Psychotherapy

OFFICIAL PUBLICATION OF THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

www.societyforpsychotherapy.org

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PSYCHOTHERAPY BULLETIN

Official Publication of the Society for the Advancement of Psychotherapy of the American Psychological Association

2026 Volume 61, Number 2

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PRESIDENT'S COLUMN

The Value of Belonging

Joshua K. Swift, Ph.D.
Idaho State University

As President, I often get the opportunity to talk to individuals about why they should be members of the Society for the Advancement of Psychotherapy (SAP). My rationale typically reflects a list of tangibles or concrete benefits that they will receive as a result of joining the division. These include access to articles published in our flagship journal (Psychotherapy) as well as our bulletin, eligibility for our numerous awards at student and professional levels, an ability to apply for our many grants that provide anywhere from $500 to $20,000 in funding for research, access to webinars that often include free CE credits, and social and networking activities online or at the American Psychological Association (APA) Annual Convention. At only $29 per year, these concrete benefits are a real deal! My argument for why people should join SAP today sounds much like the rationale I remember providing people nearly two decades ago when I volunteered for the division at multiple APA conventions. At those earlier conventions, I remember standing at a Division 29 booth and scanning badges for people who were interested in free membership so they could get access to some of the benefits mentioned above. These tangibles are alluring and very important—I know that over the years I have personally benefited from several of these things, including awards, grants, and increased knowledge and competencies from reading journal articles and online division content. But, upon further reflection, I believe the greatest benefit that I have personally received from my membership in SAP (and the greatest benefit that we have to offer) is something much less tangible. It is the value of belonging.

Benefits of Social Belonging

As therapists, most of us can quickly recognize the general benefits of belonging—after all, we have likely talked about these benefits with our many of clients at one point or another. We know that belonging, or a secure attachment, for infants and youth leads to higher self-esteem and happiness, better relationships with siblings and peers, less frequent behavioral problems, and higher academic performance (Hoffman et al., 2017; Kurland & Siegel, 2020; Wang, 2021). In adulthood, a secure attachment can lead one to being more open with others, as well as experiencing greater self-esteem, life satisfaction, and happiness when we are well-adjusted, and more frequent experiences of depression, anxiety, and loneliness when we are not (Zhang et al., 2022). Beyond just attachment styles, feeling connected, or having a shared sense of identity with others, can result in improved academic and work performance, greater life satisfaction and well-being, and higher self-esteem, as well as a number of physical health benefits (Allen et al., 2022; Parker et al., 2022). It can also be a protective factor for preventing depression and suicide (Allen et al., 2022; Chu et al., 2017; Gill et al., 2023).

We also know that belonging means something more than just being around other people (it is not all that difficult to feel lonely even when you are in a big crowd) or having stated social connections (family members, roommates,

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and “friends” may not always be that close to each other). Instead, belonging occurs when one feels connected with a stable group of others, who one believes share a similar identity or set of values, and who care about each other’s well-being (Baumeister & Leary, 1995). This type of connection is important, and some have suggested that it is the main motivator or drive for all human culture and behaviors (Baumeister & Leary, 1995).

In our technology-laden, instant gratification-driven world today, belonging seems to be something that is missing for many people. According to the 2025 Membership Marketing Benchmarking Report (a survey on membership of nearly 500 professional organization/associations), the majority of organizations report that their membership is either staying the same or in a decline (Marketing General Inc., 2025). Further, the report indicated that two-thirds of the members in the surveyed organizations are over 46 years old (one-third over 61 years old), and only about 10% are under the age of 28. In a recent article that reviewed data from the American Perspectives Survey (Bruckmann, 2025), the author reported that 12% of the population of U.S. adults currently report having no close friends, a number that has quadrupled since 1990. In addition, only one-third of the percent of adults that reported that they have ten or more close friends in 1990, now report the same. A recent Surgeon General Report (Office of the Surgeon General, 2023) indicates very similar trends, while only about one-quarter of Americans reported three or fewer close friends in 1990, almost half reported this in 2021. Further, the time spent with household family social engagement decreased by 5 hours per month from 2003 to 2020 (even though family members were stuck in their houses together in 2020 during the height of the COVID-19 pandemic). In contrast to these statistics about in-person relationships, the average Facebook user now has 155 online friends (Donnelly, 2026) and the average Instagram user has 264 followers (Lee & Elad, 2026)—Cristiano Ronaldo has over 171 million on Facebook and over 670 million on Instagram. And research suggests that teens spend an average of 5 hours per day on social media platforms (DeAngilis, 2024), but only about 1 hour per day interacting with parents. It is noteworthy that levels of reported loneliness are going up across the country (Office of the Surgeon General, 2023), corresponding with meaningful in-person connections decreasing and online superficial connections increasing. Personally, I am a bit worried to see what will happen as people in our society turn more and more to AI for interactions that historically would have occurred in person with real humans.

Benefits of Professional Belonging

Belonging in a social context is important, but the value of belonging extends beyond just connecting with family members and friends. A sense of belonging can also be critical for us to find purpose and fulfillment in the professional roles that we take on. SAP has been a place where I have belonged for the past 20 years—the members of SAP are my academic family, and the society as a whole is one of my academic homes. Let me share some of the reasons why.

First, through SAP I have been able to establish friendships with colleagues across the globe. We may not see each other often (maybe just at the APA convention or during board meetings, online webinars, or other service activities), but the connection and comradery is there. When we do see each other, it is fun hearing about how someone’s practice is going or about the latest news in their academic position. We also sometimes check in on family and learn about

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updates with hobbies. Also, as I have experienced problems with my job, they are always there to offer a listening ear, support, and suggestions of things that have worked for them when they have faced similar problems in their work settings.

Second, belonging to SAP allows me to see that there are other professionals out there with similar goals and purpose. Sometimes I feel a bit discouraged about the small amount of change that I can make in the world on my own. But, when I remember that there are many members of SAP out there who are just like me and working toward the same goals, then I feel hope again. And SAP, as an organization, has achieved and is achieving great things, including producing a large body of scientific literature that has shaped what we know about psychotherapy today, providing trainings and other education materials that helps build competencies in professionals throughout the world, and advocating on behalf of policies that provide more effective care to those with mental health needs. Through my membership in SAP, I get to be a part of the big positive changes that are moving forward.

Third, belonging to SAP gives me additional experiences of joy in my work. It is always fulfilling to get an award, grant, or another publication. SAP has been a source of many of these for me and my students over the years. On top of that though, it is also very rewarding when I see announcements about my colleagues in SAP accomplishing great things. I feel excited for them, because they are my friends and we are in this mission to improve psychotherapy together. This shared joy brings more fulfillment to my career.

Fourth, belonging to SAP helps solidify my professional identity. Rather than just being a licensed psychologist and a professor, I am also a member of the Society for the Advancement of Psychotherapy. This is a title that I can gladly share with others as I describe the nature and focus of my work. This identity also gives me individual purpose and direction—as I learn about the goals and aims of the division and the projects that members in it are collectively working on, I am inspired with ideas for next directions for my own work.

Conclusion

All of the belonging benefits that I mention above are not tangible, or something that I can put in a bag and take home when I renew my membership. But these benefits have been so valuable to me throughout my career. For those who are also members of SAP, I encourage you to continue to belong to the division and make sure to renew at the end of the year. I also encourage you to reach out to someone who is not yet a member and invite them to come and belong with us. For those who are not yet members, SAP is a wonderful professional home and I hope you will consider joining us to receive both the tangible and intangible benefits of belonging.

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ELECTRONIC COMMUNICATION EDITOR'S COLUMN

Zoe Ross-Nash, PsyD

Division 29,

We hope this message finds you well. As we continue our work in supporting and advancing the field of psychotherapy, we want to remind you that we are still actively accepting submissions for the *Psychotherapy Bulletin*. The *Bulletin* remains a vibrant space for clinicians, scholars, and trainees to share ideas, research, reflections, and innovations that move our field forward and foster meaningful dialogue across diverse perspectives.

We are continually inspired by the depth and breadth of work within our community and encourage contributions that reflect your clinical insights, research findings, and professional experiences. Whether your work highlights emerging trends, addresses challenges in practice, or explores the evolving identity of the psychotherapist, your voice is an essential part of this collective effort. Submissions may be research-informed, practice-oriented, or reflective in nature, and we welcome both seasoned contributors and first-time authors.

Your participation is what sustains the richness and relevance of the *Bulletin*, and we are grateful for the ongoing engagement of our members. If you have been considering submitting, we warmly encourage you to do so and to share your expertise with the Division.

For submission guidelines and additional information, please visit the Society for the Advancement of Psychotherapy website. Should you have any questions, feel free to reach out, we are happy to support you in the process.

We look forward to reading your work and continuing to build a dynamic and inclusive publication together.

Warm regards,
Zoe Ross-Nash

Reclaiming Psychotherapy: A Health-Centered Alternative to the Western Medical Paradigm Offered by Traditional Chinese Medicine

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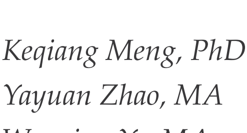

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Abstract
The dominant Western medical model in psychotherapy, centered on illness and problems, has revealed limitations including over-pathologization and poor treatment outcomes. This paper proposes Traditional Chinese Medicine (TCM) as a robust, health-centered alternative paradigm. TCM offers a holistic, person-centered approach that views mental health as inseparable from physical health, emphasizing balance (*Pínghéng Guān* 平衡), unity of mind and body (*ZhěngtǐGuān* 整体), and dialectical change (*Biànzhèng Guān* 辩证). There has been empirical support that TCM practitioners honor the focus on prevention, internal harmony, holistic root-cause resolution, and individualized care for mental well-being. Integrating TCM principles into psychotherapy can shift the focus from solely treating diseases to actively enhancing comprehensive health, promoting wellness, and cultivating innate healing capacities. This reorientation offers a more holistic, person-centered, and effective pathway for genuine mental health promotion.

Applied Impact Statement
A Traditional Chinese Medicine informed, health-centered psychotherapy paradigm offers a robust framework to address the limitations of the current illness-centric Western medical model. By reorienting psychotherapy towards a holistic, preventative, and person-centered approach, practitioners can move beyond merely removing symptoms to fostering genuine wellness, resilience, and growth that considers each individ-

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ual's unique ecological context. This paradigm provides actionable principles (i.e., recognizing the unity of mind and body, addressing root cause, promoting balance) that can lead to more effective, individualized, and culturally sensitive mental health interventions, particularly for those underserved by conventional methods. Ultimately, this reclaims psychotherapy's mission for authentic mental health promotion, potentially improving treatment outcomes and overall well-being on a broader scale.

Introduction

The field of psychotherapy is at a critical juncture, with the dominant Western medical model shaping mental health care for decades. This illness-centric approach has limitations, leading to calls for alternative perspectives to address human psychological needs and enhance well-being (Duncan, 2002; Kamens et al., 2017; Wampold & Imel, 2015). This paper proposes that Traditional Chinese Medicine (TCM) offers a robust and historically validated paradigm to reorient psychotherapy towards a truly health-centered approach.

The Crisis of the Current Paradigm: When Psychotherapy Falls Short

The current Western medical model in psychotherapy is fundamentally centered on illness and problems (Deacon, 2013). Psychotherapy has become structured around assessment, diagnosis, and treatment, similar to medical practice. This approach has raised concerns including the over-pathologization and medicalization of the human experience (Elkins, 2017; Walker, 2014). It often prioritizes treating the illness over healing the person, viewing patients as having a disease that needs to be cured. This approach has probably contributed to the paradox that increased access and availability of professional resources and opportunities co-exist with increased mental health crisis due to systemic iatrogenesis and other factors. The treatment focus has not led to great treatment outcomes and has even caused harm at times, especially for individuals from underrepresented cultural backgrounds (Sue & Sue, 2012). These limitations highlight an urgent need for a paradigm shift. The field of psychotherapy needs an approach that is psychologically beneficial, enabling individuals to genuinely improve their health and overcome challenges in a profoundly person- and health-centered manner.

