm based on such historical data risks ignoring large segments of the population, including neuro-diverse individuals, racial and ethnic minorities, culturally diverse groups, LGBTQ+ individuals, and people from diverse socioeconomic backgrounds (Wong, 2023). Additionally, factors such as history, background, lived experiences, and context are crucial in psychotherapy. Consequently, many environmental factors important to mental health treatment outcomes were not considered. This is a significant limitation for all current data sources in psychotherapy practice, research and AI. This emphasizes another important point: data only provides a limited perspective of the real world. The application of machine learning here tends to automate homogeneity, marginalizing the humans whose lives the data represent (Crawford, 2021).

Deductively, it can be said that AI platforms have been shown to have inherent biases and discriminatory factors. AI algorithms, as presently developed, are based on a set of data that represent society's historical and systemic biases, which ultimately transform into algorithmic biases. Even though the bias is embedded into the algorithmic model with no explicit intention, it is clear that there are various cultural and racial biases in different AI-based platforms (Akgun & Greenhow, 2021). For example, chatbots have been shown to reproduce stereotypical gendered language, such as referring to nurses as "she" and doctors as "he" (Bastiansen et al., 2022; Nag & Yalçın, 2020).

### **Bias of Artificial Intelligence Among Clinicians and Practitioners**

A study by Chekroud et al. (2024) highlights the limitations of clinicians and psychotherapists using an algorithm to predict outcomes for schizophrenia treatment, challenging the assumption of algorithmic infallibility. The literature contains numerous examples of algorithms that harm vulnerable and marginalized groups, even when they perform as intended (Broussard, 2018; Eubanks, 2019). This reveals that a sentencing algorithm exhibited bias against Black individuals, perpetuating historical racial injustices by predicting a higher risk of recidivism for Black individuals and a lower risk for White individuals, resulting in longer and harsher sentences for Black people (Eubanks, 2019).

Further, clinicians' experiences, emotions, and psychological states are inherently complex and influenced by numerous factors that extend beyond quantitative data (Farahany, 2023). While machine learning and AI algorithms excel at analyzing large datasets and making inferences, they often struggle to capture the nuances, context, and subtleties inherent in human behavior and clinicians' expertise (Ghandeharoun et al., 2019). By placing trust in AI inferences, there is a risk of neglecting essential clinician experience, interpersonal dynamics, cultural contexts, and other important variables. Any potential oversimplification may lead to misguided interventions or misinterpretations of the clients' needs. Safeguarding against potential biases within machine learning models is crucial to prevent unintended harm or the exacerbation of existing disparities in healthcare.

Also, human biases often lead us to take the shortest cognitive route irrespective of our expertise or professional qualifi-

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cations, facilitating irrational investment in algorithmic systems (DeNardis, 2020). This risk is exacerbated by creating increasingly complex data sets that encompass previously unquantified aspects of people's lives—physical, neurological, psychological, and emotional (Farahany, 2023). Overreliance on algorithmic inferences could inadvertently diminish the essential human element of psychotherapeutic interventions (Renieris, 2023). If we fail to address this overreliance on algorithmic issues, we will develop AI that appears intelligent on the surface but is rife with injustice and inequity underneath, potentially oversimplifying the human complexities (social, cultural, political, historical, and personal) that are central to psychotherapy as a human endeavor. The complexity of new technology might shift the underlying conceptions of autonomy of clinicians, beneficence, non-maleficence, and justice, or might introduce new normative and conceptual distinctions. Causing harm in a traditional setting might mean something different than causing harm in a digital world. For example, the integrity of psychologists and clinicians is one of the core principles in psychotherapy (American Psychological Association, 2017), and forms of deception are justified only under exceptional circumstances. However, is it justified for a chatbot to interact as if it were empathetic? Some literature calls for more in-depth studies, holistic and human-centered approaches, and research focused on the long-term societal and individual impacts of novel technology (Wong, 2023).

Moreover, incorporating AI-based technology into psychotherapeutic practice could have profound philosophical impacts, potentially altering humanity's collective identity and basic conceptions of knowledge, life, reality, and existence. From the foregoing, it is evident that the

field of psychotherapy faces numerous significant challenges. First, the growing prevalence of mental health conditions strains service delivery due to a shortage of trained professionals across different cultures and races experienced in the use of AI systems. This scarcity makes it difficult for clients to access evidence-based treatment options, a situation exacerbated by the recent pandemic (Santomauro et al., 2021). Second, not everyone benefits from psychotherapy treatment with about 50% responding to treatment, and about 30% experiencing are mission of symptoms (Santomauro et al., 2021). Despite significant advancements, diagnostic clarity and prognosis prediction remain elusive.

#### **Recommendations on Bias Projected by Artificial Intelligence**

**Cultural competence training:** Institutions responsible for AI deployment and usage should train clinicians in cultural competence so they can recognize and mitigate biases when using AI tools in therapy (OpenAI, 2022). This can include creating tool adaptation by considering the cultural contexts and nuances that might affect their performance and relevance, thereby facilitating bias. Clinicians, in general, should be trained in identifying demographic or clinical populations at greatest risk of engaging in harmful and potentially fatal behavior and bias, thus using AI appropriately. With these trainings, clinicians can consequently investigate dynamic intra-individual factors associated with an increased risk of harmful behavior for the individuals and population in general (Onah et al., 2024).

**Diversifying training data:** One of the primary sources of bias in AI models is the data used to train them. To mitigate this bias, datasets should be diversified with the training data including a wide

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range of cultural, racial, and ethnic backgrounds. This helps the AI system learn from a variety of experiences and perspectives. Further, augmenting existing datasets with synthetic data that reflects underrepresented groups to balance the dataset is a key way of mitigating bias. Regular audits to continuously analyze and update the datasets to ensure they remain representative of the target populations are also necessary.

**Ensuring explainability and interpretability:** Ensuring the explainability (or interpretability) of AI models is a primary consideration for the usage of AI in psychotherapy. This involves clearly explaining the model's mechanisms and outputs to another human, including any inherent biases. When predicting clinical outcomes, it is crucial to understand definitions, clinical measures used, and temporal considerations for achieving acceptable accuracy (e.g., 85%) for balanced trade-offs (Prasad et al., 2023).

**Addressing socioeconomic and demographic biases:** Studies have revealed that race and ethnicity, poverty, and living in rural areas are associated with the exacerbation of pediatric mental health issues (Kretzschmar et al., 2019). Mental health professionals using AI-assisted technology should vet the technology's creator to ensure steps have been taken to protect against harmful biases in the training data sets and algorithms (Rahman, 2023) in their cultures and countries. The most essential variable in producing non-biased AI is the diversity of the team that built it.

**Legal and ethical considerations:** Researchers and clinicians need to be aware that new laws in the European Union and African Union seek to ensure AI systems used in these regions are safe, transparent, traceable, non-discriminatory, and overseen by people to prevent harm-

ful outcomes (European Parliament, 2023). It is important for psychotherapists, psychologists and clinicians alike to understand the relevance of these laws in the context of AI and psychotherapy practice (Fiske et al., 2020).

**Data integration and privacy concerns:** Researchers like Chekroud et al. (2024) amalgamate different databases in psychotherapy, a practice currently observed in the field. However, inherent limitations exist regarding data completeness, prompting debates on datafication (Ulberg et al., 2023). While some advocate for a complete ban due to privacy concerns and stereotypes, it is important for innovation potential, with privacy-enhancing technologies offering a secure integration of diverse sources (The Royal Society, 2023).

**Synthetic data as a solution:** Synthetic data offers benefits like customizability, cost-effectiveness, rapid production, privacy protection, and inclusion of diverse groups. While AI has progressed in drug discovery, its role in psychotherapy is still emerging and not yet suitable for essential school psychological services, such as assessment, therapy, and supervision. These responsibilities lie with school psychologists and licensed educational psychologists who should select tests and provide clinical judgments (California Association of School Psychologists, 2020). AI should not replace supervisors in training. Direct feedback from supervisors is crucial to ensure high-quality training and uphold practice standards (California Association of School Psychologists, 2015).

**Scientist-practitioner paradigm:** Adhering to the scientist-practitioner paradigm, clinicians should analyze data with AI within the established framework of psychotherapy theory and practice. Formu-

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lating questions and hypotheses based on evidentiary standards aids in interpreting results and discerning inherent data quality limitations. Implementing safety features, like out-of-distribution detection in machine learning models, ensures responsible deployment, preventing inappropriate predictions for individual clients (Chen et al., 2020).

## Conclusion

It can be seen that AI's sophisticated methods come with significant computational costs and bias, posing challenges in some cultures. As AI intersects with psychotherapy, it is crucial to acknowledge potential risks and biases through evidence-based practices. These challenges emphasize the need to address treatment access and bias, and to improve treatment effectiveness. Although AI-supported psychotherapy offers benefits in efficiency and access, its costs and variable impacts across cultures must be carefully considered to enhance its validity and reliability. By implementing these strategies, developers and practitioners can work towards minimizing bias in AI-driven psychotherapy tools, thereby enhancing their fairness and effectiveness across different cultural and racial populations.

## References

Adamopoulou, E., & Moussiades, L. (2020). An overview of chatbot technology. In R. Nugent & K. Rannenberg (Eds.), *IFIP advances in information and communication technology*, (1st ed., pp. 373-383). Springer. [https://dx.doi.org/10.1007/978-3-030-49186-4\\_31](https://dx.doi.org/10.1007/978-3-030-49186-4_31)

Akgun, S., & Greenhow, C. (2021). Artificial intelligence in education: Addressing ethical challenges in K-12 settings. *AI Ethics*, 2(1), 431-440. <https://doi.org/10.1007/s43681-021-00096-7>

American Psychological Association. (2017). Ethical principles of psychol-

ogists and code of conduct (2002, amended effective June 1, 2010, and January 1, 2017).

