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In This Issue

Membership Domain

*Psychology at a Crossroads: The Role of Town Halls in
Building Bridges*

*Bridging the Gap: Integrating Specialized Experience into
Emerging Clinician Identity*

International Domain

*Advancing Precision Mental Health Across Cultures:
A Multimodal Ecological Momentary Assessment Study*

Professional Practice

*Practice Committee Office Hours Update:
Do You Have to Sacrifice Your Values to Maintain
Financial Stability in Private Practice?*

Features

*Suicidal Behavior Among Psychologists: Prevalence,
Drivers, and Recommended Action Steps*

*When Distress Is Collective: Implications for Clinical
Training and Supervision*

Washington Scene

*See page 127 for the Society for
the Advancement of Psychotherapy
2027 Nomination Ballot*



2026 Volume 61, Number 3

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

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Department of Education and Counseling
302 Saint Augustine Center
800 E Lancaster Ave
Villanova University
Villanova, PA 19085
rayna.markin@villanova.edu

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1493 Cambridge St.
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646-592-4517
kenneth.critchfield@yu.edu

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

DIRECTORS

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

Psychotherapy Practice
Amy Ellis, PhD, 2025-2027
Nova Southeastern University
College of Psychology
3301 College Avenue
Fort Lauderdale, FL 33317
516-459-3137
amyellisphd@gmail.com

Education and Training
Erica Marshall-Lee, PhD, 2025-2027
2005 Audubon Dr NE
Atlanta, Georgia 30329
edlee@EMORY.EDU

Membership
Jairo Fuentès, PhD, 2025-2027
Adelphi University
Gordon F. Derner School of Psychology
Hy Weinberg Center,
158 Cambridge Avenue
Garden City NY 11530
jfuertes@ADELPHI.EDU

Early Career
Yujia Lei, PhD, 2026-2028
Center for Counseling & Psychological
Services
Washington University in St Louis
One Brookings Drive, MSC 1201-323-100
St. Louis, MO 63130-4899
Office: 314-935-5955
leiyujia@wustl.edu

Science and Scholarship
Jamie Bedics, PhD, 2026-2028

Diversity
Wonjin Sim, PhD, 2026-2028
Department of Psychology
Towson University
8000 York Road
Towson, MD 21252
410-704-4307
wsim0930@gmail.com

Diversity
Changming Duan, PhD, 2025-2027
Dept. of Psychology and Research
in Education
University of Kansas
Lawrence, KS 66054
785-864-2426
duanc@ku.edu

International Affairs
Xu Li, PhD, 2024-2026
University of Illinois, Urbana-Champaign
226C Education Building
1310 S. 6th Street
Champaign, IL 61820
lixu6@illinois.edu; lixu.bnu@gmail.com

APA Council Representative
Elizabeth Nutt Williams, PhD, 2026-2028
enwilliams@smcm.edu

Jeffrey Younggren, PhD 2026-2028
jyounggren@salud.unm.edu

Student Representative
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nh10556@georgiasouthern.edu



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

6557 E. Riverdale
Mesa, AZ 85215
602-363-9211
e-mail: assnmgmt1@cox.net

EDITOR

Zoe Ross-Nash, PsyD
editor@societyforpsychotherapy.org

CONTRIBUTING EDITORS

Diversity

Susan Woodhouse, PhD and
Changming Duan, PhD

Education and Training

Erica Marshall-Lee, PhD and
Melissa Goates Jones, PhD

Ethics in Psychotherapy

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Linda Campbell, PhD

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Patrick DeLeon, PhD

Early Career

Yujia Lei, PhD and
Peter Franz, PhD

Student Feature

K'hiari Hailey

Editorial Assistants

Sarah Bondy and
Deanna Young

STAFF

Central Office

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

Website

www.societyforpsychotherapy.org

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2026 Volume 61, Number 3

TABLE OF CONTENTS

Leadership

SAP Summer Presidential Column 3

Electronic Communication Editor's Column 7

Membership Domain

*Psychology at a Crossroads: The Role of Town Halls in
Building Bridges*.....8

*Bridging the Gap: Integrating Specialized Experience
into Emerging Clinician Identity*.....17

International Domain

*Advancing Precision Mental Health Across Cultures:
A Multimodal Ecological Momentary Assessment
Study* 23

Professional Practice Domain

*Practice Committee Office Hours Update: Do You
Have to Sacrifice Your Values to Maintain Financial
Stability in Private Practice?* 29

Feature

*Suicidal Behavior Among Psychologists:
Prevalence, Drivers, and Recommended Action Steps* 37

Feature

*When Distress Is Collective: Implications for Clinical
Training and Supervision*.....42

Washington Scene

*"We're Gonna Sit And Grin And Tell Our
Grandchildren 'Bout The Time I Called This Guy.
It Was Four In The Morning"* 50

Features

*Beyond Symptom Management: Existential/
Humanistic Treatment for Combat Veterans* 54

*Psychosocial Stage Theory as a Model for Treating
Homeless Veterans* 58

*The Double Identity Crisis in Transgender
Adolescent Development* 65

continued on page 2

BULLETIN

Table of Contents, continued

<i>Childhood Adversity and Suicide</i>	71
<i>Considerations for Adolescent Mothers: Trauma-Informed and Integrated Care</i>	76
<i>Social Nutrition or Social Malnutrition: Addressing Loneliness in Ourselves and Others</i>	82
<i>Partner-Involved Approaches to Insomnia and Sleep Apnea: Integrating Sleep Science into Psychotherapy with Individuals and Couples</i>	87
<i>A Fat Positive Framework for Beginning Body Image Work with Plus Size Clients</i>	93
<i>Why the Health of Americans Will Decline and What Psychotherapists Should Do About It</i>	98
<i>From Misconception to Meaning: A Trauma-Informed Understanding of BDSM</i>	104
<i>Integrating Mindfulness into Psychotherapeutic Practice</i>	114
<i>Practical Tips for Using Social Media to Promote Your Professional Practice</i>	118
<i>The Projective Assessment Integration System (PAIS): A Guide for Student Clinicians in Training</i>	104
<i>Integrating Mindfulness into Psychotherapeutic Practice</i>	121
2026 SAP Professional Award Winners	126
2026 SAP/APF Early Career Award Winners	126
2027 Nominations Ballot	127
APA 2026 Convention—Honoring Dr. Charles Gelso	129
2026 SAP Grant Recipients!	130
2026 SAP Student Paper Award Winners!	133



PRESIDENT'S COLUMN

The Need for Collaboration

Joshua K. Swift, PhD
Idaho State University



In life, social connections matter. In my last presidential column (<https://societyforpsychotherapy.org/presidents-column-61-2/>) I wrote in detail about the value of belonging.

At an individual level, healthy social connections are a strong predictor of happiness and longevity (Allen et al., 2022; Cambieri, 2024; Waldinger & Schulz, 2023). Positive social connections can provide us with emotional support, offer tools and resources for problem-solving, and make available unique learning opportunities (particularly when those with whom we are connected are different from us). But what about at the organizational level? Can organizations benefit from collaborating with other professional organizations? Let me share an example of what can happen when professionals are not connected.

This summer I read an interesting book giving a historical account of the Chernobyl Nuclear Power Plant disaster, which occurred 40 years ago. The most fascinating part of the book to me, was the description that it provided about the efforts to contain and clean up the nuclear waste. This was uncharted waters for the scientists who were tasked with the job and they had to act as quickly as possible (there were worries that the waste would potentially trigger another explosion, possibly spread through the air and ground water, or even perhaps melt all the way through the Earth's crust). Even though the scientists assigned to the task did not know exactly what to do, there were others across the globe who did have knowledge that

could help them. However, there were many barriers that prevented any type of collaboration from taking place. Initially, one of the biggest barriers was political – the Soviet Union did not want the world to know that an accident had occurred. So the scientists had to keep things as quiet as possible and when they did reach out to colleagues in other countries, they had to ask for “hypothetical” advice for cleaning up after a “small incident.” Even when more details became known by the world, the scientists at Chernobyl were instructed to continue to minimize the scope of the problem in all communications with colleagues. Once others finally realized what had happened though, there were many who wanted to help. However, another problem was still present—the feasibility of sharing knowledge with those who needed it. Researchers from all over the world started to send their data to the Chernobyl site. It came in boxes and boxes of paper files that filled rooms from floor to ceiling. At first the Chernobyl scientists started reading through it all, searching for anything that would be helpful to them. In the end though, they realized that to find the answers they needed, it would take weeks or months for them to dig through everything. As a result, they decided to just perform all the experiments on their own, in essence, duplicating work that had already been completed by others. Forty years ago, the type of international collaboration that could have been so helpful in containing and cleaning up the nuclear waste, was just not possible.

Fortunately, we now live in a world where connections can fairly easily be

continued on page 4

made with colleagues across most borders, and information can be shared almost instantaneously. We also have tools in place that can aid in summarizing vast amounts of knowledge and can even assist in translations between languages. Our potential for learning from each other is perhaps greater than it has ever been in the past. But effort is needed to step out of our silos and engage in collaborations with others. As the President of the Society for the Advancement of Psychotherapy (SAP), one of my initiatives this year has been to strengthen our collaborations. For this reason, I chose to highlight our international partnerships during our programming at the 2026 American Psychological Association (APA) Annual Convention in Washington DC. For those of you who were not able to attend those events, I would like to report on them in my third Presidential Column.

Our Partnership with Oriental Insight

This year we celebrated the 10th anniversary of our partnership with Oriental Insight (OI). OI is a private, non-profit organization that focuses on providing a professional home for mental health therapists in China. It aims to do this through providing educational and training programming on the science and practice of psychotherapy, and by conducting research on psychotherapy effects. Back in 2016 at the APA Convention in Denver Colorado, SAP signed a formal agreement with OI in order to “promote psychotherapy in China and the United States, facilitate dissemination of psychotherapy research across language and national boundaries, promote collaboration in research and training between the two organizations, and to recruit non-APA affiliate members in China to join our organization” (<https://societyforpsychotherapy.org/new-partner-oriental-insight-organization-chinese-psychologists/>). I remember fondly sitting in the room when the agreement was signed. I was excited for

the partnership, but wondered if maybe it would only be a symbolic act, akin to just naming a park after a sister city or posting a sign somewhere stating that a collaboration exists. I could have never imagined what this partnership would actually accomplish over the past decade. Currently, about 1/6 of SAP’s membership comes from OI. Beyond just membership, through the online webinars and trainings that we have collaboratively hosted, we have been able to reach tens of thousands of mental health providers in China, sharing the latest advancements in the field with them. The collaboration between our organizations can also be seen in the many joint research projects that have been published between OI and SAP colleagues.

This year in Washington DC at the APA Convention, we wanted to do something special to recognize how meaningful the partnership has been. Luyao Ma, the OI officer who oversees the partnership with SAP, was able to attend the convention in person. During the business meeting, we presented her and OI with a small gift (a nice executive clock with our logos engraved on it) that symbolizes our past and future connection. Luyao Ma was then able to share some kind words about what the partnership with SAP has meant to their organization. Videos from Rod Goodyear and Guangrong Jiang (the two scholars who were most influential in creating the SAP/OI collaboration) were also played, with both individuals reflecting on the past as well as the potential future. Overall, I found the event to be highly meaningful and I am excited to see all that we will accomplish together over the next 10 years.

Our Connections with the SPR and SEPI

At the APA Convention we were also able to highlight our partnerships with the Society for Psychotherapy Research (SPR; www.psychotherapyresearch.org)

continued on page 5

and the Society for an Exploration of Psychotherapy Integration (SEPI; www.sepiweb.org). These two professional organizations share similar missions with SAP, and many of our members likewise hold memberships in one or both of them. Our partnerships allow us to advertise and recruit more professionals to join SAP and also provide an avenue for expanding the research, practice, and training networks for our members. In return, SAP often carries out the CE certification process for conferences and webinars put on by these groups. Of particular note, we also administer a joint poster award with both organizations. While we have been doing this for a few years now with SEPI, I am pleased to share that we have now initiated an ongoing joint poster award with SPR as well. This year at the SPR conference in Osaka Japan, SAP was able to recognize Manuel Meglio with the inaugural award for his poster titled Data-driven Classification for Estimating Clinical Cut-offs in an Argentine Adult Sample. For the SEPI conference in Malibu California, we recognized Audrey Purins with the award for her poster titled From Perceptions to Connections: Exploring PsyD Students' Attitudes toward Psychosis. In return, SPR recognized Xu Li with the award at our conference in Washington DC for his poster Belief, Bond, and Relief? Revisit Links Among Client Expectations and Outcomes. SEPI is still working on their adjudication process. I believe these poster awards are particularly important because they encourage (the awards come with a \$500 prize) the scientific pursuits for projects across the globe that align with SAP's mission. They also provide a broad exposure of SAP and its values to a wider audience of students and professionals that may not otherwise learn about our organization.