Previous attempts to shift this paradigm produced theoretically sound alternative models and frameworks, such as social construction models (Gergen, 2009; Walker, 2014), social ecological approaches (Cook, 2012), human connection and interaction frameworks (Elkins, 2017), and contextual models (Zubernis et al., 2017). However, these models have not made significant, widespread changes in clinical practice. This stagnation is likely due to several factors, including the enduring influence of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2022). The DSM diagnostic system tightly controls reimbursable services and prioritizes a narrow range of evidence-based practices. Barriers also include professional conflicts of interest, such as using clinical jargon and diagnostic labels to show one's expertise while overlooking the harm it may have on clients. According to Kuhn (1996), a truly viable paradigm must effectively describe and explain psychological distress in a universally consistent manner, while also providing clear models for problems and solutions for practitioners. This paper contends that TCM meets all the requirements for such a transformative paradigm in health service professions.

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The Traditional Chinese Medicine Paradigm: A Holistic System for Mental Health

TCM is a systematic healthcare system developed from long time clinical experience and observations, offering a compelling and potentially more effective paradigm for psychotherapy. It is a living, evolving tradition that has been observed, tested, refined, and practiced for over 2,000 years (Duan & Li, 2022). Scientifically, TCM rests on one of the longest-running bodies of longitudinal, collective clinical observation in human history (Tu, 2011). Its approach to health is inherently holistic, person-centered, and health-centered (Scheid, 2013). A fundamental insight from TCM is that mental health is not distinct from physical health; traditional TCM texts do not separate the two. Instead, TCM uses concepts like *jingshen* (精神), representing the spirit, and *qingzhi* (情志), representing emotions. Mental health thrives when *jingshen* and *qingzhi* are in a balanced state, while illness—manifested in both mental and physical symptoms—appears when there is an imbalance of these states.(Liu & Wang, 2019).

A recent empirical study by the co-authors (Duan et al., 2025) shows that current TCM practitioners in Mainland China articulate health through three interconnected perspectives that provide a solid foundation for mental health work:

- **Holistic perspective (整体观 - Zhěngtǐ Guān):** This perspective embraces the fundamental unity of form and spirit (*xing yu shen ju* - 形与神俱), recognizing the inseparable interaction of mind and body. It also emphasizes the profound unity of person and nature (*tian ren he yi* - 五脏藏神), highlighting health's deep interconnection with our environment and the natural world. Furthermore, it acknowledges how the five organs store different aspects of the spirit (*wu zang cang shen* - 五脏藏神), and how the seven emotions can directly cause disease or promote health (*qi qing zhi bing* - 七情致病).

- **Balanced perspective (平衡观 - Pínghéng Guān):** Health is understood as a dynamic state of balance between *yin* and *yang*, or between opposites of any human experience. Negative mental symptoms are seen not as signs of disease, but as signs of disharmony. Therefore, regaining health—including mental health—is a process of balancing and rebalancing, and remaining flexible, adaptable, and aligned with the cycles of nature and one's inner constitution.

- **Dialectic perspective (辩证观 - Biànzhèng Guān):** Rooted in classical Chinese philosophy, particularly yin-yang theory and the five phases (*Wu Xing* 五行), the dialectic perspective is central to TCM's theoretical framework. TCM acknowledges the inherent relativity of health, embracing heterogeneity and constant change as natural aspects of the human experience. Thus, health and illness are not fixed states but changing processes of interaction.

Within TCM, maintaining mental health involves proactive strategies, such as nourishing the body and mind to prevent illness (*yang sheng zhi wei bing* - 养生治未病), guarding the spirit within (*jing shen nei shou* - 精神内守), and adapting to the environment through conforming to nature and adapting to social environments. Mental illness itself is primarily conceptualized as emotional imbalance resulting from a complex interplay of internal (i.e., biological, physical, psychological, mental, behavioral/

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lifestyle patterns) and external (i.e., social relationships, socioeconomic conditions, physical environment) factors (Duan et al., 2025; Lin & Wang, 2019).

TCM approaches mental illness with several key treatment principles that offer profound insights for psychotherapeutic intervention, including: Holistic root cure (*zheng ti gen zhi* - 整体根治), seeking the true root of disease (*zhi bing qiu ben* - 治病求本), treating body and mind as one (*shen xin tong zhi* - 身心同治), addressing internal and external aspects simultaneously (*nei wai tong zhi* - 内外同治), strengthening righteous *qi* (vital energy or life force) and dispelling *evil qi* (*fu zheng qu xie* - 扶正祛邪), treating both root cause and symptoms (*biao ben jian zhi* - 标本兼治), and always through individualized, pattern-based treatment (*bian zheng lun zhi* - 辨证论治; Unschuld & Tessenow, 2011).

Empirical Evidence for a TCM-Informed Paradigm

Traditional Chinese Medicine (TCM) offers a holistic and pattern-based approach to mental health, framing distress as a systemic imbalance rather than an isolated biological failure or individual flaw. This is a fundamentally different approach from the Western biomedical model approach. Due to the inadequacy of current research methods, such as controlled randomized trial or correlating standardized measurement scores, its efficacy has not been sufficiently demonstrated (Duan & Li, 2021). Nonetheless, some evidence focusing on the efficacy of TCM modalities, such as acupuncture, herbal medicines, mind-body practices, and lifestyle therapies have shown promising outcomes. For instance, multiple systematic reviews and meta-analyses suggest that acupuncture significantly reduces the symptom intensity of depression (Ye et al., 2019) and anxiety (Zhang & Wang, 2020). Further, systematic reviews also suggest that the combination of Chinese Herbal Medicine (CHM) and traditional therapeutic treatment yield more effective outcomes than conventional treatment alone for major depressive disorder, often with a reduced incidence of severe adverse effects (Lin & Wu, 2021). Similarly, evidence has shown that regularly practicing Qigong and Tai Chi significantly reduces symptoms of stress and anxiety in both clinical and non-clinical populations (Chan & Lee, 2023).

The effectiveness of diverse TCM treatment modalities ultimately reflects the unified philosophical principles of TCM with mental health disorders viewed through the lens of *qi*, *blood*, *yin*, and *yang* disharmony. Thus, the interventions focus on restoring harmonious circulation and balance of the body's fundamental substances and energies. This shared philosophical coherence is theorized to be a primary reason for its collective efficacy in alleviating psychological distress (Lao et al., 2024). Clearly, the TCM core diagnostic and treatment principles offer a robust framework that can be integrated into psychological practice. Utilizing these principles allows psychotherapeutic approaches to incorporate a somatic understanding of emotional distress and/or an emotional understanding of physical distress, potentially leading to more targeted and holistic treatment outcomes.

Implications for a Health-Centered Psychotherapy Practice

The insights from the TCM paradigm have profound implications for the future of counseling and psychotherapy. The findings compellingly suggest that health service professions should fundamentally shift their focus from merely treating illness to actively enhancing a person's comprehensive health. This health-centered approach means:

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- **Adopting a holistic view.** Recognizing health as a holistic state incorporating the unity of form and spirit as well as the essential unity of person and nature. True health is understood as a dynamic state of balance and harmony.

- **Prioritizing prevention and addressing root causes.** Interventions should emphasize prevention and address the root cause of problems rather than focusing on symptom removal. Attending to the complex interplay of both internal and external factors is necessary for improving well-being.

- **Reframing the therapeutic focus.** This paradigm fundamentally reframes the therapeutic focus from one on pathology and deficits to one centered on promoting wellness, empowering clients, and cultivating their innate capacities for healing and growth. Specifically, rather than attacking symptoms, practitioners should look for ways to re-regulate the whole system—supporting what is weak, reducing what is excessive, and guiding energy to flow for the client.

Reclaiming Our Mission for Genuine Mental Health Promotion

The continued dominance of the disease-focused Western medical model in psychotherapy can be unhelpful and potentially harmful. The field of psychotherapy must pivot decisively toward enhancing health rather than solely curing disease. Traditional Chinese Medicine's ideology and comprehensive framework demonstrates significant potential as a robust alternative paradigm to what is currently offered. This proposed shift is more than a mere change in technique; it demands a fundamental reorientation of how mental health, human suffering, and the healing process are conceptualized. The integration of TCM principles with contemporary mental health practices presents a pathway toward a more holistic, person-centered approach to psychotherapeutic intervention that honors the intricate and complex nature of the vast human experience.

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Global Perspectives in Training Future Mental Health Practitioners: Challenges and Innovations from Four Continents

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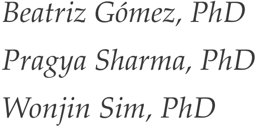

Authors' Note: All authors contributed equally to this article and are listed alphabetically. This article is based on a structured discussion presented by the same authors at the 56th International Annual Meeting of the Society for Psychotherapy Research, Krakow, Poland, June 2025.

Abstract
Amid a rapid sociocultural transformation and a growing global demand for mental health care, the effective training of future psychotherapists has become a pressing concern. This article synthesizes insights from a structured discussion held at the 56th International Annual Meeting of the Society for Psychotherapy Research, where four international professionals from the diverse regions of Argentina, Hong Kong, India, and Italy shared perspectives on psychotherapy education and supervision. Findings reveal significant global diversity in professional training and regulatory systems, alongside profound cultural influences on therapeutic practice and supervision. Despite varied institutional structures and unique local challenges—such as economic instability, cultural discomfort with emotional expression, and limited access to quality supervision—common themes emerged regarding the need for increased cultural awareness, enhanced emotional development in trainees, and creative responses to resource limitations. This article highlights innovative, forward-thinking practices, including meta-supervision, live supervision, and community-based training models. Ultimately, this synthesis underscores the imperative for a globally responsive, ethically grounded, and inclusive future for psychotherapy education and practice, suggesting that shared learning across diverse contexts is essential to addressing contemporary mental health needs.

Applied Impact Statement
Therapy training models worldwide are at a crossroads while facing the dual challenge of high demand and systemic limitations, yet they are responding with shared innovative practices. While regulations and training pathways vary significantly, from formal licensure in

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Italy to a lack of it in Hong Kong, psychotherapy training across global regions is united by similar cultural and economic pressures. Issues, such as economic instability in Argentina, discomfort with emotional expression in Hong Kong's collectivist culture, and a severe shortage of supervision in India and Italy are all being addressed with a new focus on cultural awareness, contextual relevance, and ethical practice.

Introduction

Amid a rapid sociocultural transformation and a growing global demand for mental health care, the question of how best to train future psychotherapists has become increasingly urgent. At the 56th International Annual Meeting of the Society for Psychotherapy Research in June 2025, a structured discussion was held to examine this issue through a global lens. Organized by both the International Domain and Diversity Domain of the Society for the Advancement of Psychotherapy (SAP), four distinguished professionals and SAP international members from diverse regions shared insights into the training pathways, cultural influences, local challenges, and innovations shaping psychotherapy education and supervision in their countries. Specifically, the structured discussion was organized and moderated by Dr. Wonjin Sim (SAP Diversity Committee Chair) and Dr. Changming Duan (SAP International Committee Co-Chair), with Dr. Agostino Brugnera (Italy), Dr. Harold Chui (Hong Kong, China), Dr. Beatriz Gómez (Argentina), Dr. Pragya Sharma (India) serving as discussants. This article synthesizes their perspectives for the broader psychotherapy research and practice community.

Professional Training: Diverse Systems of Regulation and Access

- **Argentina**

Dr. Beatriz Gómez described a country with one of the highest concentrations of psychologists where psychotherapy is widely accepted and can be practiced after attaining a degree in psychology or medicine. Graduate training is available but is not required. While training was traditionally psychoanalytic, both cognitive and integrative approaches have gained significant ground. Free public undergraduate education fosters access though economic instability affects long-term professional development.