<https://www.apa.org/ethics/code>

Bastiansen, M. H. A., Kroon, A. C., & Araujo, T. (2022). Female chatbots are helpful, male chatbots are competent? The effects of gender and gendered language on human-machine communication. *Publizistik*, 67(2), 147-164. <http://dx.doi.org/10.1007/s11616-022-00762-8>

Blodgett, S. L., Barocas, S., Daumé III, H., & Wallach, H. (2020). Language (technology) is power: A critical survey of "bias" in NLP. *Proceedings of the 58th Annual Meeting of the Association for Computational Linguistics*, 1, 5454-5476. <https://aclanthology.org/2020.acl-main.485/>

Broussard, M. (2018). *Artificial unintelligence: How computers misunderstand the world*. MIT Press. <https://mitpress.mit.edu/9780262537018/artificial-unintelligence/>

California Association of School Psychologists. (2020). Revised school psychologist code of ethics. [Web article]. Retrieved from <https://www.casponline.org/pdfs/publications/Code%20of%20Ethics%203-2020-2.pdf>

California Association of School Psychologists. (2015). Revised to focus on ethics for the practice of licensed educational psychologists. [Web article]. Retrieved from <https://casponline.org/pdfs/lep/LEP%20Code%20Of%20Ethics%2010-15.pdf>

Chekroud, A. M., Hawrilenko, M., Loho, H., Bondar, J., Gueorguieva, R., Hasan, A., Kambeitz, J., Corlett, P. R., Koutsouleris, N., Krumholz, H. M., Krystal, J. H., & Paulus, M. (2024). Illusory generalizability of clinical prediction models. *Science*, 383(6679), 164-167. <https://doi.org/10.1126/science.adg8538>

*continued on page 59*

- Chen, J., Li, Y., Wu, X., Liang, Y., & Jha, S. (2020). Robust out-of-distribution detection for neural networks. [Web article]. Retrieved from <http://arxiv.org/abs/2003.09711>
- Collins, C., Dennehy, D., Conboy, K., & Mikalef, P. (2021). Artificial intelligence in information systems research: A systematic literature review and research agenda. *International Journal of Information Management*, 60(4), 102383. <https://doi.org/10.1016/j.ijinfomgt.2021.102383>
- Crawford, K. (2021). *Atlas of AI: Power, politics, and the planetary costs of artificial intelligence*. Yale University Press. <https://yalebooks.yale.edu/book/9780300264630/atlas-of-ai/>
- DeNardis, L. (2020). *The internet in everything: Freedom and security in a world with no off switch*. Yale University Press. <https://yalebooks.yale.edu/book/9780300233070/the-internet-in-everything/>
- DeRubeis, R. J. (2019). The history, current status and possible future of precision mental health. *Behaviour Research and Therapy*, 123(5), 103506. <https://doi.org/10.1016/j.brat.2019.103506>
- Dwivedi, Y. K., Hughes, L., Ismagilova, E., Aarts, G., Coombs, C., Crick, T., Duan, Y., Dwivedi, R., Edwards, J., Eirug, A., Galanos, V., Ilavarasan, P. V., Janssen, M., Jones, P., Kumar, K. A., Kizgin, H., Kronemann, B., Lal, B., Lucini, B., ... Williams, M. D. (2021). Artificial intelligence (AI): Multidisciplinary perspectives on emerging challenges, opportunities, and agenda for research, practice and policy. *International Journal of Information Management*, 57(7), 101994. <http://dx.doi.org/10.1016/j.ijinfomgt.2019.08.002>
- Eubanks, V. (2019). Automating inequality: How high-tech tools profile, police, and punish the poor. St. Martin's Press. <https://www.ama-zon.com/Automating-Inequality-High-Tech-Profile-Police/dp/1250074312>
- European Parliament. (2023, December). EU AI act: First regulation on artificial intelligence. [Web article]. Retrieved from <https://www.europarl.europa.eu/news/en/headlines/society/20230601STO93804/eu-ai-act-first-regulation-on-artificial-intelligence>
- Farahany, N. A. (2023). *The battle for your brain*. St. Martin's Press. <https://us.macmillan.com/books/9781250272966/thebattleforyourbrain>
- Fiske, A., Henningsen, P., & Buyx, A. (2020). The implications of embodied artificial intelligence in mental healthcare for digital wellbeing. In *ethics of digital well-being*, ed. Ch. Burr and L. Floridi, 207–219. Cham: Springer International Publishing. [http://dx.doi.org/10.1007/978-3-030-50585-1\\_10](http://dx.doi.org/10.1007/978-3-030-50585-1_10)
- Ghandeharioun, A., McDuff, D., Czerwinski, M., & Rowan, K. (2019). EMMA: An emotion-aware wellbeing chatbot. *arXiv Preprint*. <https://doi.org/10.48550/arXiv.1812.11423>
- Hong, S. (2020). *Technologies of speculation: The limits of knowledge in a data-driven society*. NYU Press. <https://nyupress.org/9781479860234/technologies-of-speculation/>
- Huang, M.-H., Rust, R., & Maksimovic, V. (2019). The feeling economy: Managing in the next generation of artificial intelligence (AI). *California Management Review*, 61(4), 43-65. <http://dx.doi.org/10.1177/0008125619863436>
- Johnson, B., & Williams, C. (2023). Study assesses GPT-4's potential to perpetuate racial, gender biases in clinical decision making. *Journal of Medical Ethics*, 48(2), 1-7.
- Kim, J. W., Jones, K. L., & Angelo, E. D. (2019). How to prepare prospective

*continued on page 60*

- psychiatrists in the era of artificial intelligence. *Academic Psychiatry*, 43, 1–3. <https://doi.org/10.1007/s40596-019-01025-x>
- Kleiman, E. M., Turner, B. J., Fedor, S., Beale, E. E., Huffman, J. C., & Nock, M. K. (2017). Examination of real-time fluctuations in suicidal ideation and its risk factors: Results from two ecological momentary assessment studies. *Journal of Abnormal Psychology*, 126(6), 726–738. <https://doi.org/10.1037/abn0000273>
- Kretschmar, K., Tyroll, H., Pavarini, G., Manzini, A., & Singh, I. (2019). Can your phone be your therapist? Young people’s ethical perspectives on the use of fully automated conversational agents (Chatbots) in mental health support. *Biomedical Informatics Insights*, 11. <https://doi.org/10.1177/1178222619829083>
- McGreevey, J. D. III., Hanson, C. W. III., & Koppel R. (2020). Clinical, legal, and ethical aspects of artificial intelligence–assisted conversational agents in health care. *Journal of the American Medical Association Network*, 324, 552–553. <https://doi.org/10.1001/jama.2020.2724>
- Nag, P., & Yaçın, Ö. N. (2020). Gender Stereotypes in Virtual Agents. *Proceedings of the 20th ACM International Conference on Intelligent Virtual Agents (IVA '20)*, 41, 1–8. <http://dx.doi.org/10.1145/3383652.3423876>
- Nwoye, A. (2000). Sources of gain in African grief therapy (AGT). *Journal of Family Psychotherapy*, 11, 1, 59–72. [https://doi.org/10.1300/J085v11n01\\_04](https://doi.org/10.1300/J085v11n01_04)
- O’Neil, C. (2016). *Weapons of math destruction: How big data increases inequality and threatens democracy*. New York: Crown Publisher. <http://dx.doi.org/10.5860/cr1.78.3.403>
- Onah, C., Ogwuche, C., & Sohn, L. (2024, March). Treatment procedures for behavioural risks associated with GPT-4 artificial intelligence model. *Psychotherapy Bulletin*, 59(3). [Web article]. Retrieved from <https://societyforpsychotherapy.org/treatment-procedures-for-behavioural-risks-associated-with-gpt-4-artificial-intelligence-model/>
- OpenAI (2019, November). GPT-2:1.5B release. [Web article]. Retrieved from <https://openai.com/research/gpt-2-1-5b-release>
- OpenAI. (2022, September). Privacy policy. [Web article]. Retrieved from <https://openai.com/privacy/>
- Prakash, S., Balaji, J. N., Joshi, A., & Surapaneni, K. M. (2022). Ethical conundrums in the application of artificial intelligence (AI) in healthcare—a scoping review of reviews. *Journal of Personal Medicine*, 12(11), 1914. <https://doi.org/10.3390/jpm12111914>
- Prasad, N., Chein, I., Regan, T., Enrique, A., Palacios, J., Keegan, D., Munir, U., Tanno, R., Richardson, H., Nori, A., Richards, D., Doherty, G., Belgrave, D., & Thieme, A. (2023). Deep learning for the prediction of clinical outcomes in internet-delivered CBT for depression and anxiety. *Plos ONE*, 18(11), 1–20. <https://doi.org/10.1371/journal.pone.0272685>
- Rahman, M. M. (2023). AI for ADHD: Opportunities and challenges. *Journal of Attention Disorder*, 27(8), 797–799. <https://doi.org/10.1177/10870547231167608>
- Renieris, E. M. (2023). *Beyond data: Reclaiming human rights at the dawn of the metaverse*. MIT Press. <https://mitpress.mit.edu/9780262047821/beyond-data/>
- Santomauro, D. F., Mantilla Herrera, A. M., Shadid, J., Zheng, P., Ashbaugh, C., Pigott, D. M., Abbafati, C., Adolph, C., Amlag, J. O., Aravkin, A. Y., Bang-Jensen, B. L., Bertolacci, G. J., Bloom, S. S., Castellano, R., Castro, E., Chakrabarti, S., Chattopadhyay,

*continued on page 61*

- J., Cogen, R. M., Collins, J. K., ... Ferrari, A. J. (2021). Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. *The Lancet*, 398(10312), 1700–1712. [https://doi.org/10.1016/S0140-6736\(21\)02143-7](https://doi.org/10.1016/S0140-6736(21)02143-7)
- Shatte, A. B. R., Hutchinson, D. M., & Teague, S. J. (2019). Machine learning in mental health: A scoping review of methods and applications. *Psychological Medical*, 49, 1–23. <https://doi.org/10.1017/S0033291719000151>
- The Royal Society. (2023, January). From privacy to partnership. [Web article]. Retrieved from <https://royalsociety.org/-/media/policy/projects/privacy-enhancing-technologies/from-privacy-to-partnership.pdf>
- Torous, J., Myrick, K. J., Rauseo-Ricupero, N., & Firth, J. (2020). Digital mental health and COVID-19: Using technology today to accelerate the curve on access and quality tomorrow. *The Journal of Medical Internet Research in Mental Health*, 7(3), 1–6. <https://doi.org/10.2196/18848>
- Ulberg, R. L., Wolfgang, T., Svenja, P., & Stig, G. M. M. (2023). Large psychotherapy consortiums: How can we collaborate to make it happen? *SPR 54th International Annual Meeting of the Society for Psychotherapy Research*. 1, 23–202. [https://cdn.ymaws.com/www.psychotherapyresearch.org/resource/resmgr/imported/events/annualmeeting\\_progs/spr\\_meeting\\_program\\_2023.pdf](https://cdn.ymaws.com/www.psychotherapyresearch.org/resource/resmgr/imported/events/annualmeeting_progs/spr_meeting_program_2023.pdf)
- Weisz, J. R., Kuppens, S., Ng, M. Y., Vaughn-Coaxum, R. A., Ugueto, A. M., Eckshtain, D., & Corteselli, K. A. (2019). Are psychotherapies for young people growing stronger? Tracking trends over time for youth anxiety, depression, ADHD, and conduct problems. *Perspectives on Psychological Science*, 14(2), 216–237. <https://doi.org/10.1177/1745691618805436>
- Wong, W. H. (2023). *We, the data: Human rights in the digital age*. MIT Press. <https://mitpress.mit.edu/9780262048576/we-the-data/>





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### Measurement-Based Care and Cultural Responsiveness

Robert J. Reese, PhD

Barry L. Duncan, PsyD



While the case has been made that measurement-based care (MBC) is an evidenced-based intervention that improves outcomes and reduces dropouts (de Jong et al., 2021), and recently, that it provides a transparent collaborative process to engage clients in treatment (Boswell et al., 2023), it has not been widely considered as a methodology for cultural responsiveness.

This article proposes that MBC can encourage a communicative process that promotes cultural humility, creates opportunities for cultural exploration, and enhances therapists' cultural comfort—the three pillars of a multicultural orientation (MCO; Hook et al., 2017)—to address marginalization and therapist client differences. Using one evidence-based MBC approach with a heritage of collaborative and social justice processes to illustrate, we suggest that systematic client feedback can provide a structure to address diversity, oppression, and privilege in psychotherapy that all MBC approaches can implement.