This year at the APA convention, I also

chose to dedicate my Presidential Programming Hour to a panel discussion focused on international collaborations. This panel included Dennis Kivlighan (Professor Emeritus at the University of Maryland in College Park, known for his ongoing fruitful research collaborations with colleagues in Taiwan and Italy), Xu Li (Associate Professor at the University of Illinois, Urbana-Champaign and director of SAP's International Domain, known for his active research and clinical collaborations with colleagues in mainland China, Hong Kong, South Korea, Israel, and Native American tribal groups in the United States), and Luyao Ma (Hubei Oriental Insight Mental Health Institute in China and also coordinator of the institute's collaboration projects with SAP). When asked about the value and importance of international collaborations, all three panel members suggested that our understanding of psychotherapy is limited when we attempt to view it from just one vantage point. Instead, multiple perspectives allow for a more complete picture, including greater insight into how certain psychological concepts play out in different cultural and geographical contexts. Their thoughts reminded me of the ancient Indian parable of a group of blind men who encountered an elephant for the first time. Because they each felt a different part of the elephant's body, they each came away with very different views of the animal. It was not until they communicated and discussed together, that they are able to obtain a more wholistic understanding. The panel members then discussed strategies for initiating and retaining international collaborations. Each recognized the importance of humility and listening, making sure all parties have a voice and get to contribute to the development of the projects. They also encouraged an understanding of the culture of

continued on page 6

the collaborators, not just in terms of how culture might impact the specific project aims, but also to facilitate ongoing connections and relationships between partners. They suggested sharing meals together or going to cultural events when possible. For initial networking, they shared that professional organizations are a great way to meet potential collaborators. Within professional organizations, individuals from different backgrounds and countries are already often coming together coalescing around shared purposes and goals. Out-of-the-blue emails to potential colleagues were also suggested to be surprisingly effective, as most are excited to explore new collaborative possibilities with others.

Moving Forward

Overall, I believe the APA Convention was very successful in highlighting SAP's existing partnerships and for encouraging future collaborations for the organization and the field. This is an area that we have experienced tremendous success in the past and I believe it is an area that could fruitfully lead to new growth. With this in mind, we are actively engaging in efforts to establish new collaborations. For example, I recently began talks with colleagues in India, exploring the possibility of SAP being a co-sponsor of scientific content for a conference to be held in Bengaluru in 2027. Our International Domain, under the leadership of Xu Li as director and Changming Duan and Dana Tzur-Bitan as committee co-chairs, is also highly active with efforts to expand our international presence. They have a committee that includes members from more than a dozen countries. Through this

committee, they have overseen the translation of SAP materials into different languages, put on many workshops and webinars, held SAP socials at international conferences, and organized several special awards and grants that have been given out by the division. For those of you who are interested in engaging in more international collaboration in your work (whether science, training, or practice), SAP is definitely a place where you can make that happen. If you would like to know more, please feel free to reach out to me (joshua.keith.swift@gmail.com) or our international domain director (lixu.bnu@gmail.com) at any time. We have lots of ideas for ways that you can get involved.

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ELECTRONIC COMMUNICATION EDITOR'S COLUMN

Zoe Ross-Nash, PsyD, CEDS



Division 29,

Happy Summer! I hope you can enjoy some down time. This quarter was filled with a lot of growth and changes for the Electronic Com-

munications Team. In April, Lacy Sohn, PsyD stepped down from her position as the Associate Editor that she has held since 2024. Lacy contributed incredible feedback to our authors, and we are so grateful for her time with us. We wish her the best of luck in her future endeavors.

Sarah Bondy, PsyD stepped into the Associate Editor role after previously serving as the Assistant Editor of Website Content for the last two years. We wanted to welcome Maggie Grandsire, BS, who will replace Sarah. Additionally, given the increase of article submissions due to our tremendous growth over the years, we have recruited a second Associate Editor, Sierra Kuhn, MS. We are hopeful this change can improve experiences our authors have when sub-

mitting to the Website and Bulletin through faster turnaround time and more tailored feedback. We are so excited about the new members of our team and know they will be wonderful additions to our already great team.

You may have also noticed a slightly new interface on our website. We are constantly trying to optimize and improve user experience. We have been focusing on increasing our SEO so the articles that are published with us have further and broadened impact. If you have any feedback, please contact us.

Additionally, we are making more effort to increase our author visibility, we have created an “author directory,” you can find that linked [here](#).

As always, we would love to receive your submissions. Click [here](#) for more information.

Thank you,

Zoe Ross-Nash, PsyD, CEDS



MEMBERSHIP DOMAIN

Psychology at a Crossroads: The Role of Town Halls in Building Bridges

Charles Clark, MS

David Disabato, PhD



Introduction to Town Halls and the Town Hall Speaker

Attendees of the Presidential Town Hall from across the US and around the globe were excited to hear from the speaker, Lynn Bufka, PhD, ABPP. She was introduced to prospective attendees in advance, and registrants were encouraged to submit their



questions during registration or prepare to ask questions during the hour-long session. The first half of the session consisted of Dr. Bufka's commentary on four prepared questions developed by the event organizers. The second half was devoted to a question-and-answer portion where attendees submitted questions and Dr. Bufka responded.

Lynn Bufka, PhD, ABPP, became Head of Practice at the APA in 2024 after working within the APA for more than 20 years. The practice team is now part of a larger psychology team that applies psychological knowledge to develop solutions for many of the nation's pressing challenges. Practice staff's primary aim is the development and implementation of efforts to ensure psychology is an integral aspect of meeting the public's mental health needs and addressing barriers facing psychologists in their provision of services. Dr. Bufka's career has focused on using psychological knowledge to inform programs and policies about ways to improve the quality of care delivered by psychologi-

cal professionals. Her contributions include helping develop various guidelines, including the *APA Guidelines on Evidence-Based Psychological Practice in Health Care* (American Psychological Association [APA], 2021a). Additionally, Dr. Bufka frequently serves as a media spokesperson for the APA on current events and policy matters relevant to mental health and psychological practice.

Four Initial Questions About Pressing Issues Facing Psychotherapy Today

1) How is the APA advocating for psychotherapy at the national level?

As the leading scientific and professional organization for psychology in the US, the APA, and its companion 501(c)(6) organization, APA Services, Inc. (APASI), advocate for the research, education, and practice of psychology. APA broadly advocates for psychology, psychologists, and psychological services provided, including psychotherapy and funding to continue to innovate and evaluate targets such as outcomes, dissemination, and effectiveness.

As legislative challenges emerge, they continue to provide commentary, equipping professionals with guidance and lawmakers with information. For instance, the APA / APASI's response center has detailed many of these actions, including partnering with the Committee for Education Funding to draft a letter to the US Education Secretary and 8,000 messages to Congress opposing efforts to eliminate the Department of

continued on page 9

Education (American Psychological Association Services, Inc. [APASI], n.d.). Schools are a primary mental health access point in many communities, including those with geographic and economic challenges. In a meta-analysis, Duong and colleagues (2021) found that schools were the most common location of mental health services for children in the general population and children with established mental health diagnoses. Considering this, the threat to educational resources that the dismantling of the Department of Education would pose will impact the ability of many youths to access services.

Additionally, APA/APASI are working alongside other organizations to educate psychologists and other mental health community members and stakeholders about the anticipated impact of the One Big Beautiful Bill Act (2025), its nearly \$1 trillion in cuts to federal health care spending, and the resulting reduction in access to behavioral health services (APASI, 2025a). Further, when paired with the limitations placed on graduate loans and provider shortages in fields like psychology, mental health counseling, and social work, access to care is likely to be significantly impacted (APASI, 2025b). APA/APASI are working with counterparts at both the federal and state levels to prepare for the implementation of the One Big Beautiful Bill Act (2025) over the coming months and to protect Medicaid's vital role in providing access to care for millions of Americans.

2) What are some emerging pressures impacting clinical practice, training, and supervision?

When considering emerging pressures, Dr. Bufka expressed cautious optimism. More specifically, Dr. Bufka anticipates challenges with the limited opportunities offered to prospective students and trainees in psychology. Most students

pursuing graduate level education in psychology rely on federal loans and assistantships to fund their education (Doran et al., 2016). With recent threats to funding opportunities, even fewer people will have the privilege or ability to pay for their education without financial support. An additional concern is regarding the closure of training sites (where students earn clinical training hours and receive specialized training) as a result of funding prioritization changes. SAP President Stewart Cooper, PhD, ABPP, recalled the recent closure of an internship placement site in his local community that is expected to decrease the number of training sites and opportunities available to trainees, potentially prolonging the time to licensure for early career professionals and creating the loss of services for many community members in need.

Another significant area of concern is the sweeping cuts to Medicaid, which covers nearly one in three U.S. adults with a diagnosed mental illness. Medicaid provides insurance coverage to many vulnerable populations, including children, disabled individuals, low-income individuals and families, and older adults with Medicare. With vulnerable populations representing the majority of individuals who receive Medicaid, these cuts will increase out-of-pocket expenses and significantly reduce access to essential care and services (Buchmueller et al., 2015). Furthermore, agencies and providers that rely on Medicaid to operate may no longer be able to afford to remain open – thereby further limiting opportunities for individuals to obtain care. This could exacerbate the access divide in psychotherapy, where high-income Americans can more easily access private practice therapists while low-income Americans may struggle to afford therapists with avail-

continued on page 10

ability and necessary expertise (Delgadillo et al., 2016; Kugelmass, 2016).

3) *What are the implications of psychology's evolving professional structure for both doctoral and master's level providers?* The U.S. has seen an increase in the number of practicing mental health professionals who hold a master's degree (BLS, 2022; Robiner, 2006). As of 2022, some estimates suggest as many as 84% of mental health professionals in the U.S. have terminal master's degrees as opposed to doctoral degrees (Comer & Comer, 2022). According to the Bureau of Labor Statistics, the projected employment growth for substance use, behavioral disorder, and mental health counselors is expected to be 18% between 2022 and 2032 (*Strong growth projected in mental health-related employment*, 2024). Alternatively, the projected growth for clinical and counseling psychologists is at 11%. While most master's level clinicians (MLC) are trained in programs with areas of specialty, including counseling, social work, and marriage and family therapy, a growing number of programs now offer the opportunity to gain state licensure in clinical psychology after earning a master's degree (Stringer, 2025). Dr. Bufka noted there are currently 19 U.S. jurisdictions that provide psychology licensure or registration for MLCs. These jurisdictions differ in the responsibilities granted to MLC's : 6 allowing for independent practice (e.g., Texas), 11 requiring supervised licensure/practice (e.g., Michigan), and 2 offering a combination (e.g., Kansas). Depending on the state, MLCs vary in their earned title, though the term "psychologist" has traditionally been restricted to doctoral-level practitioners. Although graduates of these programs often desire to practice in psychology, state regulations vary greatly. This shift is the first step towards addressing the structural barriers

that MLCs often encounter when attempting to access the APA and its resources (see Jackson-Wolf & Nutt Williams, 2025).

Acknowledging this change, the APA established a task force focused on the accreditation of master's-level clinical, counseling, and school psychology programs to demarcate core competencies differentiating MLCs from those who hold a doctoral degree (Larson, 2019). Given the lack of such guidance outside of the Standards of Accreditation (APA, 2021d) including those delineating responsibilities and services appropriate for MLCs, the APA has since updated its Model Act for State Licensure of Psychologists (APA, 2010; Model Licensure Act; Stringer, 2025). Open questions remain about the types of client populations, presenting problems, interventions, etc. appropriate from MLCs and how this might differ (if at all) from doctor degree psychologists. In the future, it will be up to individual jurisdictions to determine whether to adopt a process for licensure of MLCs within psychology or to modify existing regulations to align with proposed national models.

The authors make note of the absence of research or evidence indicating doctorate-level psychologists are more effective psychotherapists than MLCs. Studies clearly outline the psychotherapeutic benefits to patients when working with properly trained and licensed providers compared to working with paraprofessionals or graduate students (Johnsen & Friborg, 2015; Walsh et al., 2019). However, when comparing licensed PhD/PsyD providers and licensed MLCs (and especially those with equivalent clinical experience), research has not demonstrated evidence of patients having a preference to work with doctorate-

continued on page 11

level or master's level therapists. For example, Grainger and colleagues (2022) found no significant differences in trauma-focused cognitive behavioral therapy treatment outcomes based on practitioner education level.