- **Hong Kong**

Dr. Harold Chui explained that psychotherapy remains unregulated and individuals with varied educational backgrounds may refer to themselves as counselors. Formal registration is encouraged but not mandated. At the same time, licensed professionals in clinical psychology and social work follow regulated pathways, and there are efforts to align supervision and ethics standards across these roles.

- **India**

Dr. Pragya Sharma relayed that psychotherapy training is offered in the context of dual regulatory structures under the Mental Healthcare Act and the Rehabilitation Council. Dr. Sharma noted the coexistence of clinical and counseling psychology tracks, with the former having its own licensing and supervisory systems and the latter needing clarity around similar requirements. She also described tensions due to limited institutional clarity and variation in training quality, especially citing the lack of implementation of training regulations.

- **Italy**

Dr. Agostino Brugnera shared that psychotherapy can only be practiced in Italy by licensed psychologists or medical doctors who complete a rigorous four-year postgraduate training. With more than 400 accredited programs (most of which are private), psychotherapy train-

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ing is predominantly provided outside universities. Public programs are fewer in number but generally less expensive than private programs.

Cultural Contexts in Supervision and Training

Cultural influences deeply shape how psychotherapy is practiced and how psychotherapists are trained. Dr. Gómez described Argentina as a society where therapy is a cultural norm. Clients often arrive having experienced multiple prior treatments. Yet economic crises effect therapeutic continuity and fee negotiation, requiring supervisors and trainees to navigate financial ethics and flexibility with the delivery of mental health care.

Dr. Chui emphasized that Hong Kong's exam-oriented education system fosters binary thinking and discomfort with ambiguity. These cultural legacies seem to challenge trainees' capacity for emotional tolerance and self-reflection, exacerbating the negative effects of mental health stigmatization. Trainees likely do not view themselves as potential help-seekers and may shy away from asking for support; a blind spot that supervision can and must address.

In India, Dr. Sharma noted that due to India's hierarchical norms and collectivistic culture, there tends to be a strong reverence for seniority and authority, which can sometimes inhibit open dialogue or questioning during supervision. Trainees may hesitate to express confusion, disagreement, or emotional vulnerability, faring judgment or negative evaluation. Reflective practices are slowly gaining ground, especially in programs emphasizing experiential learning.

In Italy, Dr. Brugnera reported that supervision is closely tied to the theoretical orientation of the training institution. Most psychotherapy schools are based on a single therapeutic model and supervision typically reflects and reinforces the principles of that specific approach. Further, while only a few training programs place significant emphasis on racial and cultural dynamics in mental health, a growing number of professionals are now recognizing the importance of integrating cultural competence and diversity awareness into psychotherapy education.

Contextual Challenges in Supervision and Practice

Each speaker identified distinctive local barriers and challenges in supervision and practice, emphasizing the significant influence of contextual factors. In Argentina, supervision should attend to economic inequality (e.g., fee dynamic) and address trainee risk of over-functioning in their clinical work (e.g., patient empowerment).

Trainees in Hong Kong sometimes have difficulty recognizing and articulating their own emotions. From a Western perspective, this might be seen as discomfort or a challenge in exploring clients' emotions during therapy. Dr. Chui highlighted the importance of training students to view emotions more comprehensively, taking into account that somatic and behavioral changes can also serve as indicators of a client's emotional state. Utilizing a cultural lens demonstrates that a lack of verbal emotional expression is not necessarily an interpersonal deficit and it may be the result of various cultural and contextual factors that warrants exploration.

In India, Dr. Sharma noted that qualified supervisors are scarce and especially in rural areas, leading to overburdened supervisors and limited opportunities to experience reflective supervision. Heavy caseloads and minimal financial support for supervision impede deep cultural

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fidelity in training. Additionally, stigma exists around seeking supervision as a therapist, which is a crucial but underutilized form of support.

In Italy, Dr. Brugnera cited the difficulty in securing internship placements, which vary greatly between institutions and regions. Academic and training paths are entirely separate, preventing the integration of research and clinical practice and, therefore, impeding the adoption of a scientist-practitioner model.

Innovation and Forward-Thinking Practices

Despite these challenges, each speaker shared promising developments. Argentina has implemented a meta-supervision model and has culturally adapted training evaluation tools, such as brief feedback-informed measures and video-based supervision. A supervisor training program that includes the development of multicultural competencies is currently being offered.

Hong Kong has adopted live supervision and group-based models that seem to enhance peer support and reduce trainee anxiety. These methods foster collaboration and are especially resonant in collectivist cultures. India is seeing the emergence of community-based training and reflection-oriented supervision with an emphasis on self-awareness. Lastly, Italy is seeing some programs integrating structured self-assessment and outcome monitoring tools. Even more advanced training techniques are being implemented, including video-recordings, peer supervision, and the utilization of digital supervision platforms.

Conclusion

This global conversation revealed rich diversity in psychotherapy training models and identified several unifying themes across varying geographic locations. Across all regions, the integration of cultural awareness, attention to emotional development, and creative responses to resource limitations emerged as the primary concerns in training mental health providers. While institutional structures vary widely, each context offers innovations that can inspire others. Sharing global perspectives moves us toward a more responsive, ethical, and inclusive future in the education, training, and practice of psychotherapists and mental health providers.

Clinician Stigma Toward Narcissistic Personality Disorder: Implications for Assessment, Treatment, and Clinical Practice

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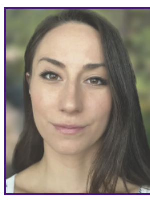

Introduction

Narcissistic personality disorder (NPD), as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR; American Psychiatric Association, 2022), is characterized by patterns of grandiosity, a need for admiration, and a lack of empathy. However, this definition limits the full representation of the disorder, primarily omitting the essential component of vulnerability (Crisp & Gabbard, 2020; Pincus & Lukowski, 2010; Ronningstam, 2016; Weinberg & Ronningstam, 2022). Across a growing body of literature, NPD is recognized as a widely heterogeneous personality disorder represented by two phenotypic presentations of vulnerability and grandiosity that exist simultaneously, expressed in either overt or covert ways (Pincus & Lukowitsky, 2009). It is a disorder of dysfunctional self-esteem regulation and identity disturbance. Despite the field's movement towards de-stigmatizing mental health, NPD and related traits remain highly stigmatized by both clinicians and the public (Finch & Mellen, 2025; Penney et al., 2017). This stigma has significant implications for the engagement, assessment, and treatment of those with narcissistic pathology. In this context, narcissistic pathology refers to enduring patterns of identity disturbance, maladaptive self-esteem regulation, and relational dysfunction that may or may not meet full DSM-5-TR criteria for narcissistic personality disorder. By some estimates, pathological narcissism occurs in as much as 20% of the clinical population (Weinberg & Ronningstam, 2022). Clinician stigma toward pathological narcissism and NPD is a common, measurable experience amongst clinicians that significantly impacts engagement, assessment, and treatment. However, clinical countertransference can be effectively utilized to improve assessment and treatment outcomes through reflective practice, training, and evidence-based approaches.

Defining NPD Stigma

Generally, people believe that NPD is untreatable and dangerous, and that the behaviors/symptoms are enacted by conscious will. Finch and Mellen (2025) note that this stigma is interesting as it posits that NPD is both uncontrollable (unchangeable) and controllable (by choice). This research explored NPD stigma through narrative interviews with clinicians who treat this population and they found that people with NPD have internalized stigma around their diagnosis, which often exacerbates intense feelings of shame. Clinicians also report that people with NPD face stigma from both the public and from healthcare providers. As a result, those with NPD tend to hide their diagnosis from loved ones and providers as they often anticipate future experiences of stigma and continued shame. Interpersonally, people with NPD are often stereotyped and labeled based on caricatures repre-

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sented in the media. Even when clients agree with the traits and symptoms represented by NPD, they struggle to accept the label as they may feel they do not fit this caricature of someone who is manipulative, aggressive, and dangerous (Finch & Mellen, 2025).

Clinician Attitudes and the Construct of Narcissism

Recent studies exploring clinician attitudes toward NPD demonstrate widely held misunderstandings about the disorder. Many clinicians believe that NPD is untreatable and dangerous due to perceptions that those with NPD are inherently prone to aggression, manipulative tendencies, and victimizing others. They tend to wonder how other clinicians have the capacity to work with such a troubling, dangerous disorder (Day et al., 2025; Finch & Mellen, 2025). Indeed, NPD is documented to be challenging to work with, not due to the danger these patients pose, but due to the extended feelings of boredom and demoralization experienced by clinicians within the countertransference (McWilliams, 2025). Nevertheless, such beliefs lead clinicians towards an aversion of treating or understanding narcissistic pathology, despite its relative frequency in clinical populations (Finch & Mellen, 2025; Weinberg & Ronningstam, 2022). Indeed, vulnerable presentations of the disorder are less recognized in the literature and typically misdiagnosed by clinicians as depression, trauma, or borderline personality disorder (BPD; Day et al., 2025).

Depictions of NPD in the media can be highly misinformed and skew both clinician and lay understanding of the disorder, including promising developments in engagement, assessment, and treatment. One explanation for this may be due to how the construct of NPD is defined in the DSM itself. The DSM captures only the grandiose aspects of the disorder, which leads clinicians and the public to understand it as a unidimensional construct of entitlement, arrogance, vanity, and low or absent empathy. The DSM construct of NPD has been criticized on this basis almost since its inception in the mid-1980s (Cooper & Michels, 1988). Further investigations of the DSM diagnostic criteria for NPD have shown that they are overly narrow, poorly differentiated from other personality disorders, and of limited clinical utility, as they emphasize externally observable grandiosity while failing to capture the vulnerable self-states central to clinical presentations (Cain et al., 2008; Gabbard, 1989; Gunderson et al., 1995). These limitations contribute to low diagnostic stability and prevalence as individuals may meet criteria during periods of grandiosity but fall below threshold when shame and self-collapse predominate (Ronningstam, 2009; Vater et al., 2014).

Clinical Countertransference in the Treatment of NPD

Clinical countertransference can be a helpful tool in the assessment and treatment of narcissistic pathology if effectively utilized. In commensurate vignettes, Day et al. (2025) found that clinicians were more likely to accurately diagnose NPD in vignettes representing a grandiose presentation (97%) but did not typically do so with the vulnerable presentation (24%). Instead, clinicians diagnosed the vulnerable vignette with depressive disorder (29%), trauma and stressor related disorder (21%), or BPD (21%). Clinicians also reported higher personality impairment in grandiose presentations of NPD while under-pathologizing vulnerable presentations, despite both vignettes having the same level of severity markers between them (Day et al., 2025). Significantly, the authors found that clinician countertransference can be

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measured and, if accurately assessed, may help to identify and distinguish grandiose and vulnerable presentations.

Disparities in the accurate assessment and severity between grandiose and vulnerable NPD presentations may be due to the measurable countertransference differentials. Day et al. (2025) found common countertransference reactions to grandiose presentations tended to be stigmatizing and included anger, lack of empathy, and hopelessness, while those reactions toward vulnerable presentations tended to be colluding and included sympathy, sadness, and vague discomfort or unease. It was theorized that stigma toward grandiose presentations of NPD impacted the assessment of personality impairment severity, while collusion with vulnerable NPD led to overlooking severity of personality impairment and accuracy of diagnosis. Notably, such collusion was shown to result in stagnant or superficial therapeutic relationships (Day et al., 2025). In another study, Penney et al. (2017) remark that clinicians often meet NPD with their own defensive strategies that include over-compensation (e.g. needing to be an expert) or avoidance (e.g. giving up), which may further impact treatment and engagement outcomes.