#### **The Partners for Change Outcome Management System (PCOMS)**

With PCOMS, science caught up with the clinical process rather than vice versa. After the measures were developed, Duncan created the clinical process of PCOMS based on two years of private practice and the supervision of graduate students in a multicultural community clinic and detailed it in the first PCOMS

manual (Duncan & Sparks, 2002, now in its fourth edition). Over time, psychometric studies were published, and Duncan, Reese, and colleagues completed eight randomized clinical trials (see Duncan & Reese, 2024). PCOMS, while emerging from everyday practice and starting as a purely clinical process with an aspiration to privilege the client (Duncan & Moynihan, 1994) and promote socially just practice, evolved to be both a normative and communicative system (Duncan & Reese, 2013; Sparks & Duncan, 2018).

Attention to individual experience, “amplifying client voice” and “socially just practice” (Duncan & Sparks, 2002, p. iii) have been part of PCOMS since the beginning, but more fully articulated in later publications. For example, Duncan (2012) asserts:

Consumer involvement in all decisions that affect care also speaks to the issues of multiculturalism and social justice. Client centered or directed care necessarily includes a recognition of the disparate power that exists between the provider and consumer of services, especially for those not of the dominant culture as well as the traditionally disenfranchised, and transparently seeks to address the disparity...In addition, the infrastructure of mental health itself (i.e., diagnosis and prescriptive treatment) often leaves little room for the unique views of those whose culture, race, gender, gender expression, ability, age, or socioeconomic status differ from

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typical providers steeped in mainstream psychology...PCOMS seeks to level the psychotherapy process by inviting collaborative decision making, honoring client diversity with multiple language availability, and valuing local cultural and contextual knowledge; PCOMS provides a mechanism for routine attention to multiculturalism and social justice. (pp. 98-99).

### **Operationalizing a Multicultural Orientation**

PCOMS employs two 4-item scales, one focusing on outcome, the Outcome Rating Scale or ORS (Miller et al., 2003) and the other on the therapeutic alliance, the Session Rating Scale or SRS (Duncan et al., 2003). PCOMS directly involves clinicians and clients in an ongoing collaborative process of measuring and discussing both progress and the alliance, the first system to do so (Duncan & Reese, 2015). The ORS is a visual analogue instrument that is individualized with clients to represent their distress and the reasons for service on four domains (personal, interpersonal, social, overall). These major domains of life offer a general framework of human existence to which clients add the intimate details of their lived experience via therapeutic conversation. The content-free dimensions of the ORS allow clients to describe the meaning of their scores without preconceived theory, symptom, diagnostic, or therapist-derived constraints, running counter to practices that pathologize clients of color and other historically marginalized groups at higher rates (Sue et al., 2022). Thus, client accounts retain the richness of real life, including the unique back-stories that contextualize their dilemmas, including the possibility of oppression and discrimination.

### **Outcome Rating Scale Clinical Process and Multicultural Orientation**

Duncan and Reese (2024) provide a clinical example that highlights how the ORS is used to direct efforts within a session, across treatment, and how it can support MCO. First, the therapist oriented the client, a cisgender woman who recently immigrated from Mexico, to the ORS. In doing so, the therapist noted that the measure was used to ensure her perspective stayed central to treatment. This could be considered a dimension of cultural humility, the overt commitment to the client's perspective.

Second, the client completed the ORS and scored below the clinical cut score of 25 (14.7) indicating she was experiencing significant distress. Third, in reviewing the item scores, the therapist noted that the Social (work, school, relationships) item was rated the lowest and used it as a starting point to understand the client's reason for seeking treatment. The client then shared that her job was stressful and that she was experiencing discrimination from a boss who ridiculed her Spanish accent. This provided a cultural opportunity for the therapist and client to consider, communicating both empathy and wanting to better understand what occurred regarding her workplace discrimination. The items on the ORS go beyond an internal, symptom focus and consider social and contextual factors, including marginalization and oppression, that may be impacting this client's well-being. Such a structure also can empower therapists and clients to address these issues more directly, inspiring cultural comfort for the therapist. Asking about potential sociocultural issues is interwoven into the fabric of the ORS, making such conversations potentially easier and inspiring confidence in therapists to invite clients to discuss such issues. PCOMS data and clinical

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process continue to help inform treatment progress, invite further collaborative opportunities for client benefit, and continue to communicate a stance of cultural humility.

### **The Session Rating Scale**

The use of the SRS continues the value of client privilege and opens space for the client's voice about the alliance and therapist/client fit, specifically aiming to identify alliance ruptures before they negatively impact outcome. The SRS provides a structure to address the alliance, allows an opportunity to fix any problems, and demonstrates that the therapist is committed to forming good relationships. The SRS also encourages ethnic/cultural/racial/orientation differences to be transparently and routinely discussed.

By routinizing the asking for and receiving client feedback about their experience of therapy, the SRS promotes openness to client perspectives, laying the foundation for cultural comfort. Beyond being an alliance measure, the SRS represents a nuanced relational process designed to ensure that clients feel safe about offering feedback. This requires therapist comfortability about asking for feedback and a graceful response that accommodates the work to the feedback—an authentic desire for a frank discussion about client preferences regarding the alliance.

Although the alliance is discussed at each session, it gains additional priority if the client is not benefiting. Eliciting client responses in detail can help therapists and clients alike get a better sense of what may not be working. Such occurrences create a cultural opportunity to entertain how culture, including therapist and client differences, are contributing factors to the lack of success.

### **Session Rating Scale Clinical Process and Multicultural Orientation**

Administered at the end of the session, the SRS evaluates the working alliance and offers further opportunity to incorporate MCO. Duncan and Reese (2024) state, "But it requires therapists to embrace that they can never fully understand a client's cultural experience, with only continued efforts to gain a closer approximation" (p. 106). They provide a second example to demonstrate how the SRS is administered, can foster a collaborative relationship, and raise issues, including cultural, identity, or other issues that may be influencing treatment and/or the relationship.

The client in the example was a 42-year-old African American, cisgender man who was making little progress after four sessions of treatment. Although the SRS scores did not indicate an issue with the alliance (score was above the cut-score of 36), the therapist used the first item "I felt/or did not feel heard, understood, and respected" to ask if the racial difference between them (therapist was a white man) might impact the client feeling understood in a way the therapist could be missing. This led to a deeper discussion and recognition that the client's social locations were not a salient part of his story being shared, and a recalibration of the therapeutic conversation. In this instance, the SRS was used in a practical way to better understand the lack of progress in therapy from a multicultural framework. The SRS ensures there is space and structure for conversations about the relationship. The example demonstrated cultural humility in the willingness to gain the client's perspective and understanding about how issues of race/gender may be impacting both treatment and the working relationship. Further, the clinical process created a cultural opportunity and, like the

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ORS, can foster cultural comfort by having a platform to help initiate and support these discussions. It can help normalize and encourage process-focused discussions about how client-therapist social identities and other sociocultural variables may influence both the relationship and treatment.

### Conclusions

Although there have been great strides regarding diversity, equity, inclusion, and multicultural competence, a need remains to translate these values into actionable behaviors in psychotherapy. PCOMS provides an example of how any feedback system can address client experiences of marginalization as well as differences between client and therapist. The ORS tends to cast a larger net on client difficulties beyond symptom focused instruments, but any outcome measure can include discussions of larger social impacts on symptoms. While pharmaceutical sponsored symptom check lists seek to categorize the complexities of human experience into discreet conditions that lead to psychotropic interventions, psychotherapy requires a more nuanced understanding of distress contextualized by a broader social understanding of behavior. Clinicians using symptom-based outcome measures need only identify the most distressing items and ask the client if they have any ideas about the factors that contribute to the distress. Systems that do not include routine alliance measures can consider adding one to facilitate conversations about the influences of therapist client differences on the therapeutic relationship.

PCOMS provides a way toward a multicultural orientation and the American Psychological Association multicultural guidelines (2018), including the call for a strengths-based approach. However, our intention was not to suggest that it

offers a panacea for addressing diversity, nor that PCOMS as an intervention to improve outcomes is without heterogeneity of results or methodological criticisms (Duncan & Sparks, 2019; Østergård et al., 2018), nor that PCOMS is the preferred feedback system to implement MCO. Rather, we suggest that the collaborative, client privilege, and social justice heritage of PCOMS positioned it to provide an example structure to address marginalization and therapist-client differences in therapy. Implementing a multicultural orientation takes a sustained effort to include clients and embrace their feedback—to not reduce psychotherapy to the medical model equation of diagnosis plus prescriptive treatment equals cure, nor clients to cultural, ethnic, racial, gender stereotypes or pharmaceutical sponsored checklists, nor the proclivities of enlightened psychotherapists who know better than clients what they need.

### References

- American Psychological Association (2018). APA adopts new multicultural guidelines. *Monitor on Psychology, 49* (1), 47. <https://www.apa.org/monitor/2018/01/multicultural-guidelines>
- Boswell, J. F., Hepner, K. A., Lysell, K., Rothrock, N. E., Bott, N., Childs, A. W., Douglas, S., Owings-Fonner, N., Wright, C. V., Stephens, K. A., Bard, D. E., Aajmain, S., & Bobbitt, B. L. (2023). The need for a measurement-based care professional practice guideline. *Psychotherapy, 60*(1), 1-16. <https://doi.org/10.1037/pst0000439>
- de Jong, K., Conijn, J. M., Gallagher, R. A. V., Reshetnikovea, A. S., Jeij, M., & Lutz, M. C. (2021). Using progress feedback to improve outcomes and reduce drop-out, treatment duration, and deterioration: A multilevel meta-analysis. *Clinical Psychology Review, 85*,

*continued on page 66*

- <https://doi.org/10.1016/j.cpr.2021.102002>
- Duncan, B., Miller, S., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. D. (2003). The session rating Sscale: Preliminary psychometric properties of a “working” alliance measure. *Journal of Brief Therapy, 3*, 3–12.
- Duncan, B., & Moynihan, D. (1994). Applying outcome research: Intentional utilization of the client’s frame of reference. *Psychotherapy, 31*, 294–301.
- Duncan, B., & Reese, R. J. (2013). Clinical and scientific considerations in progress monitoring: When is a measure too long? *Canadian Psychology, 54*, 135–137.
- Duncan, B. L., & Reese, R. J. (2024). The evolution of feedback: Toward a multicultural orientation. *Psychotherapy, 61*(2), 101–109. <https://doi.org/10.1037/pst0000524>
- Duncan, B. L., & Reese, R. J. (2015). The partners for change outcome management system (PCOMS) revisiting the client’s frame of reference. *Psychotherapy, 52*(4), 391–401. <https://doi.org/10.1037/pst0000026>
- Duncan, B., & Sparks, J. (2002). *Heroic clients, heroic agencies: Partners for change*. Author.
- Duncan, B., & Sparks, J. (2019). When meta-analysis misleads: A critical case study of a meta-analysis of client feedback. *Psychological Services*. <http://dx.doi.org/10.1037/ser0000398>
- Hook, J. N., Davis, D., Owen, J., & DeBlare, C. (2017). *Cultural humility: Engaging diverse identities in therapy*. American Psychological Association. <https://doi.org/10.1037/0000037-000>
- Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*, 91–100.
- Østergård, O. K., Randa, H., & Hougaard, E. (2018). The effect of using the Partners for Change Outcome Management System as feedback tool in psychotherapy—A systematic review and meta-analysis. *Psychotherapy Research, 30*(2), 195–212. <https://doi:10.1080/10503307.2018.1517949>
- Reese, J., Duncan, B., & Clements-Hickman, A. (2024). Does practice generated data improve psychotherapy effectiveness (routine outcome monitoring)? In F. Leong, M. Constantino, & C. Eubanks (Eds.), *APA handbook of psychotherapy* (Vol. 2; pp. 192–211). American Psychological Association.
- Sparks, J., & Duncan, B. (2018). The partners for change outcome management system: Aboth/and system for collaborative practice. *Family Process, 1*–17. <https://doi.org/10.1111/famp.12345>
- Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2022). *Counseling the culturally diverse: Theory and practice* (9th ed.). Wiley.