Dr. Bufka anticipates several trends with regard to the evolving professional structure in the field. First, she anticipates greater specialization among doctoral-level psychologists. Second, more complex cases may find themselves routed to these specialized PhD/PsyD psychologists. Third—and considering that a greater proportion of clinical supervisors and trainers may come from a PhD/PsyD background—Dr. Bufka anticipates doctoral-level psychologists will increasingly fill the role of supervisors for MLCs and trainees, shifting away from direct practice and into leadership positions, program development and implementation, community connections, and adoption of innovations.

4) What is the future of equity, diversity, and inclusion in psychotherapy amidst changing state and national policies?

There is a creeping erosion of values in the field of psychology that has the ability to significantly impact mental health and psychotherapy services in the immediate future, particularly with regard to equity, diversity, and inclusion. One of the recent changes with the greatest potential impact is the rollback of EDI initiatives. Recent legislative and executive actions, such as Executive Order No. 14168 (Exec. Order No. 14,168, 2025) regarding gender ideology and Executive Order No. 14151 (Exec. Order No. 14,151, 2025) regarding government EDI programs, have fostered unease among professionals, across domains concerned with mental health care, who recognize the potential impact of these orders and the need for equity, diversity, and inclusion (American Psychological Association,

2025; NASW responds to trump administration executive orders 2025).

Even as external pressures grow, Dr. Bufka asserted that tailoring psychological services to the individual patient with focused consideration on sociocultural factors will remain essential. Empirical evidence supports this stance, demonstrating in multiple studies that culturally adapted interventions outperform their standard version in reducing symptoms of psychopathology while increasing client satisfaction (Ellis et al., 2022; Griner & Smith, 2006; Hall et al., 2016). However, the ability to effectively adapt interventions effectively requires continued trainings in cultural humility and comfort. Trainings that are invaluable to providers at every experience and education level are, yet another significant consequence of EDI rollbacks voiced by Dr. Bufka. The faculty responsible for instilling the next generation of mental health professionals with a multicultural orientation may feel academic and legal pressure to reduce cultural training opportunities out of fear of legal repercussions. The APA continues to argue for equal access to training and education (American Psychological Association Services, Inc., n.d.), including the engendering of an appreciation for cultural differences among training professionals.

Evidence suggests that cultural formulation assignments can improve graduate students' multicultural orientation during training. These formulations provide greater understanding of critical concepts, including power and privilege in the therapy dynamic, varied intersectional identities among clients, culturally considerate approaches to addressing mental health, and balancing cultural norms of clients and their individualized lived experiences (Tormala et al., 2018). These policy changes present a clear threat to such assignments: If faculty are

continued on page 12

prevented from explicitly addressing identity, the next generations of clinicians will enter the field without the critical skills required to treat those who differ from themselves. This subsequently impacts the ability of supervisors to teach and guide their supervisees in developing these skills (Watkins et al., 2019).

Finally, these executive orders have concerning implications for practice, especially by opening the door to discredited and harmful “treatments” like conversion therapy. Conversion therapy, or “practices to change sexual orientation or gender identity/gender expression,” was commonly used before the removal of homosexuality from the Diagnostic and Statistical Manual in 1973 (APA, 2024b). The practice has shown no efficacy and carries significant risks to participants (APA, 2009). The APA has clearly condemned its use, denied any empirical support, and encouraged practitioners to affirm clients’ sexual orientations (APA, 2021c) and gender identities (APA, 2021b). Additionally, members of APA have advocated for state laws banning conversion therapy (e.g., Dr. Lucy Homans of Washington State; Homans, 2018). The recent federal changes have caused increasing concern that such practices may become more prominent. For example, Indiana passed a state law preventing the government or professional organizations (e.g., APA) from legally banning conversion therapy or other potentially harmful interventions (SB 350, 2023). Reports suggest that at least 1,300 individuals are currently practicing conversion therapy in the U.S.; state laws like this could result in more practitioners (The Trevor Project, 2023). Collectively, these changes warrant psychologists and state organizations to contact their state representatives to stop harmful practices.

Where Does the Field Go from Here?

Changes at the national level have led to rising ambiguity for many practicing professionals in the field of psychology. To clarify some of this ambiguity, the recent town hall was organized by APA Division 29 and in partnership with APA Head of Practice, Lynn Bufka, PhD, ABPP. Dr. Bufka prioritized connecting an APA representative and frontline providers in order to provide insight into the current climate within the APA and to provide a space for attendees to suggest new areas of focus and advocacy. If APA hopes to maintain trust with practitioners during uncertain times, town halls may become critical, offering a forum for direct communication. As argued here, APA/APASl’s and Division 29’s response to legislative and professional shifts will be important in shaping the accessibility, integrity, and future directions of psychology in the U.S. Deliberate and conscious communication through methods such as town halls like this one will be needed to ensure APA’s mission is sustained and to maximize impact.

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Bridging the Gap: Integrating Specialized Experience into Emerging Clinician Identity

Charles Clark, MS

Cesar Rivera, BA

Nicholas Morrison, PhD



Bridging the Gap: Integrating Special- ized Experience into Emerging Clinician Identity

This article is for those at every stage of their professional training journey: considering graduate school, navigating it, completing internships, and stepping into the workforce. We share our experiences to highlight common struggles, the hidden strengths we bring, and how to recognize what experiences transfer and which require further refinement. In a field that values generalist competence but thrives on unique



perspectives, learning how to integrate specialized experience into broader clinical practice is key. These are lessons we have learned over the years, and we share them with you in hopes they will help. Charles Clark and Cesar Rivera are graduate students in, and Dr. Nicholas Morrison directs, the Master of Arts in Counseling Program at Westfield State University (WSU). The authors have worked together in various capacities over the past several years.

In the Same Boat

Before entering my graduate program, I, Charles Clark (CC) worked in two specialized roles. I learned most as a mental health counselor for a local Sher-

iff's Department, serving incarcerated men and women. In that role, I felt confident that certain techniques or approaches were commonplace in mental health care, for instance the culture allowing for more directive and sometimes confrontational responses. However, from day one of graduate school, I realized that my perspective would need to become far more nuanced. One of my biggest challenges was learning to incorporate emotions into my clinical work, something that was rarely the focus in the correctional settings. Like many of my classmates, I would have to learn that my prior experiences provided only fragments of what it means to provide comprehensive mental health care. This development came from my instructors, fellow graduate students with alternative experiences, and my clinical practice.

With a strong foundation in psychology, lived experience from my Latin heritage, and considerable experience working with vulnerable populations, including minority communities and those with various mental disorders, I, Cesar Rivera (CR) entered graduate school with various skillsets. Through my experiences in leadership, psychological research, case management, and emergency response positions, I learned to use these skills to develop my own mental health framework. However, as I navigated my first year of graduate school, I doubted my abilities, often wondering, "Can I really do this?" Fur-

continued on page 18

ther, my Latin background was simultaneously a source of pride and stress because I often felt the pressure to succeed, represent my community well, and navigate unfamiliar environments such as university and mental health settings where people with my background are still underrepresented. Balancing cultural expectations, academic demands, and my drive to succeed in psychology created an internal tension that shaped much of my motivation and personal growth. Surrounded by classmates referencing specific theories, modalities, and articles I had never heard of made me further wonder if I could succeed in graduate school. Despite this, through mentorship and guidance from classmates and professors alike, I came to understand that my cultural background was a strength that informed my learning.

Exploring Next Steps: Considering Graduate School

When I (CC) first considered a graduate degree in mental health counseling, I was excited and unsure. While with the Sheriff's Department, I was fortunate to learn from several fantastic master's-level clinicians, who always seemed to make the educated clinical call and connected with clients effortlessly. Despite this admiration, or perhaps because of it, I was not sure I could follow in their footsteps. When it came to considering the graduate program at WSU, I brought this concern to my now-advisor, who would come to play a key role in my decision. At that time, I felt I had gained valuable experience, but I was worried that choosing the forensic concentration, compared to the traditional track, might limit my future options. My advisor helped assuage my fears.

Conversations with my advisor, friends, and family were candid and deeply encouraging. These supports helped me (CC) clarify my goals so that I could

move forward with confidence. Since enrolling in the forensic concentration, my understanding of the complexities of treating mental health concerns in the criminal-legal system, the need for robust assessment instruments, and the dual emphasis on reducing recidivism while maintaining mental health has grown. Most of all, through my courses and experience in the program, I was able to identify and label the skills I developed in these secure facilities that I could carry forward. I also grappled with other learned behaviors and beliefs that I needed to set aside or adapt. For example, because of the directive nature of the environment, having discussions regarding difficult topics such as substance use, suicidal or homicidal ideation, and other areas was much more comfortable for me. Conversely, I learned that while directiveness, which is valued in correctional settings, can be useful in some contexts, effective counseling often requires tolerating uncertainty and allowing clients space to process difficult emotions associated with major life events.

My advice for those experiencing the fear of *"I don't know what I'm doing. I'm not prepared enough"* at this stage is to be honest with those around you and have conversations with those involved. If you are able, talk to coworkers or those involved in the graduate program you are considering. They can help you find your path, and that support can make a significant difference in finding occupational clarity. Do not be afraid of the questions that will come—"Why do you need this degree?" "What other options might there be?" and "Are you ready for that commitment?". The questions are not challenges to your goals but meant to help you decide your best next steps. Take these questions, consider them, and answer them truthfully for yourself.

continued on page 11

Clinical Training: The Beginning of Graduate Study

Everyone entering graduate school has their own lived experiences, with varied cultural backgrounds and training levels. These diverse backgrounds and experiences form the foundation of a potentially strong graduate school cohort, with the opportunity to enhance training for all involved. However, to truly succeed in graduate training, students must maintain an open mind and readiness for challenge.

I (CR) feel that this self-awareness, open-mindedness, and curiosity is integral to success. My experience working for the Office of Refugee and Resettlement based in New York State facilitated my interpersonal skills, cultivated a diverse network of contacts, and exposed me to contrasting opinions and worldviews. Although I recognized my background would help in my role as a burgeoning counselor, I quickly realized it did not fully prepare me for the more technical parts of graduate training, such as clinical assessment and documentation. I had to adjust by leveraging my natural strengths against my deficits at that time. For example, while it was natural for me to be present for my clients emotionally, I struggled translating clients' descriptions into clinically appropriate language. However, by seeking supervision, and improving my case conceptualization skills, I became proficient.

Students from minority backgrounds and counselors surrounded by diverse peers and support systems often provide perspectives and community understanding that can improve culturally competent care (Kýlýč & Vaněček, 2025). Because of this, graduate programs can and should help students to harness these strengths as they transition into their roles as emerging counselors. To this end, mentors who understand their

students' cultural identities can motivate students and foster a sense of belonging in graduate school (Estrada et al., 2018), which can be invaluable.

In addition to the role graduate programs can fill, there are several steps that graduate students themselves can take to make the graduate school experience less complex, more comfortable, and more beneficial. First, students can seek mentorship from specific individuals, such as faculty, supervisors, or professionals, with whom they feel have a sufficient understanding of the student's background and experiences so that they can offer tailored guidance that aligns with the student's goals. Additionally, students can consider creating affinity groups by connecting with classmates or joining student organizations that advocate for their mental health, wellbeing, and academic success. Such steps play significant roles in making graduate school that much more digestible.

Further Identity Development through Internship

An internship is usually one of the most anticipated and nerve-wracking experiences for those pursuing graduate training in the mental health field. For many graduate students, an internship symbolizes a transition from the controlled learning environment to actual clinical practice. Even among the most confident, this process is likely to elicit feelings of doubt in the student-clinicians' skills. There may be additional pressure for one to find what they consider to be the "right" placement, especially for students coming from highly specialized previous experiences and/or predominantly minority backgrounds. In this next section, we (CC & CR) reflect on our two distinct, but similar, journeys through the internship process. Each is marked by moments of uncertainty,

continued on page 20

growth, and important lessons about what really matters to each author in the internship process.

For me (CC), finding an appropriate internship site came with unexpected challenges and anxiety. Even after completing sufficient coursework, I still felt unprepared for the internship process: *"I don't know what I'm doing. I'm not prepared enough"* came up again, and again. Additionally, I placed great emphasis on finding a "perfect" placement that would provide me with skills to bridge my previous specialized experience to a more generalized practice. I felt alone and overwhelmed. These thoughts and feelings persisted until I started talking with classmates who, to my surprise, felt the same! Those peer conversations became a lifeline and a reminder that these doubts were normal during this phase. While the emotional support was invaluable, I realized I also needed to shift my expectations about what an internship would, and would not, look like. A lesson I had to learn, sometimes painfully, was that there would be no such thing as the *perfect* placement. Instead, my ability to critically evaluate and apply what I would learn would be what mattered most, all while recognizing the expected learning curve of this new experience. As with other specialist settings, such as hospital emergency rooms or group homes, you, too, will need to foster the critical thinking necessary to assess what skills are transferable from whatever placement you obtain. Apply what you learn critically; always consider the context before applying your skills.