Many countertransference reactions to NPD often reflect or echo aspects of the intrapsychic and interpersonal dynamics of the disorder itself. NPD patients often distance themselves from others to avoid shameful or disorganizing attachment anxiety, feelings of humiliating exposure, or intolerable interpersonal dependency. In grandiose presentations, clinicians may subtly or overtly disengage from NPD patients, particularly when the vulnerable dynamics of the disorder are difficult to access or recognize. In response to grandiose vignettes, clinicians stated, "my immediate reaction is anger… my first reaction is a sense of distaste towards [the patient] …" (Day et al., 2025, p. 6). Alternatively, clinicians may overlook the covert grandiosity that often motivates overtly vulnerable presentations. In response to vulnerably presented vignettes, clinician countertransference statements included, "I felt for this man… this is a very sad state of being…," although some reported a sense of nervousness or subtle frustration towards apparent martyrdom (Day et al., 2025, p. 6). Many people with NPD seek treatment when they are experiencing a vulnerable collapse, which may appear as depression (Ronningstam, 2016). However, depression is episodic, a narcissistic character is global and enduring, identifiable in the client's history and transferential space (Day et al., 2025; McWilliams, 2011). Effectively engaging NPD patients during vulnerable periods in the disorder is critical, as they are less likely to seek care or be aware of their distress while in grandiose states.

While overt presentations in NPD patients may be confusing or inconsistent, both grandiose and vulnerable dynamics appear organized around the need to protect a fragile internal experience of self (Day et al., 2025). This may run counter to clinician preconceptions that grandiose NPD is essentially without internal distress, or sympathetic countertransference reactions to vulnerable-presenting patients that are contingent on grandiose themes not surfacing in the treatment relationship. However, appearances can be deceiving. Patients with a predominantly vulnerable presentation may present with more suicidal ideation and non-suicidal self-injury, but those with more consistently grandiose presentations are typically at elevated risk for high-intent suicide-related outcomes (Sprio et al., 2024). In such cases, grandiosity can be protective, functioning well as a kind of intrapsychic suit of armor…until it doesn't. Despite the overtly depressive

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characteristics vulnerable narcissistic patients display, they can be protected by underlying grandiosity. Conversely, primarily grandiose patients can be at risk when their grandiose defenses collapse.

It is not uncommon for NPD to be misdiagnosed for other mental health conditions or personality disorders (Day et al., 2025). Clinicians' overreliance on first impressions, while important, may impact diagnosis and treatment outcomes. This diagnostic and conceptual invisibility may recapitulate the very relational trauma thought to contribute to narcissistic pathology in early childhood (e.g., experiences of being overlooked, misunderstood, or unseen by important attachment figures). When reproduced in treatment, such enactments can lead to exacerbation of narcissistic pathology, treatment failure, and treatment burnout despite efforts to engage. For these reasons, clinicians should reflect on their early treatment impressions. For narcissistic patients, the hidden dimensions of grandiosity or vulnerability should be sought to fill out and contextualize countertransference. Through appropriate training, supervision, and education, clinicians can learn to effectively utilize the transferential space and avoid engaging in stigma or collusion that may exacerbate this disorder and thwart opportunities for engagement (Day et al., 2025; Finch & Mellen, 2025).

Lessons from Borderline Personality Disorder

Penney et al. (2017) sought to examine the stigma toward NPD through a comparative exploration of BPD stigma. Historically, people with BPD have been viewed as "manipulative, undeserving of sympathy, in control of destructive behaviors, and undeserving of healthcare resources" (Penney et al., 2017, p. 64). However, over the last twenty years, this diagnosis has been increasingly (though not fully) destigmatized, with many individuals finding access to effective treatment. The authors credit this to the development of dialectical behavioral therapy (DBT), which offered clear skills to ameliorate suffering, emphasized the impact of developmental trauma, and documented that change was possible with accurate treatment application. Despite stigmatized beliefs, NPD also has documented success in treatment and roots in developmental trauma, however, treatment happens over time and countertransference reactions are significant (Penney et al., 2017).

Penney et al., (2017) state that "[countertransference] can be a useful tool to understanding the inner experience of a patient, who does not yet have the capacity to verbalize their inner world" (p. 66). This quote emphasizes the developmental deficit inherent in NPD which includes deficits in self-regulatory processes, identity, empathy, and intimacy (Ronningstam, 2016). Children rely on the people in their life to develop healthy self-esteem, learn how to get their needs met, and learn healthy interdependence. When their caregivers are rejecting, shaming, absent, or not sufficiently attuned, children fail to develop healthy ways of achieving those needs and relating to others (Ettensohn, 2016).

Across BPD and NPD, patients express pathologies related to absent, unstable, or deficient internal regulation. Countertransference is a valuable source of clinical data that can inform the clinician of implicit mental states that the patient does not have the ability or willingness to articulate. For example, feelings of disengagement on the part of the therapist may reflect important psychodynamics in the patient, including grandiose self-

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enhancement, inauthenticity, or underlying feelings of shame or inadequacy (Penney et al., 2017). Feelings of inadequacy or admiration in the clinician can be understood to represent the patient's unwanted feelings.

While there is currently no gold-standard treatment for NPD (Crisp & Gabbard, 2020), psychodynamic and schema-focused therapy can be helpful modalities in treating this diagnosis given their emphasis on understanding developmental impacts on psychological functioning. Penney et al. (2017) and Ronningstam (2016) cite transference-focused psychotherapy (TFP) as an effective treatment for NPD, as it explores defensive structures and improves mentalizing, which is the ability to understand the behaviors of self and others. Supervision, education, and clinical groups focused on normalizing and understanding the transferential space are also helpful in treating NPD (Day et al., 2025; Penney et al., 2017). Overall, de-stigmatizing NPD, understanding its roots in developmental trauma, and increasing effective treatment and engagement strategies can help to improve treatment outcomes and ameliorate suffering for both those with NPD and the relationships it impacts as has been done with BPD populations.

Conclusion

NPD remains one of the most highly stigmatized mental health disorders by both healthcare professionals and the public. Such stigma impacts assessment, treatment, and engagement for those with NPD. Countertransference experiences toward this population among clinicians appears to also be influenced by widespread stigma, negatively impacting assessment and treatment outcomes. BPD is a personality disorder that has similar features and that has faced similar stigma, but due to advancements in treatment and destigmatizing conceptualizations, stigma towards BPD and its effective treatment have been drastically improved. Through a similar approach of understanding the developmental roots of NPD, providing psychoeducation, and working to understand and utilize clinician countertransference, the field can move toward a less stigmatizing approach to NPD. Such efforts would help improve engagement, treatment outcomes, and ameliorate the distress those with NPD and their loved one's face.

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The Myth of Monolithic Experience: Navigating Intra-Cultural Assumptions through Deliberate Practice

Joel Jin, PhD

Cultural matching between client and clinicians has long been discussed in psychotherapy as a strategy to enhance treatment engagement and therapeutic alliance (Cabral & Smith, 2011). Practitioners often assume that shared cultural background inherently improves therapeutic connection, reducing cultural barriers and enhancing understanding. Empirical evidence supports the notion that ethnic or language matching can improve treatment engagement and retention (Lim, 2025), including increased session attendance and lower dropout rates among Asian American clients. However, conflating ethnic similarity with therapeutic attunement also introduces clinical pitfalls when it substitutes for inquiry.

In my clinical work with Asian American clients, I frequently encounter the assumption of automatic understanding based on shared identity. Clients may describe familial conflicts and then assume that I already "know how it feels" because of our shared heritage. While such assumptions may feel like rapport, when left unexamined they can obscure the client's unique experience. For example, a client may have experienced significant academic pressure during childhood from their parents due to family values of upward social mobility. Yet the clinician may have not experienced similar pressure due to different childhood household socioeconomic status. Thus, the purpose of this article is to examine how cultural humility, in contrast to assumed cultural competence, enhances psychotherapy outcomes, articulates the nuances of intra-cultural assumptions, and introduces a deliberate practice framework to improve inclusive care.

Cultural Match Versus Cultural Humility in Therapy

Cultural competence, if wrongly conceptualized as a static knowledge base about a demographic group, falls short when generalized assumptions replace client-specific inquiry. In contrast, cultural humility is defined as a lifelong commitment to self-reflection, acknowledging power dynamics, and recognizing the limits of one's understanding (Tervalon & Murray-Garcia, 1998; Hook et al., 2025). Research underscores that while ethnic matching may help with initial engagement, it is therapist cultural responsiveness and attunement, that is, the capacity to understand the client's cultural expressions and meanings, that more consistently predicts therapeutic alliance and client satisfaction (Presley & Day, 2019).

Among clinicians working with Asian American clients, experiences with ethnic match are varied (Meyer et al., 2011). Some therapists note benefits of match for rapport, while others highlight that shared identity does not automatically translate into shared understanding of each client's cultural interpretation or emotional experience (Liu et al., 2024). This complexity underscores the need for clinicians to use matching as neither a panacea nor a

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substitute for active engagement with the client's narrative.

Clinical Implications of Assumed Cultural Similarity

Collusion with Generalizations.
Assuming a uniform cultural experience can validate stereotypes rather than illuminate the client's personal context. Asian American identity encompasses vast diversity in immigration history, socioeconomic status, family dynamics, and regional subcultures. Collapsing this complexity into a presumed "standard narrative" can reduce clinical depth and nuance.

Missing the Affective Core.
Therapists who rely on assumptions risk overlooking the client's unique emotional responses, which are central to formulation and treatment planning. Without deep inquiry, clinicians may interpret client experiences through their own cultural lens rather than the client's lived reality.

Foreclosing Exploration.
Clients who assume shared understanding may self-censor or bypass elaboration, leaving significant emotional material unspoken. This can limit the discovery of core beliefs, affective patterns, and relational themes essential for effective psychotherapy.

Case Example: Humility, Emotional Avoidance, and Cultural Inquiry
A second-generation Chinese American client, "Kevin," presented with burnout, chronic self-criticism, and persistent feelings of inadequacy. Early sessions focused on occupational stress and pressure to meet high standards. During the third session, he described his father's "typical" immigrant stoicism. He paused mid-sentence and remarked, "I mean, your parents were probably the same. You get the Tiger Parent thing. That's just how we're raised, right?"

My initial internal impulse was to affirm shared cultural understanding. I identify as Asian American after several years immigrating from Canada. Such a response might have strengthened rapport at a surface level. However, I also noticed a clinical concern: Kevin's statement functioned as a cultural shorthand that risked prematurely closing emotional exploration. By labeling his experience as culturally normative, Kevin appeared to bypass describing his internal emotional experience. This pattern reflected a broader treatment theme of emotional avoidance, in which he intellectualized and normalized distress rather than experiencing and articulating his underlying feelings.

Recognizing both the cultural and psychological dimensions of this moment, I responded:

> "Even though we share some cultural background, your father's experience and yours are unique. I also wonder if calling it the 'Tiger Parent thing' might make it easier to describe the situation without having to sit with what it felt like emotionally. Could you help me understand what his stoicism specifically looked like in your home and what it felt like for you as a child?"

This intervention intentionally served two purposes. First, it acknowledged cultural similarity while establishing therapeutic boundaries against assumed shared experience. Second, it gently highlighted Kevin's tendency toward emotional distancing by linking cultural labeling with emotional avoidance.

Kevin paused for an extended moment before responding. He began describing concrete childhood memories: sitting silently during family dinners, inter-

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preting his father's lack of praise as evidence that he was never "good enough," and feeling isolated despite high academic achievement. As he described these experiences, he expressed sadness and loneliness that had not previously surfaced in therapy.