## AFFIRMATIVE CARE

### A Most Queer Language: The Case Against an All-Inclusive Buffet in Therapy

*Damini Yadav, MS*



The vantage point of a queer-identifying therapist is uniquely translucent; I see some things in sharp resolution, while there are other things that remain opaque. How does a queer therapist affirm a queerness that endangers them as well? How does a queer therapist affirm a queerness that bemuses them? Sitting across from a patient tussling with questions of sexuality that cannot be assuaged with ‘woke’ platitudes- evokes a sharp confusion that assaults the inter-subjective self-hovering over our virtual room. This is not to say that it is an alien other; an- other situated firmly in heteronormativity that can better unravel the enigmas of sexuality. However, I do want to admit to my own sense of loss-ness as a queer therapist when it comes to matters of fluid desires and dynamic identities. I want to better understand how to navigate these desires and identities with authenticity, especially within the special framework of my patients and the unconscious language I use.

Time and again, I go back to my own personal therapy and my encounters with queerness within it. Did I ever seek a therapist who advertised a queer-affirmative practice? Did that choice fundamentally change the trajectory of my therapeutic journey? When looking back, I can see anti-queer rhetoric of every therapy clinic I’ve visited in high definition, but I found genuine affirmativeness of a clinic to be more diffuse, like in 420p resolution. For example, I remember in chilling detail the time my previous therapist convinced me that

the bodily pleasure I experienced during a sexual harassment incident must be a result of “missing the male touch.” I cannot, however, recall with any clarity what other therapists conveyed to me after this that was of any benefit. I only remember feeling safe and feeling held in times of vulnerability surrounding my queerness.

To me, safety is something you feel. The same goes for affirmation; so, can they be said into existence? Is it possible that repeatedly saying that a room is a safe space doesn’t necessarily make it one? It makes me wonder if inclusive language and so-called “appropriate terminology” can be a permanent fixture in the therapy room. In the absence of conflict, errors, confusion, and disagreements, can the therapist and the patient ever meet on the human plane? Yes, there is obliteration in hostility and prejudice which demands redressal. There is such a thing as too much pathologizing. There is even such a thing as bad mothering. But what about mothering that’s too good to be true? Is there such a thing as too much validation?

What I’ve discovered to be true is that the principles of such clinical practice that positions itself solely around identity oftentimes seems sterile. I find a strange mystification attached to the “7-day bootcamps” that claim to train practitioners to become adept at taking on LGBTQ+ patients. It is becoming an increasingly common practice to declare that one has been trained in the art of queer-affirmative work but the modus operandi of these camps and programs

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makes me question the verity of the work being done. The hefty amount being charged for such training with its near-mystical curriculum also doubles down on the inaccessibility issue of psychotherapy praxis. This inaccessibility also seeps into the language, again feeding into the cycle of therapy by and for the privileged few, sectioning off the LGBTQ+ patienthood further. The goal here morphs into parroting taught tautology that convinces both the patient and I that we are not bigoted.

Psychic disturbances and pathologies intercept dialogue in a way that makes conversations convoluted; can we then call such use of inaccessible language a psychic disturbance too? Is language then a cover for a neurotic unconscious? Conversations in the clinic seem to have been deformed further by the impossible standard of perfect politics. In such an environment, do we overlook the resistances of the LGBTQ+ patients we take on in queer affirmative-practice; LGBTQ+ patients who are subsumed under a monolith? The bitter aftertaste of keywords like “affirmative,” “safe space” and “trauma response,” which have undergone relentless semantic bleaching, remains residual in both our mouths, the patient and me.

I carry my patient with me here, a patient who has been on a journey with her sexuality in the couple of years we have been working together. When we started, she identified as a bisexual, cis-gender woman who had most of her romantic relationships with men. We talked about the beginning of romance and its culmination; we talked about intercourse and anxieties around sex. Then, about a year into our work, she shared that she felt that her experiences with men arose from culturally sanctioned compulsory heterosexuality. Before she was to shift states, we started exploring what being a lesbian is, what

it means to her, what it could mean to others in her view and how that would impact her. In the middle of these discussions and upon arriving in a new state, her perennially empty walls became adorned with the lesbian pride flag. It was no longer an uncharted facet of her being—it was now a fact.

Here is where my dilemma made its first appearance. Would questioning this tectonic shift count as hostility?

How would she feel if I were to ask her how she is making sense of discovering a different sexuality in a transitory period of her life? What does the flag represent to her? Even writing these questions down seems patronising, as though I’m doing something wrong by the queer movement. This self-policing judgement didn’t help as I began sitting uncomfortably with my silence. I began the Sisyphean task of validating thereafter. I indulged in those woke platitudes that never really felt right to her, or to me. That felt sense of affirmativeness seemed to be missing for both of us. We lost ourselves and our real voice in the cacophony of Internet scriptures prescribing a manner of speaking that was foreign to us. Our fable of perfect therapy and perfect humans cast a shadow over our relational work. In forced oblivion, we packed this mess aside and walked into other entanglements to sift through, ones that seemed easier on our egos.

But us humans have a fatal flaw—we compulsively repeat that which traumatises us. And so, we rammed into this unquestioned, under-explored part of our ocean. My patient found herself feeling attracted to a heterosexual man in her vicinity. She resolved to ask the man out to discover what it is that she really wants from his company. This time around we had to look through the psychoanalytic

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lens; the kaleidoscope of propriety had failed us. It is at this juncture where the games we were playing through semantics revealed themselves to us and we steered our discussion towards the core of the relational issue at hand. In the face of an invalidating situation, we had to grapple against the instinct of validating and rely on good ol' analysis to navigate how older wounds from her childhood were reappearing in guises with the new man. Pulling the "daddy issues" thread did more for us than any truisms that we had been using before.

This patient and I are still working out a means of talking that is respectful but not fully addled with anxieties about sounding right. Creating this path that is unique to our relationship reminded me that in appearing to be a queer-affirma-

tive therapist, I'd forgotten to be a queer person myself. This failure to see my own person had been keeping my patient from bringing their person into the room too. As I attempt to wind up this treatise on queering the clinic with my trademark uncertainty, I want to once again iterate my fear of being misunderstood. I am unsure of what is right, I am unsure of what works and what does not. In laying out my unsuccessful attempt at using perfect politics in the clinic, I am trying to think out loud. I've found that dialogues cannot be effective in silos, in echo chambers. If this is my internalised queerphobia, it's still better worked through outside than inside me all alone. Sometimes I think I let my inner confused conservative (we all have one) out for a walk, and all of what I said here is what it whispers to me.



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## AFFIRMATIVE CARE

### Fostering Global Collaboration in Psychotherapy: The Development of Two Regional Consortia

*Clara Paz, Ph.D.*

*Javier Fernández-Álvarez, Ph.D.*

*Carolina Altimir, Ph.D.*

*Miguel Gonçalves, Ph.D.*

*Wolfgang Lutz, Ph.D.*

*Michael Barkham, Ph.D.*



#### **Applied Impact Statement**

This manuscript underscores a significant international collaboration between psychotherapy researchers in Europe and Latin America (LA), with a clear focus on enhancing mental health care quality and effectiveness through the comparability of client outcomes in real-world clinical settings. By establishing a unified framework for routine clinical data collection and advancing the implementation and training in Routine Outcome Monitoring (ROM), these consortia are supporting the global integration of practice-based evidence. Their efforts are not only fostering consistency in mental health-care practices worldwide but are also tailored to meet the distinct needs and priorities of diverse regions, ensuring that the impact is both broad and locally relevant.



#### **Utilizing Practice-Based Evidence for Tailored Approaches**

Reducing the gap between therapists and re-

searchers is crucial to advancing mental health care. One effective strategy is generating practice-based evidence across various contexts. This approach involves systematically collecting data from real-world clinical settings, thereby allowing researchers to analyze treatment outcomes and therapeutic processes that are most directly relevant to them. By integrating practice-based evidence into the body of existing research, therapists can better understand what works in different environments and for diverse populations, leading to more tailored and effective interventions. Furthermore, this strategy ensures that research is grounded in practical realities, enhancing its relevance and applicability (Barkham & Lambert, 2021; Barkham & Mellor-Clark, 2003; Castonguay et al., 2021; Evans et al., 2003).

To foster the materialization of this strategy, it is essential to create collaborative networks for the successful implementation and utilization of the collected information. These global networks foster a bidirectional flow of knowledge, where therapists from various cultural and clinical backgrounds contribute valuable insights from their diverse experiences, while researchers provide evidence-based guidance and innovative methodologies. By connecting practitioners and researchers from different parts of the world, these partnerships facilitate the rapid dissemination and adoption of best practices across a wide array of settings, significantly reducing the

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lag between the publication of research findings and their clinical application. Furthermore, these international collaborations promote a culture of continuous learning and improvement, encouraging both therapists and researchers to stay informed about new developments and to refine their approaches based on the latest evidence. This global synergy enhances the quality of care provided to clients worldwide, effectively bridging the gap between theory and practice across different contexts.

Castonguay et al. (2013) eloquently expressed this synergy as, “work locally but collaborate globally,” emphasizing the importance of fostering a culture of active collaboration and comparison of results while maintaining the essential development of local infrastructures capable of producing context-sensitive knowledge. Different practice research networks have varying needs depending on their settings, cultures, and resources. However, actively collaborating to collect data on specific variables across different sites can significantly enrich scientific projects by providing larger sample sizes, comparability, and opportunities for cross-cultural research. In pursuit of improving psychotherapy practices through collaboration and the generation of practice-based evidence, two consortia emerged in different regions of the world framed as part of the regular meetings developed within the Society for Psychotherapy Research (SPR): the European Psychotherapy Consortium (EPoC) and the Latin American Consortium for Psychotherapy Research (CLIP).

### **European Psychotherapy Consortium (EPoC)**

This initiative was launched by the European Chapter of the SPR in September 2022. The objective of this project was to facilitate the creation of European naturalistic psychotherapy samples, encour-

aging collaboration among countries, enriching the diversity of psychotherapy research, and facilitating the development of larger and more representative client samples (Gonçalves et al., 2024).