In my (CR) case, I encountered several moments of doubt, nervousness, and confusion while preparing for an internship. As a Latino student, I am extremely proud that I get to represent my community at WSU. However, when

looking for internship placements, I found myself unsure and nervous about whether many sites would value my Latino background or even whether I would fit in. This began to change when I realized that many internship sites actively seek students with different cultural identities. This shift, from anxiety to confidence that my lived experiences would be both valued by internship placements and beneficial to clients, was a welcome one. With this lesson, there is an additional piece of guidance I wish to share with students navigating similar stressors: look for internship locations that resonate with your cultural identity and consider locations that allow you to work with diverse populations.

This was the most important lesson I learned. Additionally, internship locations that value different cultural identities are training environments that can produce more effective therapists. For example, Kýlýç & Vaněček (2025) found that students who worked with diverse populations and participated in multicultural training developed stronger multicultural counseling skills than those who only completed traditional training methods. Further, George (2023) found that social work students cited field placements (49%) and supervision (35%) as the most helpful in preparing them to work with different communities. The clinical literature demonstrates how direct, culturally informed experience builds both skill and confidence. To this end, seeking out placements that foster culturally responsive values offers significant benefits to students.

Key Lessons Learned

While our experiences seeking internship placements may have been different, we both learned that being unsure and doubting oneself is part of the internship process. Whether it is embracing

continued on page 21

ing one's cultural identity or utilizing classmates for support, the goal is to keep learning and expanding one's skills. Internships are not about being knowledgeable about everything psychotherapy; instead, they are about showing up, turning one's experiences into strengths, and continually developing a professional identity.

Transitioning into the Workforce

In many ways, my, Dr. Nicholas Morrison (NM) experience of sitting with uncertainty is consistent with those of my co-authors. As a first-generation college student, I often felt at each stage of my professional journey (undergraduate, post-baccalaureate work, graduate, and professional practice) a feeling of uncertainty. However, like many experiences in this world, it becomes easier to habituate to and accept this feeling with both time and practice, without it needing to dictate the course of life events.

With the benefit of hindsight, I can look back at my training and experiences and reflect on how my feelings at the time compare with those now. It seems to me that many prospective and current graduate students are concerned with navigating the path toward their careers the "right" (or even perfect) way. This is certainly understandable, especially given the difficulty of graduate programs in mental health fields. However, it is important to recognize that although not "all roads lead to Rome," certainly many of them do. For students concerned about the "right" path, I encourage them to recognize that many avenues exist to prepare for graduate study, including concentrations within majors, independent study, internships, practica, research positions, and post-baccalaureate work. Applicants across the spectrum to graduate programs and beyond will have a diverse array of experiences, each with their own unique sets of strengths

and deficits. What may make a candidate look appealing at one site (e.g., in-depth exposure to cognitive-behavioral principles) may put them at a disadvantage at another (e.g., the candidate does not appear open to new theoretical orientations). Even if a candidate has chosen the "right" path, it often winds and turns, with difficult terrain and obstacles along the way. Mindfully recognizing that each of us faces difficulty with the paths we have chosen will make it that much easier to navigate the more strenuous aspects with stamina and grace.

Moreover, I encourage prospective and current graduate students to recognize that, at times, it may be useful to take a different path. For example, I began my post-doctoral training expecting to pursue a career as a full-time clinician. The experience led me to realize I missed working with students and helped me to understand that my calling was in a university setting. Relatedly, I have worked with students who, after trying counseling, realized that they wanted to help others in a different way; I can recall one student who decided after an introductory counseling class to effect change at a macro level by pursuing a master's degree in public health (MPH). I encourage both prospective and current students to start from a place of values: "*What is important to you?*", "*What gives you a sense of purpose?*" I also encourage students to recognize that values can be flexible, and as such will often change with time. What matters to you in a career when you first apply to graduate school might look quite different when you seek out your first position as a credentialed professional. For example, a position at a R1-institution as a researcher may be extremely important when you first apply to graduate school; however, the ability to care for a family member's ailing health may take

continued on page 22

precedence over moving for the “perfect” job, and a genuine reflection upon what is most important to you will be important. A values-based framework will help you mitigate the anxiety about which path to take, and when, if at all, it is appropriate to deviate from that path. Graduate school and professional life rarely unfold in a straight line. By grounding choices in values, students can navigate uncertainty with greater confidence. I would remind readers that it is not the absence of obstacles, but the way we navigate them, that defines the journey along our paths.

Final Thoughts, From Us to You

As early-career professionals pursue their careers in the mental health field, it is important to recognize the value of specialized experiences in preparing us for broader, generalist practice. Equally important, though, is the ability to critically reflect on which skills to carry over, and which may need to be adapted, expanded, or left behind. In mental health counseling, we help clients build insight so they can move toward their goals. The same perspective is essential for us, too.

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INTERNATIONAL DOMAIN

Advancing Precision Mental Health Across Cultures: A Multimodal Ecological Momentary Assessment Study

Fabienne Mink, MSc

Juan Martín Gómez Penedo, PhD

Julian Rubel, PhD



Miriam I. Hehlmann, PhD

Andrés Roussos PhD

Brian Schwartz, PhD



Julia Könitz, MSc

Rocío Manubens, MSc

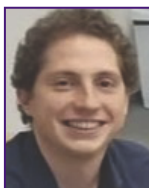
Beatriz Gómez, PhD



Javier Fernández-Alvarez, PhD

Manuel Meglio, MSc

Wolfgang Lutz PhD



Improving the Prediction of Early Treatment Responses, Dropout, and Outcome using Daily-Life Data

Psychotherapeutic approaches have repeatedly been shown to be effective, with effects comparable to those of pharmacological treatment and, in some cases, showing greater durability over time (e.g., Cuijpers et al., 2023). At the same time, overall treatment success remains modest, with more than half of patients not responding sufficiently to psychological treatment and many discontinuing therapy prematurely (Cuijpers et al., 2021; Lutz et al., 2021). More-

over, access to psychotherapeutic care remains particularly limited in low- and lower-middle-income countries, where only one in 27 people with a depressive disorder receive adequate treatment (Thornicroft et al., 2017). This highlights the continued need to better understand, across diverse settings, which patients are likely to benefit from specific interventions, which patients may be at risk of insufficient response, and how treatment can be adapted more effectively when progress is limited (Lutz et al., 2022; Nye et al., 2023).

continued on page 24

To date, research on the prediction of treatment trajectories and outcome has relied predominantly on retrospective questionnaire data collected before or repeatedly during treatment. These approaches have provided important insights and shown that treatment trajectories can be predicted from pre-treatment information or session-by-session reports (e.g., Constantino et al., 2021; Lees & Delgadillo, 2026). However, retrospective self-reports are limited by recall bias and their reduced capacity to capture experiences in real time and natural contexts (e.g., Myin-Germeys et al., 2018). From a precision mental health perspective, which aims to advance personalized psychological care, improving the temporal accuracy of assessments may strengthen prediction models and, in turn, support more tailored treatment decisions (e.g., Lutz et al., 2025).

How Ecological Momentary Assessment Can Complement Retrospective Measures

One approach to improve the precision of measurements is Ecological Momentary Assessment (EMA), also referred to as Experience Sampling Method (ESM; e.g., Hektner, 2007) or Ambulatory Assessment (AA; e.g., Trull & Ebner-Priemer, 2013). EMA involves the repeated assessment of affective, cognitive, or behavioral processes in individuals' natural environments (Stone & Shiffman, 1994). The term EMA encompasses different assessment methods, including active self-reports and passive sensing of physiological indicators, such as heart rate (Shiffman et al., 2008). By capturing experiences in real-world contexts and close to the moment of occurrence, EMA allows researchers to capture fluctuations and short-term dynamics in daily life, thereby reducing retrospective distortions and increasing the ecological validity of the collected information (e.g., Ben-Zeev et al., 2012; Wright & Woods, 2020).

Over the past decade, EMA-based research has expanded substantially across clinical psychology and psychotherapy research (Fritz et al., 2024), particularly regarding the prediction of symptom and treatment trajectories as well as treatment outcome (see Mink et al., 2025 for a systematic overview). Initial studies suggest that self-reported EMA data can improve the prediction of early treatment responses (e.g., Husen et al., 2016), treatment outcome (e.g., Hehlmann et al., 2025) and dropout (e.g., Lutz et al., 2018) beyond initial impairment assessed at baseline. Moreover, recent studies implementing passive sensing parameters yielded similar results when predicting treatment outcome (e.g., Hehlmann et al., 2021) and the severity of psychopathological symptoms (e.g., Jacobson et al., 2019; Siddi et al., 2023). However, it remains unclear to what extent the combination of EMA data modalities, including both active self-reports and passive sensing, can enhance the prediction of treatment trajectories and outcome beyond comprehensive baseline measures.

Integrating Context-Sensitive Perspectives Into Outcome Prediction

Although considerable research has examined how prediction of treatment courses and outcomes in psychotherapy can be improved, most of this work has been conducted in relatively homogeneous settings, limiting the generalizability of these models across sociocultural and socioeconomic contexts (Gómez Penedo et al., 2024). This limitation is particularly relevant given evidence that mental health problems are more prevalent in economically disadvantaged areas and that individuals from these contexts tend to show lower response rates to psychotherapy (Delgadillo et al., 2016). In addition, psychotherapy may be conceptualized and practiced differently

continued on page 25

across cultural contexts (Aafjes-van Doorn et al., 2020), while cultural adaptations of psychotherapeutic interventions have been associated with improved outcomes, underlining the importance of contextual sensitivity in both treatment and research (Anik et al., 2021; Lee et al., 2021).

From this perspective, improving prediction in psychotherapy also requires examining whether predictive models remain valid across diverse contexts, including different cultural backgrounds, socioeconomic conditions, and health-care settings. A model that performs well in one setting may not necessarily generalize to another. Integrating context-sensitive perspectives into prediction research may therefore help identify predictors that are robust across settings.

The Present Project

In the context of these research findings, the introduced EMA study examines whether multimodal daily-life data can improve the prediction of treatment responses and overall outcome in psychotherapy. More specifically, the project investigates which EMA parameters assessed via self-reports and passive sensing at treatment onset can improve the prediction of early treatment responses, dropout, and treatment outcome beyond information collected through cross-sectional baseline assessments. In addition, the study examines whether these models generalize across culturally diverse treatment settings. This may help clarify not only whether daily-life data improve prediction, but also whether such models can support personalized treatment planning across cultural environments. The preregistration of the study can be accessed here: <https://osf.io/ezpc3>.

The study draws on data from 300 patients across three outpatient clinics in Trier, Germany, Buenos Aires, Argentina,

and Osnabrück, Germany. At the beginning of treatment, patients report on their emotional and interpersonal experiences in daily life six times per day over a two-week period. At the same time, wearable devices (i.e., Garmin Vivosmart 4) are used to passively capture physiological and behavioral indicators such as heart rate, activity, and sleep. These repeated daily-life assessments are combined with baseline clinical information (e.g., initial impairment, treatment expectation, socioeconomic status) to examine whether multimodal EMA data improve the prediction of early treatment responses, dropout probabilities, and outcomes beyond cross-sectional baseline measures, and whether predictive performance remains comparable across the three study sites.

The aim of this work is not only to improve statistical prediction, but also to contribute to a more clinically meaningful understanding of treatment development. If EMA data allow the early identification of patients who are at risk of poor response or premature dropout, they may support more timely treatment adjustments and more targeted clinical decision-making. Moreover, if the cross-cultural validity of the algorithms is supported, much of the predictive knowledge generated in Europe and North America could be extended to other countries and cultural contexts, such as Latin America. This could have a substantial impact in settings with fewer resources for personalized mental health care.

Current Status and Next Steps

Currently, the prediction models are being trained on the first half of the sample. Once data collection is complete, these models will be evaluated in an independent holdout sample, providing an out-of-sample evaluation of predictive accuracy and cross-cultural validity.

continued on page 26

Conclusion

By integrating repeated self-reports and wearable-based indicators collected in patients' natural environments, this study seeks to examine whether multimodal EMA data can enhance the prediction of early treatment response, dropout, and overall outcome beyond cross-sectionally assessed baseline measures. At the same time, its cross-cultural design addresses the important question of whether the predictive performance of such models is comparable across contexts and cultures. Ultimately, this work aims to contribute to early risk detection of poor treatment responses or premature dropout, more targeted treatment planning, and a more context-sensitive understanding of therapeutic change in culturally diverse settings.