This shift illustrates how cultural inquiry can function as a pathway to emotional discovery rather than as an endpoint of explanation. Kevin later reflected that he had long viewed his emotional experiences as "just cultural," which allowed him to minimize and dismiss his distress. By examining how cultural narratives interacted with his psychological coping strategies, particularly emotional suppression and intellectualization, he developed a more differentiated understanding of his experiences.

From a treatment perspective, this moment marked a transition from cognitive description to emotional processing. It allowed us to explore Kevin's core beliefs about worthiness and relational expectations, which subsequently became central treatment targets. This case highlights how clinicians can integrate cultural humility with attention to emotional processes, recognizing that cultural narratives can sometimes function both as meaningful context and as protective mechanisms that limit emotional awareness.

Deliberate Practice: Skills for Acknowledging Limitations

To ensure that ethnic match functions as a gateway to curiosity rather than a shortcut to understanding, clinicians must develop skills that go beyond cultural knowledge and into skillful inquiry. Deliberate practice provides a framework for this development.

In my co-authored book, *Deliberate Practice in Multicultural Therapy*, we emphasize that cultural competence is not an end state but a set of clinical muscles that must be exercised (Harris et al., 2024). Specifically, Exercise 8: Acknowledging Therapist Limitations is designed for the exact scenario described above.

Specifically, clinicians can practice:

1. **Identifying the "urge to assume"** in real time.
2. **Formulating interventions** that honor cultural context while demanding personal specificity.
3. **Cultivating a stance of "not-knowing"** that invites clients to define their experience.

Cultural humility requires both cognitive sensitivity recognition of one's cultural lens and behavioral skills language that explicitly invites elaboration rather than presumption.

Conclusion and Take-Home Message

The effective integration of cultural considerations into psychotherapy hinges less on demographic match and more on clinicians' capacity to maintain curiosity in the face of assumed similarity. Although ethnic or language matching may facilitate initial engagement and retention among Asian American clients, therapeutic depth and meaningful outcomes emerge when clinicians foreground cultural humility and inquiry over assumption. Clinicians who embrace deliberate practice in multicultural therapy are better positioned to engage clients as experiential authorities of their own lives.

In sum, true rapport is not built on what we think we know; it is built on our relentless curiosity to explore what we do not.

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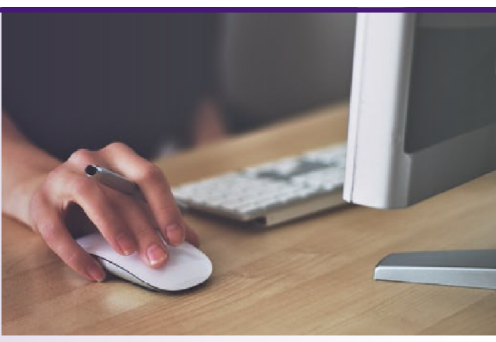

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FEATURE

No Psychologist is an Island: Building Ethical Strength Through Community

John Gavazzi, PsyD, ABPP
Randy Fingerhut, PhD

Clinical Impact Statement: This article argues that ethical practice and professional competence are sustained by community and not on individual effort alone. It advocates for a deliberate shift toward a competence constellation model where psychologists build diverse support networks of peers, mentors, and consultants. This proactive, community-based approach is essential for navigating ethical dilemmas, exploring and understanding clinical blind spots and biases, and managing personal challenges that may affect clinical practice. By fostering collective accountability and shared wisdom, this framework supports practitioner well-being, reduces isolation and moral distress, and enhances the quality and ethical rigor of client care.

Professions exist as shared communities with each profession defined by its specialized tasks and standards to uphold, including ethical codes, shared values, and professional norms. Psychology, like other professions, is grounded in a shared ethical code, specialized expertise, and a commitment to public service. These core elements are dynamic and continuously refined through ongoing professional activities, such as research, consultation, mentorship, continuing education, and peer collaboration. Through these interactions, psychologists develop a collective professional identity and reinforce ethical obligations that extend beyond individual practice. This collaborative foundation helps ensure that psychological practice remains competent, ethically rigorous, and responsive to the needs of both the clients and the greater community.

Ethical Standards as Collective Endeavors

Handelsman and colleagues (2005) created the ethical acculturation model to conceptualize psychologists' ethical development as a dynamic, lifelong process. This model explores how psychologists navigate tensions between their personal ethical views and their professional norms and obligations. If the tension between personal values and professional standards remains, psychologists may experience moral distress, which can lead to emotional, clinical, and practical complications. The process of ethical acculturation helps resolve these disparities through dialogue, mentorship, and collective reflection. Within supportive professional communities, psychologists can critically examine and adjust their ethical perspectives as their development progresses. This process strengthens individual moral reasoning while reinforcing the profession's ethical foundations.

By situating ethical competency within individual experience, cultural context, and ongoing acculturation, the ethical acculturation model helps psychologists mitigate ethical challenges, reduce the

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risk of burnout, and uphold high standards of care (Handelsman et al., 2005). Ultimately, the profession thrives when its communal ethos prioritizes collaboration, diversity, and continuous ethical integration, thereby advancing both ethical excellence and practitioner well-being.

Individual Morality and the Influence of Culture

In the United States, the cultural emphasis on individualism profoundly shapes the understanding and prioritization of moral values. Yet this individualistic focus should not obscure culture's broader role in shaping ethical frameworks. Moral values vary across cultures, particularly along the individualism-collectivism spectrum. Individuals internalize these norms to guide judgments and behaviors, reinforcing group belonging (Bentahila et al., 2021). In practice, balancing an individual's culturally shaped moral identity with the profession's collectively upheld ethical standards is essential. Integrating diverse moral perspectives helps ensure mental health care remains ethically rigorous, culturally competent, and aligned with the profession's commitment to providing high-quality, community-responsive services (Lacerda-Vandenborn et al., 2025).

Shifting to a Positive, Support-Based Framework

Ethics codes place responsibility on individual psychologists to determine their ability to perform work-related activities and take protective action when their personal problems interfere with their practice (American Psychological Association, 2017). While still important, an individual approach to competency has several limitations. First, research shows that people tend to overestimate their competency and underestimate their deficiencies (Kruger & Dunning, 1999). In addition, individuals who are less competent tend to be unaware of their incompetence. For example, Walfish et al. (2012) conducted a study finding that mental health practitioners overestimated their skills relative to their peers and inflated their rates of client progress. Furthermore, individuals who are struggling with personal challenges often lack the time, energy, and insight necessary to access the support they need. Because of these issues, a communitarian approach should be viewed as essential rather than merely beneficial.

Communitarian ethics emphasizes a collective approach to competency (Johnson et al., 2012). It stresses that individuals who are part of ethical communities have a responsibility not only to themselves but to each other. Ethical communities can function as trusted networks of colleagues who provide mutual support, offer honest feedback, and share responsibility for maintaining professional well-being and effectiveness. These networks can help counteract individual biases, normalize vulnerability, and enable early intervention before competence is compromised (Barnett & Homany, 2022). Ultimately, the communitarian approach aligns with a positive ethics framework, which emphasizes aspiring to ethical excellence rather than merely avoiding harm through its emphasis on humility, compassion, and empathy.

The Competence Constellation Model

Johnson and colleagues (2013) recommend developing and strengthening one's professional support network to enhance competency and emotional wellness. They use the term *competence constellation* to visually represent one's professional relationships in terms of intimacy and reciprocity. There are four levels to the competence constellation:

- **The Inner Core.** This represents relationships that provide the most emotional support (e.g. primary mentors, close colleagues, friends, loved ones).

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- **The Collegial Community.** This consists of more distant but caring colleagues (e.g., co-workers, supervisors, consultants).
- **The Collegial Acquaintances.** These are more formal professional relationships characterized by less frequent, surface-level contact (e.g., colleagues seen at professional conferences or continuing education workshops).
- **The Professional Culture.** This is a macro dimension that represents psychologists' values and how they influence their professional development and engagement with their collegial community.

To build an effective competence constellation, psychologists should intentionally cultivate diversity across several dimensions (Johnson et al., 2013). This involves constructing a multi-tiered network that includes peers for collegial support, mentors for career guidance, supervisors for ethical accountability, and consultants for specialized expertise. Furthermore, it is critical to incorporate diversity by including colleagues with varied backgrounds, such as prescribers, attorneys, and social workers in consideration of valuable interdisciplinary perspectives. Actively seeking colleagues with different theoretical orientations helps challenge clinical assumptions and introduce new intervention strategies. Finally, prioritizing colleagues with varied lived experiences, including diverse cultural and socioeconomic backgrounds, is essential for identifying blind spots and mitigating implicit biases. A network characterized by this deliberate diversity creates a robust system for maintaining professional competence and ethical practice.

Assessing and Building Your Competence Constellation

Building an effective competence constellation begins with systematically assessing your current professional relationships across all four levels. Start by identifying the trusted confidants who provide emotional support during professional challenges. Evaluate their availability, understanding of your professional context, and ability to offer both comfort and practical guidance. Next, examine your collegial community of supervisors, consultants, and other peers. Note the frequency and quality of your interactions with these individuals and whether they provide adequate professional guidance and fill knowledge gaps in your practice areas. Next, assess your participation in conferences and organizations to determine whether they are facilitating your continued education and professional development goals. Finally, reflect on your broader engagement with professional culture to determine whether it is consistent with your priorities and values.

Once you have mapped your competence constellation, focus on building diversity across multiple dimensions. Prioritize relationships that span different career stages, professional disciplines, theoretical orientations, and cultural backgrounds. Seek connections with professionals outside of psychology to gain interdisciplinary perspectives. This diversity maximizes the constellation's effectiveness by providing varied perspectives on ethical dilemmas, expanding treatment options, challenging assumptions, and addressing implicit biases. Practical constellation building involves joining professional organizations, establishing regular consultation groups or peer supervision arrangements, and seeking formal mentoring

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relationships. Within organizations, actively participate in committees, special interest groups, listservs, and continuing education opportunities. Technology can help maintain long-distance connections, though in-person interactions may foster deeper relationship building. Remember, sustaining these relationships requires ongoing reciprocity, regular check-ins, and openness to vulnerability in sharing professional challenges.

Conclusion

High-quality psychological practice thrives through community support and not in isolation. By intentionally developing our competence constellations and contributing to our professional communities, we can create a culture where ethical excellence and practitioner well-being flourish together. In fostering these relationships, psychologists uphold the highest standards of care, not alone but together.

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FEATURE

I'll Rest When I'm Dead: A Student's Guide to Self-Care Amidst the Hustle Culture of Graduate School

Sarah Bondy, MA

There have been many times throughout graduate school where self-care did not feel like it was for me or that it was even allowed to be for me. Who really has time as a graduate student to practice self-care, let alone regularly? While I was informed about the importance of self-care as a fundamental practice for managing burnout in graduate school, it also felt like a luxury I could not afford. It seemed like a profound concept that was meant to be forgotten if I wanted to be a competitive trainee and try to graduate on time. However, conversations surrounding self-care continued to present with both clients (where self-care was always encouraged) and fellow trainees (where a lack of self-care was commonplace), emphasizing the imbalance between what trainees are taught about self-care for clients and what trainees are taught about self-care as a professional. Through the available research and in collaborating with other trainees and colleagues, I learned I was far from alone in the struggle to understand my individual self-care needs while mitigating feelings of frustration and a lack of support from the profession to realistically integrate self-care practices throughout graduate training and into the field.

A Snapshot of Graduate Student Stress

The concept of graduate student self-care has been studied and investigated for decades. In a study published almost 20 years ago on the mental health of full-time graduate students, it was shown that 46% of participants endorsed frequently feeling overwhelmed (Hyun et al., 2006). Approximately half the participants considered seeking mental health services with only 31% confirming they received any services while in graduate school. From this data, the authors suggested several policy considerations for graduate schools to provide more adequate support for students, including prioritizing mental health resources, creating programs to foster social support, and examining how institutional goals can place undue burden on students.