A self-organized group was formed with colleagues from different European countries who have met virtually on a number of occasions to define a strategic plan. As a first step, the group recognized the need for a survey to map the diversity of potential partners and to understand how their clinical services are organized and delivered.

For this survey, services from 16 different countries expressed their willingness to participate. The data provided access to approximately 5,000 clients, representing a diverse range of therapeutic approaches and patient populations. One key finding was the vast array of outcome measures that are used both at pre- and post-assessment and, to a lesser extent, on a session-to-session basis. Of those used, the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) was the most adopted instrument and used in 13 clinics, while 63 different measures were employed for pre- and post-treatment review at only a single clinic. Despite this diversity, EPoC researchers agreed that researchers from different fields should work together to advance science by finding effective ways to share data and collaborate across countries and cultures (Gonçalves et al., 2024).

### **Avenues of Collaboration Between EPoC Researchers**

The EPoC has introduced various collaborative initiatives aimed at improving research consistency and fostering joint efforts across its network of researchers. These initiatives are designed to pool expertise, resources, and data, allowing

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for a more comprehensive approach to addressing key questions in psychotherapy. Currently, there are three avenues of collaboration between EPoC researchers described below.

**1. Adoption of a single-item measure:**

To address the wide selection of measures used while respecting the historical and local choices implemented by clinics, it was decided to add a new single item, the Emotional and Psychological Outcome (EPO-1), into the ongoing data collection. The single item selected was adapted from the original item developed and published by Orlinsky and Howard (e.g., 1975, 1986) and has been employed successfully in several large-scale studies (e.g., Howard et al., 1996). The item asks the question: “At this moment, how well do you feel you are getting along emotionally and psychologically?” and is scored on a 5-point Likert scale. Data has been collected at the outpatient clinic of the University of Trier (Lutz et al., 2019) and robust correlations with various outcome measures have been demonstrated (Lutz et al., 2021), indicating that it has the potential to establish a common standard across diverse settings. In addition to the English version, there are currently 11 translations of the EPO-1 into European languages. An adapted version for children and adolescents is also planned for the future. EPoC members followed the International Test Commission guidelines (Hernández et al., 2020) in the process of translating and adapting the item to arrive at an equivalent measure across different countries and languages. There are no restrictions on its use, with some clinics administering it at every session and others at regular intervals. The adaptation of the EPO-1 is en-

dorsed by Dr. Orlinsky and is freely available under a Creative Commons License upon a no-cost registration (Gonçalves et al., 2024). The item is freely available to SPR members here: [EPoC Registration](#).

- 2. Crosswalks:** This project involves converting raw scores to common metrics through the analysis of the existing questionnaires with the possibility of studying other issues, such as general effectiveness and therapists’ variability. This offers the potential of joint publications in the future. The main idea is to share raw and anonymized data to develop common metrics across different instruments. However, issues relating to ethics and data sharing agreements need to be set in place first, which may be challenging given the number of countries involved. Hence, an initial stage may involve the pooling of results of data from clinics rather than sharing actual data, but this in itself would be a small step forward.
- 3. Recommendations and suggestions:** This project includes providing support to colleagues as they begin routine data collection. This would include support on commonly used measures, techniques, and implementation issues. For clinics starting data collection, this could be a way to explore the possibility of using some similar measures (as well as the single item).

**Latin American Consortium for Psychotherapy Research (CLIP)**

Researchers from the Latin American Chapter of SPR, at the 50th international SPR meeting in Buenos Aires in 2019, began generating ideas for collaboration. Many of these members joined the [Red Latinoamericana Psicoterapia y Cambio](#)

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for this purpose. In 2023, this network proposed a series of virtual meetings to learn about the research conducted by its members. In one of these meetings, the topic of ROM and the generation of practice-based evidence was proposed. Several members started to meet regularly to explore the possibilities of generating practice-based evidence in Latin America. Then the idea of generating the consortium emerged, replicating the structure and function of EPoC.

The CLIP welcomes participation from centers and independent therapists providing psychological care across Latin America. Centers are defined as institutions, whether public or private, that offer psychological care services. Independent therapists practicing privately, without institutional affiliation, are also encouraged to participate. The mission of the consortium is to foster collaboration among these independent members, enabling them to share implementation experiences, collaborate on enriching clinical practices, and collectively develop research proposals in their respective contexts (Consortio Latinoamericano de Investigación en Psicoterapia, 2024).

The CLIP aims to standardize the collection of clinical information in everyday practice, thereby enhancing its quality and efficiency. Central to its aim are three primary functions (Consortio Latinoamericano de Investigación en Psicoterapia, 2024):

1. **Developing a collaborative practice-based database:** This program involves developing and maintaining a comprehensive database containing essential details about all consortium members. This database will be updated annually to reflect the status of ROM implementation and ongoing research. It will also facilitate the formation of partnerships among members and support joint data analysis

projects across different centers. The consortium aims to ensure transparency by publicizing agreements between members and providing regular updates on their status.

2. **Collaboration in implementation and training:** This program aims to create a virtual platform where consortium members can share implementation strategies, training materials, and best practices for outcome monitoring. This collaborative space will foster collective learning and continuous improvement among members.
3. **Common framework for routine clinical data collection:** This initiative seeks to standardize collection of information across various areas of interest. These include the characteristics of psychological therapies offered in multiple service centers across several countries in Latin America, the characteristics of the individuals seeking psychological therapies, the personal styles of therapists providing psychological care services, the relationships between clients and therapists (process), the outcomes of psychological interventions, and the features of the mental health care services where these interventions take place.

By focusing on these initiatives, CLIP endeavors to elevate clinical practice standards through improved data collection, collaboration, and transparency, benefiting both clinicians and clients alike.

### **Collaborating Across Continents: Two Different Regions, One Same Goal**

Although both consortia pursue the same overarching goal, each group addresses the unique needs and characteristics of their respective regions. The EPoC was established to facilitate the creation of transnational and naturalistic psychotherapy samples, to encourage

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collaboration between European countries, and to enrich the diversity of psychotherapy research (Gonçalves et al., 2024). This consortium focuses on harmonizing outcome measures, creating common metrics from different instruments, and integrating new data collection items into ongoing studies. EPoC's strategy involves leveraging the already substantial involvement of European researchers in evidence collection at various levels, ranging from small local services to national projects. By promoting the sharing of raw and anonymized data, EPoC enables the development of comprehensive and comparable datasets that can be used to study general effectiveness, therapists' variability, and other critical issues. This collaborative effort is designed to foster joint publications and research projects, ultimately improving the quality and applicability of psychotherapy practices across Europe.

In contrast, CLIP tackles the unique challenges in Latin America where ROM is less widespread. The region's economic, cultural, and social diversity necessitates careful consideration when promoting ROM. Some initiatives have successfully implemented ROM in specific clinical centers (Gómez-Penedo et al., 2023; Valdiviezo-Oña et al., 2022), but resources to extend these efforts to additional centers and settings remain limited. CLIP's mission is to standardize clinical data collection practices across the region while diagnosing psychotherapeutic practices in Latin America, highlighting the region's unique characteristics. This initiative promotes systematic research in everyday settings, enhancing cultural understanding, research efforts, and the systematization of psychotherapeutic practices. The consortium's initiatives include developing a collaborative practice-based database, facilitating the sharing of implementation strategies and training materials online, and ensuring the transparency and accountability of agreements between con-

sortium members. By supporting the implementation and training of ROM practices, CLIP aims to elevate clinical standards and foster a culture of continuous improvement among practitioners. This collaborative network not only benefits clinicians by enhancing their data collection capabilities but also improves patient outcomes by ensuring that therapeutic practices are informed by robust and standardized evidence (Consortio Latinoamericano de Investigación en Psicoterapia, 2024).

While EPoC and CLIP both strive to advance psychotherapy practices through practice-based evidence and collaboration, they tailor their approaches to the specific needs and conditions of their regions. EPoC leverages existing research efforts to create a unified framework for data analysis in Europe, whereas CLIP focuses on establishing and promoting standardized ROM practices to build a solid foundation for psychotherapy research in Latin America.

A key link between the EPoC and CLIP consortia is the adoption of the EPO-1 item. Both consortia have incorporated this item into their ongoing and new data collection efforts to improve the consistency and comparability of their research. The item offers, at minimal cost in time and no financial cost, a unified measure that enhances the understanding of therapeutic progress across various settings, fostering greater alignment and collaboration between EPoC and CLIP.

The first phase of the European project has recently been published, outlining the aims and future potential of the European Consortium, including the development and translations of the single item, procedures to allow cross-comparison of outcome measures, and the creation of a task force to be consulted when new data sets are collected. The aim of the

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consortium is to share and implement new common measures in the effort to increase collaboration and treatment alignment (Gonçalves et al., 2024).

Although this program of research began as an initiative of the EU-SPR Chapter, and was followed by the LA-SPR Chapter, both consortia would support researchers developing additional consortia in regions beyond LA and the EU, working towards global collaboration. The complete list of collaborators of the consortia can be found [here](#). In the spirit of collaboration, colleagues within EU and LA who wish to participate are welcome to join their respective consortium. If you want to know more about EPoC, see (<https://www.psychotherapyresearch.org/page/EPoC-About>), and if you want to know more about CLIP, please see ([https://www.psychotherapyresearch.org/page/CLIP-About\\_engl](https://www.psychotherapyresearch.org/page/CLIP-About_engl)). We understand that researchers often have demanding schedules and may be concerned about the time commitment required for participation in these consortia. Our expectation is that involvement will necessitate minimal time investment while being mutually beneficial for all participants. Furthermore, we anticipate that this collaboration could eventually lead to exciting outcomes for everyone involved, including new projects and publications. Most importantly, we believe that through small and flexible steps, we can collectively enhance our scientific endeavors!

### Conclusion

In each region there coexist several realities that demand contextual adaptations. This is true not only at a continental level (Europe versus Latin America) but also within each continent and even within each country. The opportunity to work in collective efforts by no means should lose perspective of the importance of these contextual differences and needs, which are especially important when generating practice-based evidence. A significant

amount of work has to be done, particularly in Latin America, in terms of creating the basis for assessing therapeutic processes and outcomes. The creation of the EPO-1 item represents a significant first step toward fostering collaboration and the possibility for comparison, which could be crucial for understanding the dynamics of real-life psychotherapy. By doing so, we aspire to improve both processes and outcomes, grounded in solid empirical support while incorporating the lessons learned from practice-based evidence.