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PROFESSIONAL PRACTICE DOMAIN

Practice Committee Office Hours Update: Do You Have to Sacrifice Your Values to Maintain Financial Stability in Private Practice?

Wilson Trusty, PhD

Marcy Rowland, PhD

Jake Jackson-Wolf, LCPC

Amy Ellis, PhD



The Practice Committee has been hosting “Office Hours” to debunk some of the most common myths about private practice. Our most recent talk was centered around the dichotomy between the financial piece of private practice and concerns of sacrificing values as practitioners in order to make a living in private practice.



Private practice can be a way of energizing yourself and engaging with the community to do clinical work that you’re most passionate about. If you couldn’t make it, that’s okay, we’re sharing the take home points from our call in this article.



We invite you to join us for our next Office Hour discussions:

- 9/15/26 12pm-1pm EST
 - Myth: Group practices are the way to go to build passive income
 - Reality: There are multiple models of running a group practice but none of them involve passivity.

- <https://nova.zoom.us/j/6986910134>
- 11/17/26 12pm-1pm EST:
 - Myth: Insurance or bust to be successful in private practice and private pay is the only surefire way to go in private practice
 - Reality: There are so many ways to set-up payment structure to be successful
- <https://nova.zoom.us/j/6986910134>

About the Panelists

Marcy Rowland: I work primarily with adolescents and adults, doing individual, couples, and family counseling. I am in full-time solo private practice. I don’t have any other employees; it’s just me managing everything from scheduling, greeting people at the door, intakes, billing, all that fun stuff. I’m looking forward to sharing some of my experiences with you today about those things and how I’ve been able to bring some of my counseling psychology values in particular, social justice issues into my work.

Wilson Trusty: I’m also in central Pennsylvania. I do private practice part time. I’m a full-time research psychologist at Penn State and then have a small private practice where I do autism assessment on the side. I’ve been in solo private practice but recently took on an independent contractor who also does assess-

continued on page 30

ment. I work completely with adult autism assessment. I do therapy as well, just not in my private practice, but here at Penn State's Counseling Center. I am also early career and have been in private practice for about a year and a half.

Jake Jackson-Wolf: I'm a licensed clinical professional counselor in Towson, MD. I am the owner of B'well Counseling Services, a group private practice employing a variety of mental health professionals including several professional counselors, a clinical social worker, a clinical psychologist, and a clinical art therapist. We see clients across MD and FL virtually and in person at our office in Towson. We have a variety of specialties including couples therapy, sexual health concerns, eating disorders and body image, trauma, and general mental health issues like anxiety, depression, and life transitions. I have been in practice for nine years.

Amy Ellis: Like Wilson, I have a full-time job at Nova Southeastern University as an Associate Professor and Director of the Trauma Resolution & Integration Program, but also maintain a part-time private practice. My practice is entirely telehealth, and I treat individuals with histories of complex traumatization. I'm located in South Florida but do have PSY-PACT so see clients in other states as well.

What is it like to run a one-person show?

Marcy: I think I mentioned that I am a bit of a one woman show here. And so, one of the things that comes to my mind when I think about the intersection of social justice and ethics alongside the pressures of generating an income is scheduling. Initially I feared that I would never be able to build a full-time caseload, never be able to have enough clientele on my schedule to cover my overhead, let alone make a living. And

I've been pleasantly surprised in a lot of ways with regards to how different my real-life experience has been. And certainly, some of that is probably a result of living in a rural community where I think service providers are at a shortage here. But that then puts me in a unique position to be thoughtful about the way that I schedule my time from an ethical or social justice perspective. Being available to my adolescent clients outside of their school day for appointments is very important to me as I recognize their current situation may have already caused them to miss school. So, my office hours might look different than somebody else's office hours, because I do tend to be here a little bit later in the afternoon and evening and every other Saturday to try to meet the needs of the particular clientele that I'm working with. I also try really hard not to schedule back-to-back clients who might attend the same school to protect their privacy and confidentiality, hopefully minimizing awkward interactions or overlapping social circles that might make people feel uncomfortable or keep them from seeking services. Those are just a couple of the things that I'm keeping in mind as I am considering how my values and the actual function of my practice might work together.

In considering personal (e.g., spending time with family) and professional values (e.g., making an income), how do you decide how to schedule?

Marcy: It is important to me to have some consistency in my personal life as well, so I do try to keep one evening to myself and really do protect that time. One of the perks, I suppose, of doing your own scheduling is that I am in charge of that. I can absolutely block off that time on my schedule. But then it is also up to me to respect my own bound-

continued on page 31

aries. And again, sometimes that pressure of wanting to be there for people and meet them where they are puts me in a bit of a bind at times. But I think I'm doing right by me and right by my clients when I am trying to respect those boundaries for myself.

Wilson: Similar thoughts from me too. As somebody who has a full-time job plus private practice, I know that if I work in the evenings after my full-time job, I am not happy and I get burnt out really fast. And so, for me, my private practice is Saturday mornings, 8 a.m. to noon. That's when I rent out my office space and I do my best to keep everything contained to that. Now that's not always feasible if I have to do a phone consultation or get a third-party report. But as much as I can, having firm boundaries is something that helps a lot.

What was your decision like to go in-network with insurance versus private pay only and balancing being accessible but also making a living?

Marcy: I mentioned that I work and live in a fairly rural community and private pay would be a significant financial burden to a lot of folks who live where I do. So, I have made the decision to go in-network with insurance, and I find the reimbursement rates highly variable depending on the insurance company. However, some of them can be quite fair. That has really worked for me. But also, being able to make decisions about sliding fee, as I operate under a hybrid model as well. I have the privilege of allowing folks to continue services, even perhaps once they have lost their insurance due to divorce or job loss or might be between insurances for a period of time. I can make those decisions for myself and maintain continuity of care for folks even once they might have had a significant change in their financial status. And that's really important to me to be able to do that. Also working with

adolescents as well, their health insurance is oftentimes tied to their parents. At no fault or decision of their own, sometimes they find themselves in a situation where their insurance has changed or they no longer have the ability to pay. Knowing that I can make those decisions to provide for myself financially, but also maintain some continuity for clients is really something that's important to me. It's something I value about being my own employer in these kinds of situations.

Wilson: I think my situation is unique in some ways doing assessment in private practice. I take private pay only. And in general, the reimbursement rates for assessment are a lot lower than for therapy. I did the math once, and if I took the most common insurance in this area, I would net about \$25 an hour for assessment, and that's just not feasible. I can't afford to take insurance, essentially. That is a struggle and a values question, because there are plenty of people who will reach out to me and say that they can't afford it. I don't like that fact, and at the same time from a personal perspective, it's not feasible to take insurance. Now I do occasionally complete a free autism assessment here in the counseling center where I work, and that's a way that I try to make that a little bit more accessible, at least to the student body here. I think it depends on your operating expenses, the insurance reimbursement rates for the services that you're offering, and the reimbursement will be a little bit different depending on the location, the specific insurances that you're working with, etc.

Marcy: It's tricky, and some of this then also reflects on the question or the topic of scheduling as well. I have the luxury of being able to make more money if I'm willing to work more hours. That's another way to think about balancing

continued on page 32

those things for yourself, and also then thinking about not just one week at a time, but maybe a whole year at a time as well. Because I don't have PTO days, I have to sort of build those into my budget for the year along with my expected expenses and costs and income. Wanting to protect that time, means that some weeks have more scheduled clinical hours on them than others.

Amy: What I'm hearing is that it really depends on what your values are. I think sometimes we get this bad rap that we should never have a value of wanting to have an income and in reality, it's okay to want to have a very safe, stable income. And it's also okay to want to have a particular clientele in your practice. For me, I don't accept insurance, and what that means is I get a particular clientele that can afford private pay and that isn't always in alignment with the clients that I want to work with. That's why I offer pro bono and sliding scale/reduced rate services. And so, I'm hearing in this conversation that it's deeper than just "do you take insurance" or "do you not take insurance", but who are the clients that you want, what's your niche, what's your population, as well as where are you going to feel the most sense of fulfillment while also not burning yourself out? That's why I always struggle with these types of questions because it's just so much more nuanced in terms of who you are and what you want to configure your perfect constellation of how you want to structure your finances.

Jake: And to make it even more complicated, the question has historically been, "do I operate in or out-of-network with insurance or private pay only"? When I think today that conversation is even more complicated by, "do I operate in-network with insurance by signing up with one of these platforms that's going to do this for me, and I'm essentially

working under their group practice?" Something I've talked about before is how I've explored other third-party payers more recently. For example, I've signed contracts with EAPs and partnered with nonprofits that want to offer therapy services and might get grant funding. And so, thinking a little bit broader about the choice. It isn't just "do my clients pay me or does a private insurance company pay me?" but thinking about the different sources and ways of diversifying your income streams. For example, I'm outside of DC in Baltimore and a year ago there was a huge federal workforce that was deeply impacted a year ago as all these federal employees lost their jobs and insurance. So, thinking through it more broadly than just in or out-of-network, or private pay or insurance-based, just adds to the complication.

How do you get information about reimbursement rates to adequately financially plan?

Wilson: They're not available and people are not allowed to disclose the exact amounts. People who take insurance would probably have more knowledge of this but as somebody who is out of network, I can't actually get the exact reimbursement rate. My understanding is that you have to work with the insurance companies to get that right now. That's different with Medicaid and Medicare as all of that is public. Private insurances tend to use that as a benchmark to some extent.

Jake: People who are not in-network anymore know what they used to get paid, and they are no longer contractually obligated to withhold the information. So, that's one avenue to explore, if you know anyone who was previously in-network and has access to those rates. Or, if you've been a patient somewhere in-network or you know someone who has been treated, EOBs (Explanation of
continued on page 33

Benefits) list what the contracted rate is with the provider.

Amy: However, the reimbursement rates depend on where you're located so that adds another factor.

Should I ever end my relationship with an insurance company if the rates are too low?

Marcy: Don't be afraid to end your relationship with an insurance company that is not doing right by you, whatever that might be. You can dump them. Though, you may not be able to get back on if your needs were to change, but you're not stuck with them forever.

Jake: And it can be hard to end a relationship with insurance companies. They ignored three letters saying I would like to be off the panel. In one instance, I sent a letter in October saying I plan to be no longer credentialed as of December 31st of this year and they made it retroactive to the date that the letter was sent. So, then I had to re-credential for three months. If there's a game to be played, they will play it. And with persistence you can usually get your way.

How do you determine what insurance panels to apply for?

Amy: You can look at insurance as either it's a marketing strategy where people who have XYZ go onto the website, and then they get funneled to you because they want to use their insurance, or you can look at it like "ah, yes, my clientele keeps coming to me, and they really want me, and I'd be able to retain them if I were on XYZ insurance". It might not make as much sense to go for XYZ insurance because they offer a \$200 reimbursement rate if nobody has that insurance and nobody's coming to you for your particular expertise. Wilson mentioned Medicare, and I think that's a legitimate one to consider, that there's a lot of people who have Medicare, and

it's a very public amount of money that you know, and you can anticipate, and it doesn't seem to carry the same issues. And don't forget, there's also the middle path of doing single case agreements.

Do you think there should be a reduced rate for seeing a patient more than once a week? And what would you do if a patient demanded that?

Amy: I have done this and learned a lot of lessons along that path. Let's say I have a client who is paying \$10 for a weekly session, which is aligned with my social justice lens. And then unfortunately, the client starts struggling and it becomes clinically recommended that I start seeing them twice a week. So now they're paying \$20 per week. When the time comes for the client to start being seen once a week, the question looms of whether you should go back to \$10/week or keep the \$20/week because you know they can afford it. The way to protect against this is to have a specific reduced rate contract that I have my client's sign. One of the factors is that it's time limited. It's 12-15 weeks and then we will reevaluate so that I'm not locked into anything. And that if we determine that we want a higher frequency than what we're already meeting at, that that will be a collaborative decision as to whether I'm the right fit.

I do think it's a useful reminder to clients as they re-sign every couple of months to not take things for granted. In short, morally, my answer is yes, you should offer more sessions if somebody needs it, and at reduced rate as we want to increase access. As a businessperson, I think that there's more nuance involved in it.