Despite the research recommendations from years ago, stress among graduate students continues to be a significant concern. A recent study of clinical psychology trainees examined trainee workload, training culture, burnout, and overall mental health (Hunt et al., 2025). The authors found that participants reported working approximately 50-60 hours a week with most students reporting they still could not get everything done. Additionally, 67% of participants indicated they were severely emotionally exhausted. An important discrepancy was revealed demonstrating that 70% of participants reported their programs' faculty discussed self-care although 83% of participants reported self-care was not a priority in their programs despite these discussions. This study highlights how graduate school remains a stressful environment for students and simply talking about the importance of self-care is not enough.

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Factors of Graduate School Contributing To Stress

High Workload

Hunt et al. (2025) highlight how experiencing stress, burnout, and a lack of self-care in graduate school is not an individual issue and is actually a common experience shared among trainees, with long work hours and a high workload identified as significant contributing factors. Work-life balance has also been shown to be important for graduate students' reported quality of life (Yusuf et al., 2020). Working long hours in any job can be stressful and make it difficult to balance the demands of work-life and home-life; however, there may be specific factors about graduate school that make work-life balance especially challenging. One facet of work-life balance that is unique to graduate students is the nature of the work being comprised of many types of tasks, including classwork, clinical hours (often across various clinical settings), jobs (which may or may not include graduate assistantships), research duties, and professional development. Additional stress presents surrounding the time management of these varied responsibilities and tasks (Yusuf et al., 2020). While the variety of experiences can support the development of well-rounded graduates, it also requires the frequent adjustment to new roles, new supervisors, and new expectations.

Financial Stress

The life component of work-life balance can also bring challenges for graduate students. Yusuf and colleagues (2020) identified a number of stressors outside of academics that graduate students reported as stressful, including work, finances, home-life, and social-life. Finances in particular were identified as the second most common source of stress after work schedule/work obligations (Yusuf et al., 2020). Debt from graduate school loans, lack of additional funds after meeting basic needs, delaying life milestones due to financial stress, and an inability to pay for healthcare were all identified as factors of graduate student financial stress and were shown to be associated with symptoms of anxiety and depression (Szkody et al., 2023). Financial stress can be particularly impactful for graduate students who relocate and move closer to their programs due to the additional costs of moving and potentially lacking a support system when moving to a new area.

Graduate School Culture

Graduate school requires individuals to spend a significant amount of time within the school system, so it makes sense that the social climate of the program is a contributing factor of students' well-being. Research points to the culture of graduate school impacting students through either systems that capitalize on less expensive labor provided by graduate students (Hyun et al., 2006) or by not meeting students' needs in facilitating self-care (Hunt et al., 2025). Alternatively, when participants identified their program as having a positive social climate, they also reported higher overall well-being (Hunt et al., 2025; Yusuf et al., 2020). This suggests that how graduate programs approach work demands and the messages surrounding self-care are significantly important for graduate students' quality of life.

Suggestions for Systemic Change to Graduate Programs

Hunt and colleagues (2025) identified several ways graduate programs can collectively change to better support students:

- Increase financial support for students
- Create a cap on the number of hours graduate students are required to work
- Reduce the number of required courses

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- Create more flexibility within the competency system, allowing students to choose which competencies to spend more time on and potentially specialize in
- Re-evaluate the current competencies, their requirements, and the various routes to meeting those requirements
- Reduce the number of clinical hours required to apply for internship
- Embed time for administrative work into trainees' schedules
- Restructure incentives for research
- Support students' boundaries to better manage their workload

Surviving as an Individual in a Flawed System

Looking at graduate school as an imperfect system that can be changed and improved upon is essential for making a lasting impact on future students. The research by Hunt and colleagues (2025) is a great reminder that change is possible and something we can actively strive toward. The issue I have faced as a trainee is balancing hope for the future with the reality of needing to survive within a flawed system. The following guidelines have been helpful for me as I work to provide better care for myself as a graduate student and trainee. My hope is that it will resonate with other trainees as they too work to provide self-care.

Guideline 1: Self-care isn't a class to pass. As a student and resident perfectionist, my first inclination when facing burnout was to give myself homework. I figured if I could learn all about self-care and ways to avoid burnout then I would not experience it. I read about what burnout is, how burnout relates to stress, and ways to manage it. If self-care was a test, I wanted to ace it. It was incredibly exhausting. What I did not do was rest and I certainly did not practice self-care.

What has been helpful for me is leaning into self-compassion, listening to my body, and maintaining my boundaries (including the boundaries I created for myself). It has been important to let go of the idea of perfection when it comes to self-care practices by consistently prioritizing showing up for myself each day in the best way I can. Thinking about my values and how they diverge from the hustle culture of graduate school has also helped me say, "No" to opportunities or activities that would push me over my maximum capacity.

Guideline 2: The frozen pizza is fine. Holding firm boundaries with myself regarding the *life* portion of *work-life balance* has also been important. I have seen this show up for me surrounding cooking and eating, feeling pressure to consistently make homemade, nutritious meals for myself and my partner nightly. This pressure has likely come from multiple sources, including finances, gender roles, and the genuine desire to support my health. The goal to cook more at home is not bad in and of itself, but the pressure I placed on myself to do it in a specific and rigid way created unnecessary stress, especially in light of all the other responsibilities I had to maintain.

Giving myself permission to take shortcuts was tremendously helpful. When I had the means, this looked like meal service kits that came with all the ingredients, pre-cut and pre-portioned. At other times, this looked like making a double batch of meals, one to eat now and one to freeze for later. Finally (and perhaps most importantly), this looked like giving myself permission to not *always* cook a homemade meal. I learned to appreciate the stack of frozen pizzas in my freezer that frequently served as a last-minute lifesaver by providing much needed nourishment and reduced stress

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from relinquishing the self-imposed pressure to maintain high standards despite their unrealistic attainability.

Guideline 3: Finding life outside the microscope. For me, graduate school often felt like living under a microscope. There seemed to be constant observation, evaluation, and comparison to other trainees who were trapped battling the same obstacles. Ruminating thoughts regarding how my client workload and clinical performance compared to other trainees seemed inescapable, especially since a significant amount of time is spent alongside classmates and colleagues who are experiencing relatable and high levels of overwhelm. Seeking support from other student trainees in this process has the potential to create environments filled with comparisons and distinctions instead of fostering a space with reliable validation, normalization, and a consistent presence.

Seth and De Cantis (2022) adequately captured my experience in their description of *busy bragging*; "Unfortunately in graduate school, the notion of hard work can quickly transform into a kind of 'busy bragging' —an urgency to constantly share your overwhelming schedule" (p. 450). The authors reflect that sharing these details with others is not always a bad thing, however, I quickly learned a consequence of the *busy brag* (at least for me) was the normalization of an overwhelming workload and the consistent pressure to keep up no matter what the cost.

A significant factor that allowed me to expand my world outside of the microscope was unlearning the imposed value placed on grades as well as reconnecting with parts of my life that did not involve school work or clinical training. As well-trained and proficient students, grades for high achieving graduate students are often viewed and treated as the bottom line. And while this mindset can be beneficial throughout earlier school years to motivate and engage students, maintaining high academic standards within a comparative and evaluative environment can create undue stress that may feel unfamiliar and even more uncomfortable. Shifting my mindset to focus on comprehending content and applying skills was pivotal for me to de-emphasize the significance and influence of grades on my clinical skillset and abilities. Additionally, reconnecting with important hobbies and aspects of my other identities outside of student/trainee was significantly beneficial and a crucial part to my developing self-care practices. While part of me reasoned that I could take on additional professional responsibilities, prioritizing other interests and hobbies was important to be able to view myself as something other than (and much more than) a productivity machine.

Guideline 4: Burnout is not a bad word. For a long time, I felt ashamed to admit I was burnt out; it felt like a personal failure. Not only did avoiding the word *burnout* not change (let alone improve) my situation, it also made me feel more alone and more ashamed. Being honest with myself was the first step to engaging in meaningful self-care. Once I was able to admit I was experiencing burnout, I felt more empowered to ask for support and I noticed my ability to manage stressors began to improve.

Conclusion

Throughout my training as a graduate student, I have learned that self-care is a requirement that cannot be ignored, especially as a trainee navigating a flawed system that prioritizes productivity and profit over personal well-being and longevity. My ability to engage in self-

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care is a work-in-progress and that is something I have learned to accept without complacency. I've also learned that work-related burnout (including for trainees and students) is not only okay, but necessary to talk about in order to change a system that creates, nurtures, and perpetuates it. And finally, I've come to accept that the old adage, "I'll rest when I'm dead," simply will not do.

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FEATURE

Navigating Dementia Care: Balancing Cognitive Decline, Emotional Well-Being, and Caregiver Resilience in Later Life

Ayesha Riaz, MS
Mohammad Saifullah Qureshi, PhD

Clinical Impact Statement

This case explores the lived realities of dementia care within a South Asian cultural context, emphasizing how cognitive decline intersects with emotional vulnerability, caregiver strain, and family systems. Despite the progressive and irreversible nature of dementia, structured psychosocial interventions—including reality orientation, reminiscence therapy, and caregiver psychoeducation—can preserve functional abilities and enhance quality of life. This case underscores the pivotal role of caregiver resilience and the need to strike a balance between patient dignity and the practical demands of caregiving (Livingston et al., 2017; Prince et al., 2016).

Dementia as a Global Challenge

Dementia represents one of the most pressing public health challenges of the 21st century. Globally, an estimated 55 million people are living with dementia, a number expected to double every 20 years as populations age (World Health Organization, 2021). Dementia is a disorder characterized by progressive neurocognitive decline affecting memory, orientation, judgment, and daily functioning, and is often accompanied by behavioral and psychological disturbances (Livingston et al., 2017). Unlike many psychiatric conditions, dementia entails a trajectory of irreversible loss, requiring long-term adaptation by patients and their families (Prince et al., 2016).

Dementia in South Asia and Pakistan

While dementia is often framed as a *disease of aging* in high-income countries, its impact in South Asia, including Pakistan, is compounded by demographic, cultural, and healthcare challenges. In Pakistan, awareness of this condition remains limited, with diagnostic facilities remaining scarce and social stigma pervasive (Shah et al., 2018). The burden of care is overwhelmingly borne by families (often within joint households) where caregiving is viewed as a moral and religious responsibility. Such cultural strengths coexist with challenges, as caregiver fatigue, limited professional support, and financial strain increase vulnerability to burnout (Adelman et al., 2014).

Case-Based Approach

Case illustrations provide a powerful lens through which to understand the lived realities of those living with dementia, allowing for the integration of clinical detail, psychosocial context, and therapeutic reflection (Launer, 2020). This article presents the case of a 64-year-old Pakistani woman called Farida who has a dementia diagnosis, situating her clinical presentation within broader cultural and theoretical frameworks. Through her story we explore the complexities of balancing cognitive decline, emotional well-being, and familial adaptation in the face of progressive loss. Farida's journey illustrates how dementia not only reshapes an individual's sense of self but it also transforms the emotional fabric of the

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family system. Her case underscores the profound human need for connection, meaning, and dignity—even as memory fades and roles evolve (Erikson, 1982).

Background and Demographics

Farida is a 64-year-old widow and homemaker residing in Rawalpindi, Pakistan. She was born and raised in a traditional family system and married in her early 20s. Throughout her life, she identified strongly with her role as a homemaker, caregiver, and later on as a grandmother. Her late husband, a retired civil servant, had provided financial stability, and together they raised three children. Following his passing, Farida continued to live in a joint family system with her children and grandchildren.

Presenting Concerns

Over the past two years, Farida's family noticed gradual changes in her memory, behavior, and daily functioning. She began forgetting the names of close relatives, misplacing common household items, and repeating questions within short timeframes. Initially dismissed as normal aging, her symptoms began to progress. Farida increasingly relied on others for daily reminders, displayed emotional lability, and developed repetitive behaviors, such as repeatedly checking locks on doors.