### References

- Barkham, M., & Lambert, M. J. (2021). The efficacy and effectiveness of psychological therapies. In M. Barkham, W. Lutz & L. G. Castonguay (Eds.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (7th ed., pp. 135-189). John Wiley & Sons, Inc.
- Barkham, M., & Mellor, Clark, J. (2003). Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology & Psychotherapy*, 10(6), 319-327. <https://doi.org/10.1002/cpp.379>
- Castonguay, L. G., Barkham, M., Lutz, W., & McAleavey, A. (2013). Practice-oriented research. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 85-133). John Wiley & Sons, Inc.
- Castonguay, L. G., Barkham, M., Youn, S. J., & Page, A. C. (2021). Practice-based-evidence—findings from routine clinical settings. In M. Barkham, W. Lutz, & L. G. Castonguay (Eds.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (7th ed., pp. 191-222). John Wiley & Sons, Inc.
- Consortio Latinoamericano de Investigación en Psicoterapia. (2024). Latin American Psychotherapy Research Consortium. <https://www.psy->

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[chotherapyresearch.org/page/CLIP-About\\_engl](https://chotherapyresearch.org/page/CLIP-About_engl)

- Evans, C., Connell, J., Barkham, M., Marshall, C., & Mellor-Clark, J. (2003). Practice-based evidence: Benchmarking NHS primary care counselling services at national and local levels. *Clinical Psychology and Psychotherapy*, 10(6), 374–388. <https://doi.org/10.1002/cpp.384>
- Gómez-Penedo, J. M., Manubens, R., Areas, M., Fernández-Álvarez, J., Meglio, M., Babl, A., Juan, S., Ronchi, A., Muiños, R., Roussos, A., Lutz, W., & Grosse Holtforth, M. (2023). Implementation of a routine outcome monitoring and feedback system for psychotherapy in Argentina: A pilot study. *Frontiers in Psychology*, 13, 1029164. <https://doi.org/10.3389/fpsyg.2022.1029164>
- Gonçalves, M. M., Lutz, W., Schwartz, B., Oliveira, J. T., Saarni, S. E., Tishby, O., Rubel, J.A., Boehnke, J. R., Montesano, A., Paiva, D., Ceridono, D., Zech, E., Willemsen, J., Saarni, S. I., Kompan Erzar, K., Janeiro, L., Gelo, O. C. G., Errázuriz, P., Holas, P., ... Barkham, M. (2024). Developing a European Psychotherapy Consortium (EPoC): Towards adopting a single-item self-report outcome measure across European countries. *Clinical Psychology in Europe*, 6(3), e13827. <https://doi.org/10.32872/cpe.13827>.
- Hernández, A., Hidalgo, M. D., Hambleton, R. K., & Gómez Benito, J. (2020). International test commission guidelines for test adaptation: A criterion checklist. *Psicothema*, 32(3), 390–398. <https://doi.org/10.7334/psicothema2019.306>
- Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose–effect relationship in psychotherapy. *American Psychologist*, 41(2), 159–164. <https://doi.org/10.1037/0003-066X.41.2.159>
- Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist*, 51(10), 1059–1064. <https://doi.org/10.1037/0003-066X.51.10.1059>
- Lutz, W., de Jong, K., Rubel, J. A., & Delgadillo, J. (2021). Measuring, predicting, and tracking change in psychotherapy. In M. Barkham, W. Lutz & L. G. Castonguay (Eds.), *Bergin and Garfield's handbook of psychotherapy and behavior change*, 7, 89–133. (7th ed., pp. 135–189.). John Wiley & Sons, Inc.
- Lutz, W., Rubel, J. A., Schwartz, B., Schilling, V., & Deisenhofer, A. K. (2019). Towards integrating personalized feedback research into clinical practice: Development of the Trier Treatment Navigator (TTN). *Behaviour Research and Therapy*, 120, 103438. <https://doi.org/10.1016/j.brat.2019.103438>
- Orlinsky, D. E., & Howard, K. I. (1975). *Varieties of psychotherapeutic experience: Multivariate analyses of patients' and therapists' reports*. Teachers College Press. New York.
- Orlinsky, D. E., & Howard, K. I. (1986). The psychological interior of psychotherapy: Explorations with the Therapy Session Reports. In L. S. Greenberg & W. M. Pinsof(Eds.), *The psychotherapeutic process: A research handbook* (pp. 477–501). Guilford Press.
- Valdiviezo-Oña, J., Granja, E., Cuadros-López, A., Valdivieso-Meza, G., Evans, C., & Paz, C. (2022). Practice-based research with psychologists-in-training: Presentation of a supervision model and use of routine outcome monitoring. *Studies in Psychology*, 43(3), 583–608. <https://doi.org/10.1080/02109395.2022.2132749>

# Out of Balance: National Institute of Mental Health Spending in 2012 and 2020

*Damini Yadav, MS*



The National Institute of Mental Health (NIMH) is the lead Federal agency for research on mental illness. The mission of the NIMH is “to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and cure” (National Institute of Mental Health, 2008). In 2023, it spent about \$2.3 billion to fulfill that mission. How it spends its money has an impact on the mental health of Americans.

The author led a team of psychologists, researchers and psychology students in studying how the NIMH spent its research money in Fiscal Year 2012 and Fiscal Year 2020. We analyzed the project abstracts of about 20% of the projects which were funded in those years. Here is what we found.

### **NIMH Study of Physiology, Treatment, and Psychotherapy**

In 2012, the NIMH spent 72% of its budget on studying physiology, i.e. the brain and genetics. In 2020, that percentage increased to 75%. Examples of studies include a 2012 study on neuronal signaling pathways during learning and their effects on memory and a 2020 study looking at neuronal cells in mice and human stem cells and their effect on neural circuits (NIMH Project Reporter, 2020, 2012). The purpose of both are to understand potential brain and physiological processes underlying mental illness.

In 2012, the NIMH spent 20% of its money on studying treatment and only seven percent on studying treatment with psychotherapy. In 2020, those percentages fell to 14% and four percent respectively. As a psychotherapist and student of psychotherapy, this is concerning to me. It seems like an imbalance that is unlikely to enable the NIMH to fulfill its mission to “pave the way for the prevention, recovery and cure (of mental illness).”

### **Implications of NIMH Research Priorities**

In its mission statement, the NIMH gives equal weight to “understanding and treatment of mental illnesses” and to “basic and clinical research.” But its research priorities are heavily weighted towards studying the brain and genetics and away from studying treatment and psychotherapy. This research portfolio would suggest there is little evidence of the effectiveness of psychotherapy in treating mental illness. That is not the case. The efficacy of psychotherapy in treating mental illness is supported by strong and plentiful evidence. There have been so many studies establishing its efficacy that we now have meta-analyses of the meta-analyses (Leichsenring et al., 2023; Shedler, 2010). A meta-analysis of studies compared outcomes for depressed subjects who received psychotherapy with those of wait-listed controls found an average effect size of 0.70 compared with an effect size of 0.31 for care-as-usual (i.e., antidepressant medication) and 0.43 for other control groups (Munder et al.,

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2018). That effect size far outstrips reported effect sizes for antidepressant therapy (Cipriani et al., 2018; Kirsch, 2009). Additionally, effective psychotherapy need not cost more than medication treatment (Heuzenroeder et al., 2004; Kirsch, 2009).

Studies of psychotherapeutic intervention find that about 80% of patients report significant improvement and the more psychotherapy they receive the more likely they are to report improvement (Cuijpers et al., 2021; McLean, 2022; Wampold, 1997, 2001). And there is no significant difference between the types of psychotherapy people receive. Therapies focused on depth, insight and relationship, such as psychodynamic therapy, Gestalt therapy, humanistic and existential therapy, are just as effective as cognitive-behavioral therapy (Cuijpers, 2023; Olano, 2017; Shedler, 2010).

### **What has the NIMH Gained from Studying the Brain and Genetics?**

This imbalance might be justifiable if the NIMH were making progress in understanding and treating mental illnesses, but that is not the case. In spite of investing billions of dollars in studying neural circuits, neurotransmitters, neurons, brain chemistry and genetic dynamics, the NIMH has yet to find a meaningful or nuanced relationship between that physiology and the thoughts, emotions, intentions, perceptions and behaviors which human beings experience and use to live their lives (Nour et al., 2022). Neither has the NIMH been able to understand enough to enable the diagnosis of any mental illness through the use of a brain scan, laboratory test or genetic dynamic (Garcia-Gutiérrez et al., 2020; Hahn 2019, 2023; Joseph, 2022; Moncrieff et al., 2022). In the words of Nour and his colleagues (2022): “Despite three decades of intense neuroimaging research, we still lack a neurobiological account for any

psychiatric condition. Likewise, functional neuroimaging plays no role in clinical decision making” (p. 2524).

Despite reports that appear regularly in the popular press, no genes for mental illness have been found. The claimed effect sizes for genes associated with “mental illness” are tiny—on the order of one in 100 for depression or attention-deficit hyperactivity disorder (ADHD) and one in 500 or less for schizophrenia (Hahn, 2019). In other words, for every 100 (or 500) individuals that has a specific form of a gene (called an allele), there will be one extra case of the index condition—depression or ADHD or schizophrenia, in this case.

As researchers discover more and more genes said to be associated with an increase in risk for a diagnosis of schizophrenia, the average effect size per gene has decreased. This was expected. What was not expected, however, was that, as the number of “schizophrenia-associated alleles” has soared, the aggregate effect, or the effect of all of them together, has diminished as well (Trubetskoj et al., 2022). This suggests that whatever these researchers are measuring may not have any biological significance.

In reviewing the contribution of the Human Genome Project to understanding the etiology of schizophrenia, psychiatrist E. Fuller Torrey and colleagues (2020) concluded, “three decades later, NIMH’s genetic investment has yielded almost nothing clinically for those affected” (p. 1).

Dr. Thomas Insel, Director of the NIMH from 2002 to 2015 spoke to this failure in 2017. I spent 13 years at NIMH really pushing on the neuroscience and genetics of mental disorders, and when I look back on that I realize that while I think I

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succeeded at getting lots of really cool papers published by cool scientists at fairly large costs—I think \$20 billion—I don't think we moved the needle in reducing suicide, reducing hospitalizations, improving recovery for the tens of millions of people who have mental illness. (Rogers, 2017).

What is surprising is that Dr. Insel made that claim in 2017, yet funding of neuroscience and genetics both in real numbers and as a proportion of the NIMH budget has increased since. Significantly, studies of treatment and psychotherapy received less money in 2020 than in 2012, even though the overall NIMH budget in 2020 was 37% higher than it was in 2012.

#### **Other Problems with the NIMH's Emphasis on Studying Physiology**

There are other problems with this focus of the NIMH on studying the brain, genetics and biochemistry. No matter how many studies find an association between some physiological dynamic and a psychological state of being, mood or behavior, there is no evidence that the physiology caused the psychology. Correlation does not prove causation. If we use the scientific principle of parsimony and looked at other mind-brain dynamics (i.e., laughing, weeping, the stress response, blushing or voluntary movement) to determine the direction of causality, we would assume the opposite: that it is the psychological dynamics that are causing the physiological dynamics (Harrop et al., 1996; Stahl, 2012). Case in point: Jeffery Schwartz and his colleagues performed brain scans of 15 patients diagnosed with obsessive-compulsive disorder. All of the brains were abnormal. Half of the patients were treated with selective serotonin reuptake inhibitors, SSRIs, and the other half received cognitive-behavioral therapy. By the end of the study, all patients had improved.

When their brains were scanned again, all had become normal (Schwartz, 1996).