Jake: It's also worth evaluating whether or not that's the right level of care or place for the person to be treated. One of the therapists that works in my practice

continued on page 34

shared that their client needed to see them more often but couldn't afford it. And my approach is, then this might not be the right place right now. Let's figure out a plan for getting you to a place that's more sustainable. I think it opens the door to that conversation. As for the word "demand", there's something more to investigate. If I'm the client presenting with "here's how this is gonna work..." versus collaboration and an egalitarian negotiation. At the end of the day, it's the therapist's call about what fees they're willing to accept or not.

Marcy: There can often be some challenges too around how much time a client might be accessing you outside of session as well. It's important to have a conversation about whether time spent addressing their issues over the phone should be another scheduled session, or whether we have a 20-minute phone call that is not billable to insurance. Those conversations aren't always easy to have. Thinking through having a policy about that, even if it's just a policy for yourself, so that you're not always making those decisions time and time again, but rather having a rubric that you use for yourself to think about whether it's a higher level of care that's needed here, or whether we are going to need to schedule a second session, because there's so much time being spent outside of sessions still dedicated to the same client or the same issue.

Wilson: I can share another experience with that too and the importance of being really clear about expectations from the outset. In my practice, I always do 15-minute consultations to see if somebody's appropriate for services. And one of the questions I ask is if they're having any difficulty paying for basic needs like food, transportation, medical care. And if somebody answers "yes" to that, I have a really frank conversation with them about whether this is a good idea for them to get

an assessment since they're having this financial concern. Because if they're saying they're having this problem with finances and basic needs, I don't feel like that is ethical to put that additional financial burden on clients, unless there's some sort of clear plan in place. I had one client who said that they were fine financially but during the intake it became clear that they didn't understand how much they were going to pay or how their income compared to fees. And so, I did some consultation with another assessment psychologist and ultimately had a phone call with the client, met with them once for free to explain the situation and make a referral to somewhere that they could potentially have their insurance covered. I made that decision because I wouldn't have taken them on if I had known about the financial difficulties that they have because it wouldn't be fair to them.

How do you handle chronic late cancellations and/or rescheduling?

Wilson: Part of this feels tongue in cheek because with autism assessment, there are almost no cancellations or no-shows because people have usually been waiting for a long time, so consistency is really excellent. I will say in therapy I have a clear attendance policy that's laid out in the consent document, where if they don't give me advance notice, it's a \$100 no-show fee. And, that if they have 3 absences within a 5-week period, unless we've agreed on that in advance, that's an automatic termination. And the reason for that is that they're not going to be able to benefit if they're not coming consistently and it's taking slots that other people could have used. For me, I view that as an ethical issue. Thinking about the ethics code, if it's reasonably clear that somebody is not benefiting from therapy, you have an ethical obligation to terminate. And so, you're actually doing more harm than good if you keep somebody who's not consistently attending. In

continued on page 35

that case, you need to get them to something else that they can actually benefit from. I'd say that it's not ethically justifiable to keep somebody on if they're having that much of a problem. Now, of course, there are always individual circumstances, and you also need to provide termination counseling to make sure that they're set up well. But for me, I'm very boundaried about that.

Marcy: I would say I follow a similar guideline, although I think my situation is complicated a bit by working with adolescents who are often dependent on other people to get them to their appointments. But thinking about accessibility, it's also why I chose the office location that I did. I'm walkable from the high school and the junior high. Again, that doesn't fit everybody's needs; pivoting to telehealth at a moment's notice is another way I've been able to help kind of reduce the barriers to access, but also maintain some more consistency on my schedule, on my end as well.

Jake: I have a group practice and when people in the group come to me and say, "I feel so terrible, I'm gonna have to charge them, should I give them a freebie?" I always say, "tell me more about why you feel bad about doing exactly what you agreed to do?" There's something interesting to explore there, usually for ourselves, about why do I feel this guilt, or why do I feel like I should give someone a freebie? So many folks have it written one way and then the first no-show or late cancel go, "oh, well, I usually give people the first one." And if you want to give people the first one, write that into your agreement. Because there's actually some potential liability in that. If you lay something out and make an agreement, and then you don't abide by it, what are we demonstrating to clients? Or, if you do choose to not give someone a freebie and it comes up in another setting, they're like, "hey, I

see Jake too. Yeah, he's always so chill about the late cancel. And they're like, what? He's charged me every time."

Amy: I think it all boils down to what you have in your informed consent document, and the way I was trained is that your informed consent is a living, breathing document. I do have that spelled out that you always get one freebie, for whatever reason I also have it specifically noted that within 90 days, if you have three or more cancellations or reschedules, we will talk about it and potentially change the time of your appointment. I will no longer be able to hold that existing appointment. And to be explicit, I charge my full fee for cancellations which you can do in private pay but may not be able to do with insurance-based fees.

Wilson: I've learned generally that I have to spell things out more clearly and be more consistent and more explicit about things than when I'm working in an organizational setting.

Marcy: And for those of you who might be working with adolescents or children or families, making sure that it's clear to every member invested in the arrangement. Because again, my 14-year-old kids aren't paying their late cancel or no-show fees.

Jake: And I see a lot of couples, and I've had a similar issue, where if one member of the couple shows up—especially if they're coming to my office separately—if one shows up and the other one will be 10-15 minutes late, my operating on a "no secrets policy" with couples, I'll say, "you can sit here, but I'm also not going to bring you in until we're ready to start." And this is the time that we scheduled, this is the time that we have. And so, it's certainly something to talk about when it's a pattern.

continued on page 36

How do you prevent burnout when it comes to balancing ethics/aligning your values and wanting to earn well?

Wilson: You know, one concern that we've talked about here is does this policy distract from the client care piece? So, being very clear with people and explaining your no-show policy, does that in some way, interfere with relationship building? And I think that's a relevant concern because we spend a lot of time talking with colleagues about the logistical pieces, but how do we still stay grounded in what we're wanting to do clinically with our clients here?

Marcy: I think all of these conversations are relational and it is an opportunity to build trust and safety even by outlining what one can expect from treatment. I think alliance can be built even in talking about boring paperwork and consent with a client. But then in terms of preventing burnout, I think a lot of that is on me to be sure that I'm scheduling myself appropriately. One of the signs of burnout for me is if I am grateful when somebody doesn't show up for their appointment that I'm probably over scheduling myself. And so that's one indicator that I might need to change how I'm operating.

Jake: That makes me think of the old expression about business ownership: I didn't want to work 40 hours for somebody else, so I work 100 for myself. We need to try to notice what that balance is of the upside that you get to chart your own destiny and then the other emotional labor that comes with that. I also think it's self-reflective, just trying to find enough space to sit and think, how's this going for me? What do the next three years look like? What's the next five years look like? What's the next week look like?

Wilson: I like the relational part of this, too, and that, even in setting these clear boundaries this is part of forming a safe therapeutic space. I'm actually moving out of state to a different job. I'm going to be keeping my private practice but will be switching from assessment to telehealth therapy and having an independent contractor who's staying here and doing assessment. In making that transition I was emailing all of my contacts in the community letting them know that I was leaving and introducing this independent contractor who's going to be taking over for me. It was an interesting experience reaching out to all of these agencies in the community, individual therapists and people, and seeing all at once "here are the connections that I've made in the community, the people that I know." It hit home to me that regardless of your practice model, you can have in mind this business piece and at the same time form these really strong relationships with your community, making partners, becoming a trusted resource. I think I've experienced that more in private practice than working at an organization because I can go out as the individual practitioner and form these personal relationships on behalf of my practice and not necessarily just under the umbrella of a group.

Marcy: And thinking about how that aligns with values as well. Having the opportunity to respond to something in the community as it might occur, whether that's a tragic loss in the school, or a need for training, being able to step into some of those roles and having relationships with community partners that might tap you as somebody who could provide that service. It's sometimes as gratifying to be working outside the four walls of this office as it is to be sitting on the couch here.



FEATURE

Suicidal Behavior Among Psychologists: Prevalence, Drivers, and Recommended Action Steps

Samuel Knapp, EdD, ABPP

Jeff Sternlieb, PhD

Sandy Kornblith, PhD



Suicide is a serious threat to public health, and healthcare professionals, including psychologists, are not immune to it. Few experiences are as shocking to psychologists as learning that one of their colleagues has died from suicide. The experience often leaves their patients feeling bewildered or traumatized (Kleespies et al., 2011).

This article reviews the prevalence of suicide and suicidal behavior among psychologists, identifies potential drivers of suicidal behavior, and recommends steps to reduce the risk of suicide among psychologists.

Prevalence of Suicidal Behavior Among Psychologists

Using data from the National Violence Death Reporting System, Li et al. (2022) found that American psychologists had the fourth-highest rates of suicide among studied healthcare professionals, following psychiatrists, non-psychiatric physicians, and dentists. The rate of suicide among psychologists is 16 suicides per 100,000, compared to 14 suicides per 100,000 among the population in general (Wang et al., 2020).

Consistent with findings from the study of suicides in the general public, Li et al. (2022) found that male psychologists

were more likely to die from suicide than female psychologists. Also, psychology-suicide decedents were older with an average age of 53 years old, and female psychologists had more previous suicide attempts than male psychologists. Finally, more than 60% of the suicide decedents were either divorced, widowed, or never married, consistent with findings that being married reduces the risk of suicide (Li et al., 2022)

The data from Li et al. is similar in many ways to the findings of Dalum et al. (2024), who studied suicides among health care professionals in Norway, where psychologists had rates of suicide higher than what would be found in the general population, but lower than the rate of suicides among physicians, veterinarians, and pharmacists. The reasons for the lower rate of suicide among psychologists are not known. However, the population of psychologists in Norway is more likely to include more young women (who have lower rates of suicide) and who do not have easy access to medications as a means of suicide, compared to professionals who can legally prescribe medications.

The authors could not find recent studies on the prevalence of suicidal thoughts among psychologists. Nonetheless, a 2010 survey of members of the American Psychological Association found that 18% of psychologists had suicidal thoughts at some time in their lives (American Psychological Association,

continued on page 38

2010, cited in Kleespies et al., 2011). Among the population in general, the lifetime prevalence of suicidal thoughts is almost 16% (Nock et al., 2008).

Even though most people with suicidal thoughts do not attempt suicide, the presence of suicidal thoughts suggests that a person is in psychological pain and could benefit from therapeutic interventions (Jobs & Joiner, 2019). Therefore, our scope of concern deals not only with the less than 1% of psychologists who die from suicide, but also with the larger percentage of psychologists who have thoughts of suicide, or have a risk of developing suicidal thoughts, even though they do not attempt suicide.

Factors Related to Suicides

In exploring why psychologists die from suicide, we take a two-factor approach, considering the factors influencing suicides among the population in general as well as the unique factors among psychologists. Of course, every person with suicidal thoughts has a unique life history and experience, although knowing the commonalities may help guide effective interventions.

Factors Related to Suicidal Distress in the General Population

Among the population in general, the external circumstances related to a risk of suicide include lower income, less education, less access to health care, less social support, a recent loss or stress, strains in close relationships, gender (men die from suicide more commonly than women), age (risk of suicide increases with age), and exposure to human suffering from witnessing, perpetrating, or being a victim of violence, injury, or disease (O'Connor, 2021). Among the population in general, the internal states related to suicide include perceived burdensomeness (e.g., a belief that others would be better off if I were dead), en-

trapment (e.g., a belief that one's life is intolerable and that there is no end to the suffering), ruminations (e.g., repetitive, unwanted negative thoughts), and self-devaluing thoughts such as shame or perfectionism (O'Connor, 2021).

Factors Related to Suicidal Distress Among Psychologists

The same factors that lead to suicide among the population in general should also apply to psychologists. Nonetheless, psychologists may have unique life circumstances or characteristics that could exacerbate or mitigate the risk of suicide. Some of the external circumstances of psychologists suggest that they should have lower rates of suicide than the population in general. For example, their incomes are higher than those of most Americans and therefore, are more likely to have health insurance when they need treatment. Also, because of their training, psychologists presumably know more about suicide, its antecedents, and ways to prevent it. Nonetheless, when people enter an acute suicidal state, their emotions can easily override more rational processes. Furthermore, the training of psychologists may give them a false sense of exceptionalism or a mistaken belief that their education makes them immune to mental illnesses or suicidal thoughts.

Other circumstances in the lives of psychologists should suggest that they will have a higher risk of suicide than the population in general. For example, a psychologist's work can be grueling. It could mean working with difficult patients, experiencing stalking, cyberstalking, assaults, or threatened assaults on patients, patient suicides, therapy-interfering behaviors, exposure to trauma, and the difficulty of dealing with emotionally distressed people. Working in institutions can bring challenges, but working in an inde-

continued on page 39

pendent practice can be lonely and isolating (Yang & Hayes, 2020).