As the undiagnosed illness progressed, her personality appeared to shift. She became suspicious of family members, occasionally accusing them of hiding her belongings. She also demonstrated periods of withdrawal, alternating between moments of irritability and agitation. These behavioral changes created tension within the household and increased her caregivers' stress.

Clinical Assessment

Farida underwent a comprehensive neuropsychological and behavioral assessment to evaluate the extent of her cognitive decline and the associated functional implications. The responses on the Mini-Mental State Examination (MMSE; Folstein et al., 1975) produced a score of 18 out of 30, indicating moderate cognitive impairment. She showed deficits in orientation (i.e., frequently misstating the date and current location), short-term recall, and attention span. These findings were consistent with the family's reporting of Farida's repetitive questioning, more frequent disorientation in familiar environments, and difficulty following conversations.

The Clock Drawing Test (CDT) provided additional diagnostic insights. Farida was asked to draw a clock face with an hour and minute hand displayed to show a specific time, which she was not able to complete with accuracy. She placed all the numbers clustered on one side of the clockface and subsequently mispositioned the clock hands, failing to represent the requested time. These errors suggested impairments in executive functioning, visual-spatial processing, and conceptual understanding of time, which are cognitive domains commonly impacted and compromised in dementia patients. The CDT results alongside her MMSE profile confirmed the diagnosis of moderate-stage dementia with significant cortical involvement (Folstein et al., 1975; Shulman, 2000).

Projective testing utilizing the House-Tree-Person (HTP) Drawing Test highlighted the presence of emotional and identity-related disturbances for Farida. Her drawings were incomplete, distorted, and lacked detail, often reflecting themes of helplessness, insecurity, and cognitive disorganization. The fragmented nature of her drawings suggested a reduced capacity to implement problem-solving strategies and a diminished coherence of self-concept, which are both characteristic of progressive dementia (Launer, 2018).

Family and Caregiver Context

Following her husband's death, the care-

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giving of Farida shifted primarily to her eldest daughter, who received support from her siblings and extended family. While the joint family system provided a protective social structure, the burden of Farida's daily car—involving supervision, managing behaviors, and providing reassurance—began to weigh heavily on her caregivers. Feelings of frustration, guilt, and helplessness were reported, mirroring global caregiver experiences across cultures and contexts (Adelman et al., 2014; Prince et al., 2016). The family initially sought medical advice from a general practitioner and then a neurologist, who confirmed a dementia diagnosis. Pharmacological treatment was started and subsequently at the family's request due to their preference for preventive, non-pharmacological interventions aimed at improving daily functioning and emotional stability.

Application and Analysis

Dementia and the Erosion of Identity

Farida's case illustrates central features of dementia, which are the gradual erosion of memory and, subsequently, selfhood. According to Erikson's (1982) theory of psychosocial development, older adulthood is characterized by the psychosocial conflict of integrity versus despair. This stage involves a reflective evaluation of one's life, where individuals strive to achieve ego integrity by accepting their life experiences as meaningful and coherent. Successful resolution is marked by a sense of fulfillment, wisdom, and acceptance of aging and mortality. In contrast, failure to achieve integrity may result in despair, characterized by regret, dissatisfaction, fear of death, and feelings that life opportunities were missed. In Farida's case, her emotional struggles and reflective concerns suggest challenges in navigating this stage, as she appears to grapple with unresolved life experiences and a diminished sense of purpose. For individuals living with dementia, this developmental challenge is magnified as memory loss and disorientation undermine the capacity for life review and meaning-making. Farida's repetitive questioning and disorganized projective drawings reflected not only neurocognitive decline but also a struggle to sustain identity in the face of fragmentation.

Behavioral Symptoms as Adaptive Responses

Farida's suspiciousness and repetitive checking behaviors can be understood through a compensatory lens as an attempt to impose control and predictability amid cognitive disarray. Such behaviors, which are often distressing to caregivers, may represent adaptive responses to the anxiety produced by disorientation (Livingston et al., 2017). Recognizing these patterns can reframe them from problems to be eliminated into signals providing useful data and requiring empathetic support to manage.

Caregiver Burden

Caregiver burden and caregiver strain are multidimensional constructs that encompass emotional distress, physical exhaustion, and financial hardship (Adelman et al., 2014). In collectivist cultures like Pakistan, caregiving is often seen as an inherent duty that is continually reinforced through shared cultural and religious values. While this can and does foster resilience, it can also inhibit caregivers from seeking external support and recognizing signs of burnout (Shah et al., 2018). Farida's daughter shared that caregiving for her has been both an honor and a burden, capturing the inevitable duality of the caregiving experience.

Theoretical Integration

From a biopsychosocial perspective, Farida's case encompasses the intersection of biological decline (neurodegeneration), psychological consequences (anxiety, identity confusion), and sociocultural factors (family dynamics, cultural expectations). The family's adjustment aligns with the Double ABCX model (McCubbin &

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Patterson, 1983), whereby dementia-related stressors are moderated by family resources and coping processes over time.

Therapeutic Process

Farida's therapeutic journey consisted of eight structured sessions conducted over a period of three months, supplemented by regular caregiver meetings to ensure continuity of care and the consistent implementation of interventions. The overarching goal of the treatment plan was to address the cognitive and emotional challenges associated with dementia while simultaneously strengthening the family's understanding of the diagnosis, coping strategies, and caregiving effectiveness (Launer, 2018; Livingston et al., 2017). Each component of the intervention was designed to preserve Farida's remaining cognitive abilities, enhance her sense of self and social connections, and reduce distress for both her and her caregivers.

The therapeutic approach integrated multiple evidence-based approaches, allowing for a holistic and person-centered framework (Prince et al., 2016). Cognitive strategies were aimed at stimulating mental activity, maintaining orientation, and slowing the rate of decline. Emotion- and behavior-focused strategies were implemented to support Farida's psychological well-being and daily functioning. Equally important, caregiver involvement was emphasized throughout, ensuring therapeutic principles extended beyond the session setting into the home environment.

This integrative approach recognized that dementia care is not solely about managing symptoms but also about fostering dignity, familiarity, and emotional security in the face of progressive change (Erikson, 1982). Through structured sessions, consistent reinforcement, and collaboration with family members, the therapeutic process sought to create a supportive environment that maintained Farida's engagement, reduced confusion and agitation, and empowered her caregivers with practical skills and emotional resilience. To implement a holistic plan, each intervention was carefully selected to target specific cognitive, emotional, and behavioral needs while actively involving caregivers in the process. The table (see page 39) summarizes the therapeutic approaches used, highlighting their goals, structured activities, and observed outcomes across the course of treatment.

Treatment Outcomes

By the final session, Farida exhibited noticeable stabilization in her cognitive functioning and a significant reduction in agitation. She demonstrated increased engagement with and enjoyment of reminiscence-based activities, often singing familiar and nostalgic songs and recalling family stories with visible emotional warmth. Although her memory deficits remained, Farida's overall demeanor was calmer and she displayed a greater sense of comfort and connection in her home environment. The therapeutic interventions seemed to foster cognitive engagement, emotional security, and relational harmony with family members noting improved communication and emotion regulation skills, creating a more peaceful and manageable home environment for both Farida and her caregivers/family. Her caregivers reported more confidence in their caregiving abilities, which decreased overall stress and increased their appreciation for the interventions and strategies that support the well-being of both Farida and her dedicated caregivers and family members.

Future Directions for Dementia

The prognosis for dementia remains guarded and with gradual decline expected. However, this case underscores several future directions.

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Therapeutic Approach	Goals	Intervention Description	Outcomes / Observations
Reality Orientation Therapy (ROT)	Enhance temporal and spatial orientation; reduce confusion.	Calendars, clocks, and labeled household items were introduced throughout the home. Sessions included guided recall of time, place, and familiar people, emphasizing repetition and routine.	Improved awareness of time and surroundings; reduced disorientation and anxiety; increased comfort through environmental familiarity.
Cognitive Stimulation Therapy (CST)	Maintain cognitive engagement; stimulate memory and attention.	Structured activities such as matching games, word recall, and problem-solving tasks were tailored to her abilities, promoting mental activation.	Variable performance with noticeable enjoyment and engagement; occasional moments of accurate recall and improved mood.
Reminiscence Therapy	Strengthen long-term memory and identity; foster emotional connection.	Use of family photo albums, traditional songs, and familiar scents to evoke autobiographical memories and meaningful discussions.	Increased emotional expression and recognition of family members; reduced agitation; improved sense of self and dignity.
Behavioral Management Strategies	Manage agitation and repetitive questioning; promote calm communication.	Caregivers were trained in reassurance, redirection, and non-confrontational responses. Distraction techniques used during restlessness.	Reduced frequency of agitation; improved emotional climate at home; enhanced caregiver confidence.
Family Psychoeducation	Improve caregiver understanding, coping, and self-care.	Provided education on dementia progression, communication techniques, and importance of routines. Emphasized emotional support and normalization of challenges.	Decreased caregiver guilt; improved coping and collaboration; greater acceptance and emotional resilience within the family.
Sensory Stimulation Therapy (SST)	Enhance sensory engagement, reduce agitation, and promote relaxation.	Sessions incorporated tactile materials (soft fabrics), soothing music, aromatherapy with familiar scents, and gentle hand massages to stimulate multiple senses.	Increased relaxation and alertness during sessions; reduced restlessness and anxiety; moments of calmness and connection observed.

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- **Prognosis and care planning.** Dementia carries a guarded prognosis with gradual decline; early medical, legal, and financial planning is recommended to prepare families for progressive needs.
- **Sustaining cognitive engagement.** Ongoing cognitive stimulation therapy (CST) and reminiscence activities can help maintain functional abilities and provide emotional enrichment.
- **Caregiver support and resilience.** Continuous psychoeducation, access to support groups, and community-based programs—including religious organizations in Pakistan—can reduce caregiver burnout and strengthen coping.
- **Cultural sensitivity.** Interventions should respect cultural expectations, balancing societal values of filial duty with caregiver well-being.
- **Policy implications.** There is a need for dementia-friendly healthcare services in Pakistan, including primary care provider training and community awareness campaigns.

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WASHINGTON SCENE

"On The Road Again.... Seein' Things That I May Never See Again"

Pat DeLeon, PhD

Why Not Join APA President Wendi Williams? Katherine McGuire, Chief APA Advocacy Officer spent nearly twenty-five years on Capitol Hill, retiring after having served as Staff Director for the U.S. Senate Health, Education and Pensions (HELP) Committee. Appreciating the importance of psychology's personal involvement in the political/public policy process, she has regularly been providing special opportunities for our colleagues to become actively engaged. Under her leadership, the APA Psychology PAC recently convened a virtual conversation with Representative Andrea Salinas (D-OR), bringing together APA leadership and PAC members to discuss federal mental health, substance use, and workforce priorities. First elected to Congress in 2022, Rep. Salinas is the first Latina to represent Oregon and currently serves as Co-Chair of the Congressional Mental Health Caucus.

During the program, APA CEO Arthur Evans led a fireside chat with Rep. Salinas where she discussed ongoing legislative efforts related to mental and behavioral health care and the importance of strengthening a diverse and sustainable mental health workforce. Her background in the Oregon state legislature—including leadership roles and service on health care and behavioral health committees—has informed her work in Congress, where she continues to engage with stakeholders on policies affecting access to care and workforce development.