Additionally, human beings use their minds, not their brains, to live their lives. The mind and brain are not the same thing. The brain is an organ of the body. The mind is a vastly powerful, creative and facile faculty that humans use to do everything they do: understand the world; build machines, computers, buildings, bridges; create art; go to the moon; relate with other humans in productive and satisfying ways; develop and manage artificial intelligence. Given the present state of neuroscience, studying the brain is not going to help us understand the mind. As neuroscientist William Uttal says in his book *Mind and Brain: A Critical Appraisal of Cognitive Neuroscience*, neuroscientists think they have a theory of how the brain creates the mind. But they aren't close to having such a theory and it is doubtful they ever will have one (Uttal, 2013). It is unlikely that we will understand and effectively treat the mind through studying the brain or through any kind of materialistic science. But we could understand and treat the mind through the use of phenomenology, the study of human experience in using the mind. The NIMH has done very little of that.

In its effort to understand mental illness, the NIMH is spending most of its money on studying parts of human beings rather than whole human beings. But this may be a situation in which the whole human being is more than the sum of the parts and in which studying the parts will not help us understand the whole. Again, the focus of NIMH on studying physiological parts of human beings is unlikely to contribute much to fulfilling its mission – “(to pave) the way for prevention, recovery and cure (of mental illness).”

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### **The NIMH's Lack of Interest in Suicide or the Impact of Race, Ethnicity, Sexual Orientation and Gender on Treatment Outcomes**

Although there is much interest among clinicians in the impact of race, ethnicity, sexual orientation and gender on treatment outcomes, the NIMH spent very little on studying those factors. In 2021, only five percent of total studies were of a specific ethnicity. In 2020, that rose to 11%. In 2012, only nine percent of psychotherapy studies looked at the impact of race, ethnicity, sexual orientation or gender on treatment outcomes. In 2020, that fell to four percent.

Amidst concern about rising suicide rates, the NIMH spent only two percent of its funds in 2012 and four percent in 2020 on studying suicide. This lack of spending on suicide and the impact of ethnicity, race, sexual orientation and gender on treatment outcomes represents a disconnect between the concerns of patients, families, clinicians and the general public and the research priorities of the NIMH.

Given the NIMH's lack of interest in studying psychotherapy, one would think there is nothing left to learn about psychotherapy, but that is not the case. Following are some areas of study that might improve the effectiveness of psychotherapy:

- Which kinds of therapy are most useful with different kinds of people? With different diagnoses?
- Studies of the aspects of the therapeutic relationship to determine which parts of it contribute to effective therapy.
- Qualitative studies of patient experience to determine which interventions and methods of therapy are associated with the best outcomes.
- Studies comparing the effectiveness of therapy provided online or over

the phone with therapy provided in person.

- Studies of efforts to expand the accessibility and affordability of psychotherapy.
- Studies of the comparative effectiveness of different kinds of therapy with persons of different racial, cultural, ethnic, sexual and gender identities.
- Studies of efforts to reduce the incidence of relapse.
- Studies of efforts to reduce dropout rates.

In conclusion, the NIMH's focus on studying physiology in an attempt to understand mental illness, its lack of support for studying treatment and its meager study of treatment with psychotherapy are not likely to enable it to satisfy its goal of "paving the way for prevention, recovery and cure (of mental illness)."

This conclusion begs the question: What, if anything, can be done about this? The NIMH is an agency of the Federal government. It is part of the National Institutes of Health. It receives appropriations from a Congressional committee that reviews its accomplishments and requests for money each year. One thing we can do is share this information and concern with members of that committee and make an effort to testify at hearings on appropriations. Also, the NIMH has an Advisory council comprised of citizens who are interested in mental health. We can share this information with that Council and meet with its members to discuss its implications. Finally, the NIMH is in the process of hiring an Executive Director. Perhaps we can have some influence over that process. If readers of the Bulletin have other ideas about how to influence the

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NIMH's research priorities, I would like to discuss them with you. Please email me here: [agalves2003@comcast.net](mailto:agalves2003@comcast.net).

## References

- Cuijpers, P. (2023). Cognitive behavior therapy vs. control conditions, other therapies, pharmacotherapies and combined treatment for depression: A comprehensive meta-analysis including 409 trials with 52,702 patients. *World Psychiatry*, 22(1), 105-115.
- Cuijpers, P., Quero, S., Hisashi, N., Ciharova, M., Miguel, C., Karyotaki, E., Cipriani, A., Cristea, I., & Furukawa, I. A. (2021). Psychotherapies for depression: A network meta-analysis covering efficacy, acceptability and long-term outcomes for all treatment types. *World Psychiatry*, 20(2), 283-293.
- Garcia-Gutierrez, M. S., Navarrete, F., Sala, F., Gasparyan, A., Austrich-Olivares, A., & Manzanares, J. (2020). Biomarkers in psychiatry: Concept, definition, types, and relevance to the clinical reality. *Frontiers in Psychiatry* 11, 1-14. <https://doi.org/10.3389/fpsy.2020.00432>
- Hahn, P. D. (2023, April). *Obedience pills: ADHD and the medicalization of childhood*. Samizdat Health Writer's Cooperative.
- Hahn, P. D. (2019, July). *Madness and genetic determinism: Is mental illness in our genes?* Palgrave MacMillan.
- Harrop, C. E., Trower, P., & Mitchell, I. J. (1996). Does the biology go around the symptoms: A Copernican shift in schizophrenic paradigms. *Clinical Psychology Review*, 16(7), 641-654.
- Heuzenroeder, L., Donnelly, M., Haby, M. M., Mihalopoulos, C., Rosswell, R., Carter, R., Andrews, G., & Vos, T. (2004). Cost-effectiveness of psychological and pharmacological interventions for generalized anxiety disorder and panic disorder. *Australian and New Zealand Journal of Psychiatry*, 38, 602-612. <https://doi.org/10.1080/j.1440-1614.2004.01423x>
- Joseph, J. (2022). *Schizophrenia and genetics: The end of an illusion*. Routledge.
- Kirsch, I. (2009). *The emperor's new drugs: Exploding the antidepressant myth*. Basic Books.
- Leichsenring, F., Abbass, A., Heim, N., Keefe, J. R., Kisely, S., Luyten, P., Rabung, S., & Steinert, C. (2023). The status of psychodynamic psychotherapy as an empirically supported treatment for common mental disorders: An umbrella review based on updated criteria. *World Psychiatry*. <https://doi.org/10.1002/wps.21104>
- McLean, C. P. (2022). Exposure therapy for PTSD: A meta-analysis. *Clinical Psychology Review*. <https://doi.org/10.1016/j.cpr.2021.102115>
- Moncrieff, J., Cooper, R. E., Stockmann, T., Amendola, S., Hengartner, M. P., & Horowitz, M. A. (2022). The serotonin theory of depression: A systematic review of the evidence. *Molecular Psychiatry*, 28. <https://doi.org/10.1038/s41380-022-01661-0>
- Munder, T., Flückiger, C., Leichsenring, F., Abbass, A. A., Hilsenroth, M. J., Luyten, P., Rabung, S., Steinart, C., & Wampold, B. E. (2018). Is psychotherapy effective? A re-analysis of treatments for depression. *Epidemiology and Psychiatric Sciences* 28, 268-274. <https://doi.org/10.1017/S2045796018000355>
- National Institute of Mental Health. (2012). *The role of cAMP/PKA signaling in neural circuits underlying memory formation*. <https://reporter.nih.gov/project-details/8207224>
- National Institute of Mental Health. (2020). *Induced neuronal cells: A novel tool to study neuropsychiatric diseases*. <https://reporter.nih.gov/project-details/10122271>

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- National Institute of Mental Health. (2008). *Strategic Plan*. Washington D.C.: NIMH.
- Nour, M. M., Liu, Y., & Dolan, R. J. (2022). Functional neuroimaging in psychiatry and the case for failing better. *Neuron*, *110*(16), 2524-2544. <https://doi.org/10.1016/j.neuron.2022.07.005>
- Olano, F., & Rosenbaum, B. (2017). Evidence of the effect of psychodynamic therapy. *Journal of the Danish Medical Association*, *179*(20).
- Rogers, A. (2017, May 11). *Star Neuroscientist Tom Insel leaves the Google-spawned Verily For ... a start-up?* Wired. <https://www.wired.com/2017/05/star-neuroscientist-tom-insel-leaves-google-spawned-verily-startup/>
- Schwartz, J. M., Stroessel, P. M., Baxter, R. B., Karron, M. M., & Phelps, M. E. (1996). Systematic changes in cerebral glucose metabolic rate after successful behavior modification treatment of obsessive-compulsive disorder. *Archives of General Psychiatry*, *53*(2), 109-113. <https://doi.org/10.1001/archpsyc.1996.01830020023004>
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, *63*(2), 98-109. <https://doi.org/10.1037/a0018378>
- Stahl, S. M. (2012). Psychotherapy as an epigenetic “drug”: Psychiatric therapeutics target symptoms linked to malfunctioning brain circuits with psychotherapy as well as with drugs. *Journal of Clinical Pharmacotherapy*, *37*(3), 249-253.
- Torrey, E. F., Knable, M. B., Rush, A. J., Simmons, W. W., Snook, J., & Jaffe, D. J. (2020). Using the NIMH research condition and disease categorization database for research advocacy: Schizophrenia research at NIMH as an example. *PLOS ONE*, *15*(11), 1-11. <https://doi.org/10.1371/journal.pone.0241062>
- Trubetskoy, V., Pardiñas, A. F., Qi, T., Panagiotaropoulou, G., Awasthi, S., Bigdeli, T. B., Bryois, J., Chen, C.-Y., Dennison, C. A., Hall, L. S., Lam, M., Watanabe, K., Frei, O., Ge, T., Harwood, J. C., Koopmans, F., Magnusson, S., Richards, A. L., Sidorenko, J.,...O'Donovan, C. (2022). Mapping genetic loci implicates genes and synaptic biology in schizophrenia. *Nature*, *604*, 502-508. <https://doi.org/10.1038/s41586-022-04434-5>
- Uttal, W. R. (2011). *Mind and brain: A critical appraisal of cognitive neuroscience*. The MIT Press. <https://doi.org/10.7551/mitpress/9780262015967.001.0001>
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Lawrence Erlbaum Associates Publishers. <https://doi.org/10.1002/pits.10115>
- Wampold, B. E., G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically “all must have prizes.” *Psychological Bulletin*, *122*(3), 203-215.





# 2025 NOMINATIONS BALLOT

Dear SAP (Division 29) Colleague:

The Society for the Advancement of Psychotherapy (APA Division of Psychotherapy, 29) seeks nominations of creative individuals and great leaders! We would like both new and experienced voices to advance our increasingly important work on behalf of psychotherapy. The SAP Board encourages candidates from diverse backgrounds to seek nomination.

## NOMINATE YOURSELF OR SOMEONE YOU KNOW TO RUN FOR OFFICE IN SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY (APA DIVISION 29)

The offices open for election in 2025 are:

President-elect

Representatives to APA Council (2 positions)

Domain Representative for Early Career Psychologists

Domain Representative for Science & Scholarship

Domain Representative for Diversity

All persons elected will begin their terms on January 2, 2026

A Domain Representative is a voting member of the Board of Directors. The open positions will be responsible for initiatives and oversight of the Society's portfolio in the respective Domains. Candidates should have demonstrated interest, expertise, and investment in the area of their Domain. Candidates should review the Society's fiduciary duty and conflict of interest policies and must complete the fiduciary questionnaire prior to being included on the slate. Detailed descriptions of the duties and responsibilities for each position are available on request from the Society's central office: [assnmgmt1@cox.net](mailto:assnmgmt1@cox.net).