Approximately 36% of psychologists reported feeling burned out in 2023 (APA, 2023). Although we found no studies linking burnout or occupational stress to suicidality among psychologists, such a link has been found with other health-care professionals. For example, Okon et al. (2025) found that, among mental health workers, greater compassion fatigue was associated with an increased risk of having suicidal ideation, suicide planning, and suicide attempts.

Addressing the Risk of Suicide Among Psychologists: It is More Than Just an Individual Responsibility

Addressing the risk of suicide among psychologists means addressing their risk of burnout and distress. Although it is important to have services available for those psychologists who struggle with suicidal ideation, focusing only on a few at high risk gives the impression that there is something wrong or different with psychologists who need help with self-care. Instead, it is equally, or perhaps more important, to create an atmosphere or culture within psychology that promotes the well-being of all psychologists by encouraging self-reflection, the use of self-care strategies, and building relationships with others. This requires a multifaceted approach involving training programs, professional associations, hospitals, outpatient agencies, and other employers, as well as individual psychologists, recognizing that no single program or intervention will be equally helpful for everyone.

Training Programs

Training programs can be places where psychologists develop work habits and attitudes that endure throughout their careers. Graduate programs can incorporate self-care into the curriculum and strive to foster a supportive culture for

students. The curriculum can address students' symptoms of distress and career challenges, as well as myths about self-care among psychologists (e.g., the myth of professional exceptionalism). Graduate programs and internships can encourage students to adopt a mindful approach to their work, engage in productive self-doubt, set appropriate boundaries with patients, value close connections with their co-workers, and be aware of the harm that could come from unproductive schemas. Schemas such as perfectionism or relentless self-sacrifice may be inadvertently endorsed or rewarded in graduate training. However, they may put students at risk of burning out later in their careers. High standards, without self-compassion, can lead to burnout.

Graduate programs and internships should be prepared to support students who are struggling with self-care issues, such as those who experience stressful or traumatic events or conflicts during practicum or internship placements. This could include, for example, shame-free analysis of adverse events (such as the attempted suicide of a patient) or offering mentoring to students who are struggling with self-care issues. They can help students normalize self-reflection by discussing their concerns, focusing on remedying mistakes or shortcomings rather than demonizing them.

Professional Associations and Institutions

Professional associations can establish active psychology wellness committees that provide education on self-care and resources for members. They can also offer interactive continuing education programs designed to promote well-being and self-reflection, as well as provide other forums for psychologists to meet and build relationships. They can provide experiences such as consultation services on self-care, ethical, or

continued on page 40

practical issues, which may reduce worry or distress among psychologists.

Institutions that employ psychologists need to move beyond the notion that self-care is entirely a personal responsibility. An ironic situation could arise when an institution offers yoga or meditation classes to help its employees manage stress, yet maintains institutional policies on sick leave, workload, or administrative responsibilities that lead to fatigue, demoralization, and burnout. Institutional demands to provide care at a level of service beyond the psychotherapists' abilities or resources need to be discussed in a safe forum where, if possible, they could decline to offer the services.

Individual Psychologists

Just as the stressors facing every psychologist are unique, so too are the activities or therapeutic interventions to promote well-being, which can vary from person to person depending on their life circumstances, personal histories, preferences, and career stage (Norcross & VandenBos, 2018). Nonetheless, self-reflective and social support-building activities appear to be especially important (Riccio & Fisher, 2025).

Individual psychologists can look out for themselves and one another by creating support groups and embedding themselves within a competence constellation focused on promoting their own and others' well-being (Johnson et al., 2012). These groups can help them construct self-care strategies as part of their daily routines, thereby supporting work-life balance. They can foster a willingness to set appropriate boundaries with patients and others. Psychologists can expand the concept of self-care to include any activity that alleviates stress or promotes well-being. This could include, if appropriate, therapeutic risk management skills, com-

petence in handling patients with therapy-interfering behaviors, and learning good ethical decision-making strategies when handling difficult situations, such as conflicts with agencies.

Recommendations

Addressing the issue of suicide among psychologists requires more than just providing services for those in imminent distress. It also means challenging the current professional culture that discourages psychologists from recognizing their pain and vulnerabilities and engaging in productive self-reflection. Training programs, professional associations, and individual psychologists can take steps to address this toxic aspect of professional culture.

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continued on page 41

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When Distress Is Collective: Implications for Clinical Training and Supervision

Bahareh Sahebi, PsyD, LMFT



Over the past several years, a recurring pattern has emerged in clinical consultation and supervision among therapists working with clients from diaspora communities affected by war, political repression, migration, and ongoing sociopolitical instability. Many of these clients are not responding primarily to past trauma in the conventional sense. They are responding to circumstances that are still actively unfolding. They are waking up each morning to messages from family members living in war zones, under authoritarian governments, or in environments shaped by unpredictability, fear, and chronic threat. Some are monitoring internet shut-downs to determine whether loved ones are still reachable. Others are watching videos of political violence unfolding in cities where their parents, siblings, or childhood friends still live.

For many, even ordinary aspects of family life such as obtaining medication, attending school, purchasing food, or communicating safely with loved ones become increasingly uncertain under conditions of war, repression, economic collapse, or internet disruption. Many are living in prolonged states of suspended anticipation, waking each day unsure whether loved ones remain reachable, safe, arrested, displaced, or alive. The nervous system is not reacting to a completed event but to an environment that continues generating fear, uncertainty, grief, and helplessness day after day (Herman, 1992; Miller & Rasmussen, 2010).

Therapists often attempt to conceptualize these experiences primarily through intrapsychic or individually focused frameworks, quickly moving toward emotional regulation, grounding, cognitive distortions, or media boundaries. While these interventions may help, they can also narrow the frame of the problem by locating distress primarily within the individual rather than within the larger relational and political systems shaping the client's emotional world.

The Training Gap in Contemporary Psychotherapy

Most therapists are trained within models that prioritize the individual as the primary unit of distress (Pinsof et al., 2018; Engel, 1977). Clinical training programs often emphasize diagnosis, symptom reduction, emotional regulation, cognitive restructuring, attachment history, and intrapsychic functioning. In supervision, therapists can often feel clinically disoriented when working with clients whose suffering is being generated and maintained by chronic sociopolitical realities rather than by discrete past events.

Clients may present with anxiety, hypervigilance, emotional exhaustion, compulsive monitoring of the news, difficulty sleeping, or chronic dread. Yet unlike many traditional trauma presentations, the threat is often not over (Herman, 1992; Miller & Rasmussen, 2010). For some clients, the nervous system never fully stands down because the conditions generating the fear remain unresolved and continuously evolving.

continued on page 43

Clients may spend hours monitoring encrypted messaging platforms waiting for confirmation that loved ones are still alive during political unrest or internet shutdowns. Others may carry financial and emotional responsibility for family members living within collapsing economies or active instability (Miller & Rasmussen, 2010).

Without a wider clinical lens, these experiences can easily become overpathologized. Hypervigilance may be conceptualized solely as anxiety (Summerfield, 1999). Repeated checking behaviors may be viewed only as dysregulation or compulsivity. Difficulty disengaging from traumatic information may be framed primarily as poor boundaries or emotional overinvolvement. While these interpretations may contain elements of truth, they can unintentionally obscure the larger systems actively generating and maintaining distress.

One of the most meaningful shifts that can occur in consultation is helping therapists move from asking, “What is wrong within this person?” to also asking, “What systems is this person currently trying to survive, manage, remain connected to, or emotionally metabolize?” Clients who initially experience themselves as “too anxious” or “unable to cope” often feel differently once their distress is understood within the context of ongoing relational and political realities. The goal is not to romanticize suffering, but to help therapists differentiate pathology from adaptation to chronically abnormal conditions.

For some clients, current geopolitical crises may also reactivate earlier histories of migration, displacement, political persecution, exile, war, or unresolved family grief carried across generations. In these situations, present-day fear is not experienced only in the present

tense. Persistent instability may reopen older experiences of ambiguous loss (Boss, 2006), interrupted mourning, family silence, or inherited anticipatory fear that had never been fully metabolized psychologically or relationally.

Despite growing attention to sociopolitical and collective sources of distress, many therapists may receive relatively limited training in conceptualizing distress across political, collective, and transnational systems (Comas-Díaz et al., 2019; Neville et al., 2024). Traditional multicultural training often focuses appropriately on identity and culture, but may spend less time addressing the psychological effects of political violence, authoritarianism, forced migration, chronic surveillance, or continuous digital exposure to collective trauma (Falender & Shafranske, 2004; Hook et al., 2013).

In supervision, this narrowing often becomes visible in subtle ways. Therapists may focus heavily on helping clients disengage from news exposure without fully exploring what remaining informed emotionally represents within the client’s family or cultural system. Others may encourage grounding strategies without sufficiently acknowledging that aspects of the client’s fear are connected to realistic rather than imagined threat.

Some clinicians may unintentionally interpret ongoing preoccupation with events abroad as evidence of enmeshment or poor individuation without adequately appreciating the moral, relational, and cultural responsibilities many clients experience toward family and community members living under threat. These moments are rarely about lack of empathy. More often, they reflect limitations in training models that were not designed for a world in which many clients now

continued on page 44

live psychologically across borders, political systems, digital networks, and prolonged collective crises simultaneously.

Expanding Case Conceptualization in Supervision

A meaningful shift supervision can offer therapists working with collective and transnational trauma is expanding the level at which cases are conceptualized. Rather than locating distress exclusively within the individual, supervision can help clinicians begin mapping the multiple systems simultaneously shaping the client's emotional experience (Bronfenbrenner, 1979). What first appears as generalized anxiety may look very different when understood within the context of political violence, migration history, family responsibility across borders, identity disruption, and ongoing uncertainty regarding loved ones' safety.

For example, a therapist may initially describe a client as "emotionally flooded" or "overly consumed" by events happening in another country. But once supervision begins exploring the larger context, the picture often becomes more complex. The client may be the primary English-speaking family member responsible for translating information, navigating immigration systems, sending money abroad, communicating with frightened relatives, or monitoring whether family members remain reachable during internet shutdowns or military escalation. What first looked like an individual symptom may in fact be embedded within an active relational and survival system extending across borders.

A framework such as Integrative Systemic Therapy (IST) offers supervisors a metaframework for understanding client difficulties within a dynamic web of interacting biological, psychological, relational, and broader sociocultural systems rather than locating distress

solely within the individual (Pinsof et al., 2018; Russell et al., 2022). This broader lens can help clinicians move beyond exclusively individual-level formulations when working with clients affected by collective and transnational trauma. From an IST perspective, collective and transnational trauma are not viewed merely as contextual stressors that influence an otherwise intact individual, but as forces that can shape functioning across multiple levels of human experience simultaneously. Prolonged exposure to authoritarian systems, political instability, forced migration, chronic surveillance, war, or collective threat may influence emotional well-being while also reorganizing relational processes, family dynamics, identity development, meaning making, and patterns of adaptation across interconnected systems.

Over time, these environments may shape how people monitor danger, regulate emotion, trust others, organize family roles, and make meaning of their experiences. What appears intrapsychic may instead reflect adaptations emerging within broader relational and political systems. From a supervisory perspective, systemic frameworks help therapists move beyond understanding collective trauma as background "context" and toward recognizing how these broader environments may actively shape the architecture of psychological and relational functioning itself. This approach does not require therapists to become geopolitical experts, but rather more contextually aware of the broader systems shaping the client's emotional world.

Therapist Reactions, Positionality, and Supervisory Blind Spots

Some therapists may feel overwhelmed by the scale of suffering clients describe and unconsciously shift too quickly to

continued on page 45

ward symptom management or emotional containment. Others may move prematurely toward reassurance, grounding, or cognitive reframing in an effort to reduce helplessness in the room. Still others may become overly identified with the client's experience and struggle to maintain emotional boundaries or clinical clarity.

These reactions are understandable. Collective trauma often places therapists in contact with forms of suffering that do not resolve neatly within the structure of weekly psychotherapy. Unlike many traditional trauma models where the traumatic event has already occurred, clients affected by war, political violence, authoritarian repression, or prolonged instability may continue living inside active uncertainty throughout treatment (Herman, 1992; Miller & Rasmussen, 2010).

There are moments when therapists may feel pulled toward trying to emotionally "solve" conditions that are fundamentally larger than the therapy itself. Clients may also experience profound isolation when the realities shaping their distress feel psychologically invisible within the broader societies in which they now live. In some cases, therapists may themselves begin experiencing a growing sense of helplessness, emotional exhaustion, or even anticipatory dread as they repeatedly sit with suffering connected to conditions they cannot meaningfully change within the therapy itself.