The personalized examples which Rep. Salinas provided of working "across the aisle" for the betterment of our nation—for example, to block the Administration's initially proposed draconian reductions to SAMHSA—were inspirational. She also made it very clear that stories highlighting one's own family issues with mental health and/or substance use experiences definitely *do* make a lasting impression on potential advocates and local, state, and national policy makers. As Katherine emphasized at this year's Practice and SPTA Leaders Conference: "Advocacy is the bridge between psychology and policymakers. It translates lived experiences into policy-relevant terms, brings evidence to decisionmakers, and ensures policies reflect clinical reality instead of assumptions. Without that bridge as the core infrastructure, policy still gets made—just without the benefit of what psychology knows and without the knowledge of what practitioners need."

A Community of Genuine Interest: Steve Behnke—"One of the most rewarding aspects of directing the APA Ethics Office was the opportunity to offer workshops for our associations. Ethics workshops are a primary way for APA to support the important work that happens on the local level. Associations from Guam to British Columbia to the Virgin Islands advance psychology in myriad ways. Invitations to speak were always an honor, and I was especially pleased to help the associations generate funds to further their work. Perhaps the most enjoyable part of the experience was the opportunity to share a meal with

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association leaders, members, and students, where I was able to hear about current issues and challenges. Ethics education and consultations are terrific resources for all APA-affiliated psychologists."

"Like a band o' gypsies, we go down the highway": Earlier this year, "21 State Attorneys General wrote a letter to National Academy of Sciences (NAS) President Marcia McNutt and President-Elect Neil Shubin in which they stated that the NAS should remove from its website the chapter on climate science in the 4th edition of the Reference Manual on Scientific Evidence. The chapter was prepared for, and in collaboration with, the Federal Judicial Center. Responding to pressure from these 21 AGs, the Federal Judicial Center removed the chapter. The AGs accused the NAS of a long history of political bias. They demanded a response and asked, among other things: 'Why did the National Academies include a chapter on climate science that is not based on balanced or sound science?'

"The consensus that human activities are responsible for the rapid and damaging change in the climate is overwhelming. This consensus on global warming is so ubiquitous that finding advocates for 'the other side' is virtually impossible—any conflicts of interest by the authors of the chapter on climate science are not relevant to the main point. Numerous previous reports came to the very same conclusions as the chapter in the reference manual. The NAS publishes settled science, which scientists are in the best position to defend and explain. It is important to note that the DOE report attempting to rebut this settled science on the causes of global warming was based on demonstrably false data and analysis.

"Accordingly, NAS President McNutt informed the 21 AGs that the chapter would not be removed from its website. The American Meteorology Society and associated societies issued a powerful statement urging that the climate science chapter be restored in the Manual with cogent reasons why this should be done. Several eminent legal scholars co-authored an article explaining why the deletion of this chapter will make it harder for judges to wade through the scientific complexities they face in the courtroom.

"I am neither a climate scientist nor a legal scholar but as a scientist I can state unequivocally that the climate chapter of the Reference Manual is, in fact, in accord with, and based upon, a vast amount of research by a large number of qualified climate scientists, as is thoroughly documented in the chapter…. Whatever one's preferences, public policy decisions should be based on facts, not preferred outcomes, and every policy decision should be informed by a sober analysis of cost/benefit trade-offs.

"Following receipt of President McNutt's letter to the 21 AGs informing them that the chapter on climate sciences would remain on the NAS website…. the 21 AGs, joined by three others State AGs, wrote the Secretaries of Transportation, War and Energy and stated that 'Federal agencies should investigate whether NASEM should be suspended or disbarred from federal funds.'

"Defunding NASEM would be an enormous blow to the state of scientific research in the United States. President Abraham Lincoln signed into law the Congressional authorization that formed the NAS in 1863 'to provide independent, objective advice to the U.S. government and other organizations on science, technology, and health policy."

Forging Ahead into the Unknown: It is very pleasant to reflect with longtime colleagues possessing vision on the difference they have been able to make for

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the profession and for those benefiting from psychologists and other behavioral healthcare providers. Slightly over a decade ago (2013), Tim Elliott of Texas A&M University shared with us his efforts to partner with public health in order to provide psychological services to rural clinics. That spring he obtained 1115 Medicaid Waiver funds to expand their efforts to three additional counties. "Right now we are in Leon County and Madison County. This fall we should initiate services in Washington County (in Brenham, home of Blue Bell ice cream). Next fall we should open up in Grimes and Burleson counties. All with doctoral students as the 'service providers' and they get practicum hours they need in the process."

Fast forward to this past December 29th. "Oh, it's grown tremendously from those days. In 2013 I hired my protégé, Carly McCord as a post-doc and in the ensuing years she took over the leadership of the small clinic that expanded to 4 then 6 counties and developed a center that attracted more state funds. In time, other colleges on campus got involved. More counties, jails, public school districts. She took it to the next level. And to cut to the chase, Carly is now the Director of the Texas A&M Telehealth Institute. It is officially recognized by our Board of Regents, and its mission serves the A&M system (not just the College Station campus). Above and beyond anything I ever envisioned.

"I retired in August, 2024. I cannot tell you how proud I am of Carly and the work she's done. Now she has a psychology internship in place. Her staff is tremendous. A special moment occurred for me in October when my wife and I stayed in Fort Davis State Park in far west Texas, in the Big Bend area. There in Fort Davis—the town with the highest elevation in the state—is a 'container' primary care clinic. And our A&M Institute staff provides the mental health services to that clinic, which is approximately 520 miles away from College Station. [https://telehealth.tamu.edu/index.html].

"*Further Reflections*: Tim — Quantitively, 10,000+ people served to date (force multiplier is the families and communities they belong to); 70,000+ hours of therapy delivered via telehealth; $10M+ value of services provided at no cost to the patient; 35+ peer reviewed publications; 100+ peer reviewed presentations; 10+ dissertations from the clinic; and 200+ psychology doctoral students from clinical, counseling and school psychology, and mental health related fields (force multipliers for rural, underserved, and telehealth) have earned practicum hours. The Telehealth Institute now provides training for students from nursing, medicine, nutrition, and pharmacy.

"Carly—Qualitatively: We needed Public Health + Psychology. One discipline without the other would have stalled progress for both fields. It's the public health mindset that drives psychology to be scalable. This work didn't start as a clinic, it started as a relationship between us, public health and community members. At the outset and even today many people like county judges and school counselors were just as central as faculty. Trust came first. Scale came later. And scale wasn't possible without trust and community partnership. Training shapes careers long after graduation and grants ending.

"Psychology doesn't have a relevance problem: we still have deployment problems (sustainability, limited financial structures, usability, digital literacy and user experience of telehealth platforms in general—broadband access… people want it in their hands. We've done a pretty good job as a nation on making hub and

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spoke models of delivery feasible in terms of broadband, but direct to consumer is still challenging and this plus the essential ingredient of community is why we shouldn't abandon the hub and spoke and academic community partnership model just to set up links to sign up for services like the consumer market. This is still super needed for rural, low-resourced people and THEY are the backbone of America. I don't think we innovated for innovations sake then or now. But in research and academics and funding, innovation is measured and weighted. We innovated in service of access and workforce development/training the next generation."

What makes this rural health story particularly satisfying is appreciating the extent to which during that time insurance companies (including Medicare and Medicaid), policy makers, and the behavioral healthcare professions were quite hesitant to fully embrace the virtual (i.e., telehealth) provision of mental health and substance use care. As always, the rhetorical questions: How do we know the quality of care is equivalent? What percentage of trainee supervision time would be appropriate to be conducted virtually? And not surprisingly, At what rate should virtual psychotherapy be reimbursed? We would only ask: Did we learn anything from our very positive COVID experiences with virtual communications? And as always, Shouldn't the patient be empowered to make the ultimate decisions regarding his/her health care? Tim and Carly waded into *unchartered waters*, embracing interprofessional collaboration as visionaries typically do. As Tim reflects: "Hire good people with the right skills and intangibles, give 'em what they need and stay out of their way." "The life I love is makin' music with my friends" (Willie Nelson, *On the Road Again*). Aloha,

Pat DeLeon, former APA President – Division 29 – April, 2026

SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY 2026 APA Convention Program

Thursday August 6th

Personalizing Psychotherapy to Therapists' Effectiveness Differences Chair: James Boswell Speakers: Michael Constantino, Averi Gaines, Alice Coyne ***CE session***	10:00 AM – 11:00 AM Room: Walter E. Washington Convention Center, Level Two: 204C	Symposium
Division 29 Poster Session I	11:30 AM – 12:30 PM Room: Walter E. Washington Convention Center, Level Two: Hall D, Solutions Center, Posters	Poster
ACT for Infertility and Reproductive Grief: Psychotherapy in Practice Chair: Clayton Brigance ***CE session***	1:00 PM – 2:00 PM Room: Walter E. Washington Convention Center, Level Two: 204C	Skill Building
Division 29 Editorial Board Lunch	1:00 PM – 2:00 PM Room: Marriott Marquis Washington, DC, Level Four: Capitol	INVITATION ONLY
Routine Measurement of Cultural Comfort as a Correlate of Process and Outcome Chair: Theodore Bartholomew Speakers: Brandon Hoang; Shreeya Kulkarni ***CE session***	2:30 PM – 3:30 PM Room: Walter E. Washington Convention Center, Level Two: 204C	Symposium
Working With Trainee Anxiety: Skills for Relationally Attuned Supervision Chair: Aileen Terrazas Speakers: Jason Hindman, Pamela Aguilar, Israel Arevalo, Apurva Tandon	4:00 PM – 5:00 PM Room: Walter E. Washington Convention Center, Street Level: 144A	Skill Building

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Friday August 7th		
Trauma-Informed Clinical Approaches to Borderline Personality Disorder Chair: Minzhou Sun	8:30 AM – 9:30 AM Room: Walter E. Washington Convention Center, Street Level: 146B	Skill Building
Harnessing Technology to Advance Therapist Well-Being and Effectiveness Chair: Matteo Bugatti Speakers: Colby Schramel, Miles Evanisko Discussant: Jesse Owen	11:30 AM – 12:30 PM Room: Walter E. Washington Convention Center, Street Level: 146B	Symposium
Mutually Beneficial International Collaboration: Learning from a Decade of Partnership Chair and President: Joshua Swift Speakers: Rodney Goodyear, Guangrong Jiang	2:30 PM – 3:30 PM Room: Walter E. Washington Convention Center, Level Two: 209C	Division Presidential Address
Strengths and Flourishing in Psychotherapy: Emerging Directions Chair: Steven Sandage Speakers: Catherine Eubanks, Michael Constantino, Jesse Owen ***CE session***	4:00 PM 5:00 PM Room: Walter E. Washington Convention Center, Level Two: 202A	Symposium
Division 29 Social Hour	5:30 PM - 7:30 PM Room: Marriott Marquis Washington, DC, Level Two: Salon 14	Social Hour

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2026 APA Convention Program, continued

Saturday, August 8th		
Steps to stepped care: Theory, implementation, and research considerations Chair: Caroline Lucy Speakers: Zoe Lapham; Alexandros Maragakis ***CE session***	10:30 AM – 11:30 AM Room: Walter E. Washington Convention Center, Level Two: 204C	Symposium
Losing a Real Relationship: Celebrating the Life and Work of Charlie Gelso Chair: Rayna Markin Speakers: Jairo Fuertes, Dennis Kivlighan, Elizabeth Nutt-Williams, Andres Perez-Rojas, Cheri Marmarosh, Jesse Owen Discussant: Clara Hill	12:00 PM – 1:00 PM Room: Walter E. Washington C onvention Center, Street Level: 151B	Symposium
Division 29 Poster Session II	3:00 PM – 4:00 PM Room: Walter E. Washington Convention Center, Level Two: Hall D, Solutions Center, Posters	Poster
Division 29 Virtual Poster Session	10:00 PM – 11:00 PM Room: Virtual Poster Hall: Virtual Posters	Virtual Poster Session

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PSYCHOTHERAPY BULLETIN

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

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

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