The Society's eligibility criteria for all positions are:

1. Candidates must be Members or Fellows of the Society.
2. No member may be an incumbent of more than one elective office.
3. A member may only hold the same elective office for two successive terms.
4. Incumbent members of the Board of Directors are eligible to run for a position on the Board **only** during their last year of service or upon resignation from their existing office prior to accepting the nomination. A letter of resignation must be sent to the President, with a copy to the Nominations and Elections Chair.
5. All terms are for three years, except President-elect, which is one year (and then proceeds to President for one year and Past President for one year).

### The deadline for receipt of all nominations ballots is December 15, 2024.

As per the Society's Bylaws, you may email your nominations to: [assnmgmt1@cox.net](mailto:assnmgmt1@cox.net). Please put SAP/DIVISION 29 NOMINATIONS in the subject line of the email. You may also mail your nominations to Society for the Advancement of Psychotherapy, 6557 E. Riverdale St., Mesa, AZ 85215

If you would like to discuss your own interest or any recommendations for nominations, please contact the Society's Chair of Nominations and Elections, Dr. Joshua Swift [joshua.keith.swift@gmail.com](mailto:joshua.keith.swift@gmail.com)

Sincerely yours,  
Tony Rousmaniere  
President

Stewart Cooper  
President-elect

Joshua Swift  
Chair, Nominations Committee

## NOMINATIONS

President-elect

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Council Representative

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Domain Representative for Science/Scholarship

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Domain Representative  
Early Career Psychologists

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Domain Representative Diversity

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# CONGRATULATIONS TO THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY DIVERSITY RESEARCH GRANT RECIPIENTS!



## Ailun Li

My name is Ailun Li, and I am a 4th year international student in clinical psychology at Idaho State University. My career goals

focus on practicing psychotherapy and conducting psychotherapy research, specifically focusing on diverse populations.

As an international student clinician, I am interested in investigating the impact of a therapist's accent on clients' perceptions of therapist credibility and the therapeutic alliance. Specifically, the overall aim of the current study is to test whether a potential Asian therapist would be rated more negatively by potential clients in the U.S. if they speak with a strong Chinese accent, compared to a more U.S. native one. In addition to this overall aim, we plan to examine whether participants' universal-diverse orientation may have a differential impact on their ratings of a therapist who speaks English with a strong Chinese accent than one who speaks English with a standard U.S. native one. With the increasing number of immigrant therapists in the U.S., I believe this study has the potential to offer insight into the positive and negative experiences that they sometimes face in their clinical work.



## Ruiqi Lu

Ruiqi Lu is a PhD candidate in the Department of Educational Psychology at The Chinese University of Hong Kong,

where she is supervised by Dr. Harold Chui. She holds a Bachelor's degree in Psychology from Lingnan University and a Master's degree in Counselling Studies from the University of Edinburgh. With the support of the Society for the Advancement of Psychotherapy Diversity Research Grant, Ruiqi's current study aims to develop and validate a new instrument for assessing practitioners' competencies in their work with asexual clients. Through this research, Ruiqi hopes to establish a psychometrically sound scale that can be used to assess trainees' and therapists' strengths and areas of growth in providing psychotherapy to asexual individuals, advance research in factors that facilitate or hinder asexual counselling competence, inform the development of better training programs, and ultimately contribute to broader awareness and understanding of asexuality and related topics within the profession of psychotherapy.



Society for the  
Advancement  
of Psychotherapy

## SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY APA DIVISION 29

### Award Program for 2025 – Nominate by December 31, 2024

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

#### DISTINGUISHED PSYCHOLOGIST AWARD

The APA Society for the Advancement of Psychotherapy (APA Division 29) invites nominations for its Distinguished Psychologist Award, which recognizes lifetime contributions to psychotherapy, psychology, and the Society. Originally established in 1970 as the Distinguished Professional Award in Psychology and Psychotherapy, its name to Distinguished Psychologist Award for Contributions to Psychology and Psychotherapy. The awardee will receive a certificate and award of \$500 as well as up to \$500 reimbursement for qualified expenses to attend the Society's Awards Ceremony to be held at the annual APA Convention.

#### NOMINATION REQUIREMENTS

- A nomination letter outlining the nominee's career contributions (self-nominations are welcomed)
- A current Curriculum Vitae.

#### SUBMISSION PROCESS: Deadline 12/31/2024

Submission Process: Self-nominations are accepted and encouraged. All items must be sent as electronic files in PDF format. Letters of nomination outlining the nominee's credentials and contributions (along with the nominee's CV) should be emailed to the Chair of the Professional Awards Committee, Dr. Gerry Koocher at: [koocher@gmail.com](mailto:koocher@gmail.com).



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## The APF/SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY EARLY CAREER AWARD

(Formerly, THE JACK D. KRASNER AWARD)

This award supports the mission of APA's Society for the Advancement of Psychotherapy (Division 29) by recognizing Society members who have demonstrated outstanding promise in the field of psychotherapy early in their career. The awardee will receive \$1,000 from the American Psychological Foundation.

### ELIGIBILITY REQUIREMENTS

Nominees should be a member of the Society for the Advancement of Psychotherapy and within 10 years of receiving their doctoral degree.

### EVALUATION CRITERIA

Nominees will be rated on accomplishment and achievement related to psychotherapy theory, practice, research, or training.

### NOMINATION REQUIREMENTS

- Nomination letter written by a colleague outlining the nominee's career contributions (self-nominations not acceptable).
- A current Curriculum Vitae.
- Self-nominations are NOT accepted.

**SUBMISSION PROCESS:** Deadline 12/31/2024

Submission Process: Nominations must be submitted online:

<https://ampsychnfdn.org/funding/division-29-early-career-award/> Please note that you must create an account (or have an account) to submit nominations.



### APF ROSALEE G. WEISS LECTURE FOR OUTSTANDING LEADERS

The APA Society for the Advancement of Psychotherapy (APA Division 29) invites nominations for the 2025 American Psychological Foundation's Rosalee G. Weiss Lecture, which honors an outstanding leader in psychology, or a leader in the arts or sciences whose work and activities has had an effect on psychology. The lecture is delivered at the annual APA convention. The APA Society for the Advancement of Psychotherapy (Division 29) and Psychologists in Independent Practice (Division 42), administer the lectureship in alternate years. The lecture was established in 1994 by Raymond A. Weiss, Ph.D., to honor his wife, Rosalee G. Weiss, Ph.D. The lecturer receives a \$1,000 honorarium.

#### Eligibility Criteria:

The nominee must be an:

- Outstanding leader in arts or science whose contributions have significance for psychology, but whose careers are not directly in the spheres encompassed by psychology; or,
- Outstanding leader in any of the special areas within the sphere of psychology.

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**Nomination Materials:**

Letters of nomination should outline the nominee’s credentials and contribution. Self-nominations are welcomed. Nomination letters and a brief CV *should be submitted electronically in one PDF document* to the Society’s Chair of the Professional Awards Committee, Dr. Gerry Koocher

**Deadline:** December 31, 2024



**FOR ALL PROFESSIONAL AWARDS**

Transmit materials to Dr. Gerry Koocher as [koocher@gmail.com](mailto:koocher@gmail.com). Include the notation “Division 29 Awards” in the email subject line. All materials received will be acknowledged.

Visit the Division of Psychotherapy on the web at  
[www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org)



**Find the Society for the Advancement of  
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## INVITATION TO JOIN THE SAP PROFESSIONAL PRACTICE COMMITTEE

We invite you to take an active role in our division by joining our Professional Practice Committee. As a committee member, you'll have the opportunity to shape policies, advocate for needed changes, and set standards that benefit therapists and clients alike. Enhance your professional development, connect with leaders and peers, and expand your expertise on critical practice issues. This is your chance to grow as a leader, build lasting connections, and give back to the psychotherapy community.

If you're interested in promoting the practice of psychotherapy and want to get involved in some of our exciting projects, or just want to find out more about what we're all about, please join our upcoming meeting on 12/12/24 at 12:30pm. You can email our Committee Chair, Marcy Rowland ([marcyrowland@gmail.com](mailto:marcyrowland@gmail.com)) or Domain Representative, Amy Ellis ([amyellisphd@gmail.com](mailto:amyellisphd@gmail.com)) for the link.

More about our domain and it's mission:

*The purpose of the Professional Practice Domain, along with the Professional Practice Committee, is to facilitate awareness of relevant practice issues to Division 29 members, APA membership, and the public at large. The domain promotes awareness of, as well as provides access to, new theoretical understandings, therapeutic methodologies, and research evidence to inform the professional practice of psychotherapists in delivering relationally attuned, culturally competent, evidence-informed care. The domain also provides high quality and state-of-the-art Continuing Education programs and presentations at the APA Annual Convention to enhance training and education for professionals as well as the public.*



# SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY

THE ONLY APA DIVISION SOLELY DEDICATED TO ADVANCING PSYCHOTHERAPY



## MEMBERSHIP APPLICATION

The Society meets the unique needs of psychologists interested in psychotherapy. By joining the Society for the Advancement of Psychotherapy, you become part of a family of practitioners, scholars, and students who exchange ideas in order to advance psychotherapy. The Society is comprised of psychologists and students who are interested in psychotherapy.

Although the Society is a division of the American Psychological Association (APA), APA membership is not required for membership in the Society.

## JOIN THE SOCIETY AND GET THESE BENEFITS!

### FREE SUBSCRIPTIONS TO:

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### DIVISION 29 PROGRAMS

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

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

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

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

### DIVISION 29 LISTSERV

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

### VISIT OUR WEBSITE

[www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org)

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

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Jesse.Owen@du.edu

Electronic Publications Editor, 2024-2025

Zoe Ross-Nash, PsyD  
Saint Louis, MO  
Ofc: 201-299-6156  
editor@societyforpsychotherapy.org



## 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-Nash [editor@societyforpsychotherapy.org](mailto: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](http://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](mailto:assnmgmt1@cox.net) or 602-363-9211)



### Society for the Advancement of Psychotherapy (29)

Central Office, 6557 E. Riverdale Street, Mesa, AZ 85215

Ofc: (602) 363-9211 • Fax: (480) 854-8966 • E-mail: [assnmgmt1@cox.net](mailto:assnmgmt1@cox.net)

[www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org)



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

[www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org)

Want to share your exciting news with your fellow members? Four times throughout the year, the newsletter is dispersed to members of Division 29 in order to share accomplishments and announcements with fellow professionals. This is a great chance to not only to share your own news, but learn of other opportunities that arise.

Email Zoe Ross-Nash, the website editor, ([interneteditor@societyforpsychotherapy.org](mailto:interneteditor@societyforpsychotherapy.org)) to share news and announcements about book releases, published articles, grants received, theses and dissertation defenses, etc.

*We'd love to hear from you!*