Supervision can help create space to think about these reactions without shame or defensiveness (Bernard & Goodyear, 2019; Falender & Shafranske, 2004). A recurring therapist-client dynamic that often emerges for discussion in supervision is the therapist's understandable pull toward restoring safety and regulation before fully recognizing the extent to which the client's distress

may be rooted in genuinely unsafe or unpredictable external conditions. In these moments, therapists may unintentionally locate the problem primarily within the client's nervous system rather than also within the conditions surrounding them. This is rarely about lack of care. More often, therapists are trying to apply clinical models built primarily around individual stress and psychopathology to situations involving ongoing collective and sociopolitical threat.

At times, therapists may inadvertently interpret adaptive survival strategies through overly pathologizing lenses. Hypervigilance may be understood solely as dysregulation rather than as a nervous system adapting to environments where danger has historically been unpredictable or difficult to anticipate. Emotional preoccupation with political events may be viewed primarily as poor boundaries rather than as evidence of ongoing relational and moral attachment to loved ones living under threat.

During one supervision consultation, a therapist described growing frustration that a client continued checking encrypted messaging platforms late into the night despite repeated conversations about sleep hygiene, anxiety management, and reducing compulsive monitoring behaviors. As the consultation unfolded, it became clearer that the client's brother had recently disappeared during political unrest, and periods of internet shutdown often preceded mass arrests in the region where the family lived. What initially appeared as compulsive checking behavior began to look different once placed within the context of ongoing uncertainty, fear, and relational responsibility.

Behaviors initially understood primarily as dysregulation or poor boundaries may begin to make more sense once the

continued on page 46

broader systems organizing the client's emotional world become visible. Supervision can also help therapists examine how their own social and political location shapes clinical assumptions. Therapists who have lived primarily within stable democratic systems may unconsciously underestimate the psychological impact of chronic surveillance, censorship, state violence, or the experience of living with limited institutional trust (Hook et al., 2013; Sue & Sue, 2016). Concepts such as safety, agency, autonomy, and self-expression may carry very different meanings for clients whose lives have been shaped by authoritarian systems or political instability. Digital communication has also altered the psychological experience of collective trauma itself. Geographical distance no longer necessarily creates emotional distance from war, repression, political violence, or collective fear.

Furthermore, this work also requires therapists and supervisors to become more informed about the political and sociocultural realities shaping the lives of the populations they serve. As migration and digital communication collapse geographical distance, clients are often psychologically impacted by wars, authoritarian systems, economic collapse, and collective crises occurring far beyond the countries in which they physically reside. At the same time, algorithmically shaped media environments can leave therapists unfamiliar with large-scale humanitarian realities profoundly affecting the clients sitting across from them.

Supervision can play an important role in helping therapists recognize these gaps with curiosity rather than defensiveness. The goal is not for therapists to become political analysts or foreign policy experts, but to develop enough contextual awareness to more fully understand the environments, fears, losses, and rela-

tional realities clients may be psychologically navigating across borders.

Supervision becomes especially important in helping therapists differentiate between distress that is disproportionate to present conditions and distress that remains connected to active, unresolved realities. Without this distinction, there is a risk that therapy unintentionally communicates that the client's suffering exists mainly because of inadequate coping rather than because they are attempting to psychologically navigate genuinely destabilizing conditions.

Another supervisory goal involves helping therapists tolerate complexity without collapsing into ideological certainty themselves. Clients affected by collective trauma may hold deeply conflicting emotions simultaneously. A client may feel fear of war while also feeling hatred toward an authoritarian regime. They may feel relief at political disruption while simultaneously grieving civilian suffering. They may feel emotionally exhausted by political engagement while also feeling unable to disengage from it. Supervision can help therapists resist the urge to prematurely simplify these tensions into more emotionally manageable narratives.

Practical Supervision Strategies

As more therapists begin working with clients affected by collective trauma, migration, political violence, and transnational family stress, supervision may need to become more intentional in helping clinicians expand beyond exclusively individual models of distress. This does not require abandoning traditional clinical frameworks but rather widening the lens through which suffering is understood. Supervision may require slowing down the impulse to immediately organize distress into familiar diagnostic categories before sufficiently

continued on page 47

exploring the broader systems shaping the client's experience (Falender & Shafranske, 2004).

The supervisory challenges created by collective and transnational trauma are not entirely unprecedented. During the COVID-19 pandemic, supervision models rapidly expanded to address new clinical realities and modes of practice (Sahebi, 2020). Today's sociopolitical and transnational stressors may require a similar expansion in how supervisors conceptualize distress, context, and adaptation.

Supervision may involve shifting from "What symptoms is the client experiencing?" toward "What conditions is the client psychologically navigating?" That shift alone can change the feel of the therapy. Many clients are simultaneously navigating fear for loved ones abroad, migration-related strain, financial responsibility toward family members, and continuous exposure to traumatic information. Holding these layers together often reduces premature pathologizing, particularly when behaviors such as compulsive monitoring reflect not only anxiety, but also attachment, vigilance, responsibility, or attempts to maintain connection during crisis.

Another important supervisory task involves helping therapists differentiate realistic from symbolic threat. In situations involving war, political repression, or family members living in dangerous environments, aspects of the feared outcome may be objectively possible rather than distorted (Miller & Rasmussen, 2010). Without this distinction, therapy can unintentionally invalidate the client's reality.

In practical terms, supervision may include questions such as:

- Which aspects of the client's fear are realistic, historical, symbolic, or trauma-amplified?
- How does ongoing connection to family or community abroad shape the client's emotional functioning?
- What cultural meanings are attached to staying informed, remaining engaged, or emotionally witnessing suffering?
- What might be lost emotionally or relationally if the client disengages completely?
- How might the therapist's own assumptions about safety, autonomy, or control be shaping conceptualization?
- Are there ways the therapist may be unintentionally individualizing what is also systemic suffering?
- What interventions help regulate the nervous system without invalidating the broader reality the client is living within?

Conversations like these help therapists move beyond rigid either-or conceptualizations. Some clients need grounding. Others need permission to remain emotionally connected to collective grief, fear, or responsibility toward people they love.

Practical Clinical Considerations in the Therapy Room

One important shift involves differentiating between realistic and symbolic threat before moving too quickly toward cognitive restructuring or anxiety reduction interventions. In some cases, clients are not catastrophizing. They are attempting to emotionally function while people they love remain in objectively unstable or dangerous environments. Premature reassurance can unintentionally leave clients feeling psychologically

continued on page 48

unseen or emotionally alone in the reality they are carrying.

Therapists may also need to assess how exposure to traumatic material is functioning emotionally and relationally before focusing exclusively on behavioral reduction. For some clients, continuously monitoring news or events abroad may represent not only dysregulation, but also attachment, responsibility, vigilance, or attempts to maintain emotional proximity to loved ones during crisis.

Chronic immersion in traumatic information can contribute to nervous system activation, emotional exhaustion, sleep disruption, and diminished functioning (Holman et al., 2014; Silver et al., 2013). Therapists may help clients develop more sustainable ways of remaining informed while protecting psychological functioning through intentional media boundaries, restorative practices, supportive relationships, and differentiating meaningful connection from compulsive overexposure. Some clients may also carry profound guilt related to geographic safety, struggling with the emotional dissonance of remaining physically secure while loved ones continue living within danger, repression, or instability abroad.

Therapists may also need to become more comfortable naming sociopolitical realities directly when those realities are central to the client's distress. In some cases, clients experience profound relief when therapists demonstrate enough contextual understanding to recognize that the suffering being described is not occurring solely inside the individual psyche, but within broader systems of instability, repression, displacement, or ongoing threat. In many situations, excessive therapeutic neutrality around active political violence or authoritarian threat may itself become experienced by

clients as a form of emotional distancing or contextual minimization.

Conclusion

As collective trauma, migration, political instability, and transnational family systems increasingly shape the realities clients bring into therapy, supervision and training may need to evolve alongside these changes. Many clients are attempting to psychologically function within environments marked by uncertainty, collective grief, chronic threat, and ongoing relational responsibility that extend far beyond the individual alone.

Expanding systemic conceptualization does not mean abandoning clinical intervention. Clients may still benefit from grounding, emotional regulation, and trauma-informed care. However, these interventions often become more effective when therapists are also able to recognize the broader systems shaping the client's emotional world. At its core, this work asks therapists to think differently about distress. Not all suffering originates solely from dysfunction within the individual. Sometimes distress reflects adaptation to environments that are unstable, dangerous, unresolved, or collectively traumatized. Helping therapists recognize that distinction may become an increasingly important part of contemporary clinical supervision.

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“We’re Gonna Sit And Grin And Tell Our Grandchildren ‘Bout The Time I Called This Guy. It Was Four In The Morning”

Pat DeLeon, PhD



The National Academy of Medicine (NAM):

Reflections by Victor Dzau, having served 12 years as President of NAM: “When I arrived in 2014 at what was then

called the Institute of Medicine, the organization had reached a long-awaited crossroads. Within a year, we became an independent Academy alongside the National Academy of Sciences and the National Academy of Engineering. We navigated the challenges of a complex transition, developed a new organization, and established a stronger leadership platform for health and medicine within the National Academies organization [NASEM].

In the years that followed, we transformed what it means for an Academy to serve. We pioneered new models for collective and global impact—including Action Collaboratives, International Commissions, Grand Challenges, and more. We focused on catalyzing change at the systems level and improving outcomes at the highest possible scale—confronting monumental challenges like the health impacts of climate change, the needs of an aging world population, global pandemics, and the crisis of substance use, to name a few. We maintained a steady focus on improving the performance of the US health system, including by supporting the wellbeing of its workforce. And amid historic breakthroughs in science and technology, we built essential policy scaffolds to ensure equitable and responsible implementation.

We have navigated extraordinary challenges. During the COVID-19 pandemic, we mobilized expertise, informed public understanding, and advanced solutions at a time of profound uncertainty. We navigated daunting societal challenges including firearm violence, racism, and access to reproductive health care. Through innovative communications and partnerships, we tackled the challenges of infodemics and the spread of inaccurate information and worked to strengthen trust in science and evidence. Amid significant political and financial pressures for research and public health, we have consistently spoken up for science, evidence-based policy making, and the broad societal benefits of sustained investment in biomedical and health research. We have never strayed from our commitment to health equity and our conviction that advancements in science, medicine, and health must be made accessible to all.

Perhaps most importantly, we have invested in the future. Through the Emerging Leaders in Health and Medicine program, established in 2016, and new and innovative fellowship models, including at the state and international level, we are cultivating a new generation of leaders who will carry our mission forward. [Subsequently, the NAM Council affirmed that those selected for the program will henceforth be known as “Victor J. Dzau Emerging Leaders in Health and Medicine Scholars.” And, over \$5 million has already been in-

continued on page 51

vested in a quasi-endowment to provide enduring support.]

As I look ahead, I am convinced that the need for the trusted leadership, independent expertise, and evidence-based guidance provided by our Academy—and the broader National Academies organization—has never been greater. We are operating in a period of profound change and growing complexity. Public trust in institutions can no longer be taken for granted, while misinformation and disinformation spread at unprecedented speed and scale. Scientific and health priorities are increasingly shaped by political, social, economic, and cultural forces, often complicating the path from evidence to action. At the same time, transformative advances in artificial intelligence, biotechnology, and data science are reshaping nearly every aspect of society, creating extraordinary opportunities alongside significant ethical, societal, and security considerations.

In this context, we must ask ourselves several fundamental questions: How do we maintain independence and credibility? How do we demonstrate value in a more skeptical and divided society? How do we ensure that scientific and technological advances improve lives broadly rather than deepen disparities? And how do we continue to earn the trust of the communities we seek to serve?

In tackling these questions, several priorities will be especially important, but above all else, the Academy must remain a champion and leader for scientific integrity, evidence, and health equity. In so doing, it will be important to strengthen our ability to communicate clearly, rapidly, and effectively across a changing media and information landscape. We must continue to cultivate diverse, engaged, and forward-looking leadership among our members, fellows, scholars, and staff. We should continue to guide

the development of emerging technologies and ensure that innovation advances the public good. And we should remain not only a national organization, but also a globally minded one prepared to address challenges that cross disciplines, sectors, and borders.

For decades, we have used this quote from Goethe in the frontmatter of our reports: ‘Knowing is not enough; we must apply. Willing is not enough; we must do.’ I trust that the NAM will continue to demonstrate not only that we produce rigorous, evidence-based guidance, but also that our work drives meaningful impact across policy, practice, and population health.†

The 2026 APA Psychologists in Politics

Events: For those interested in the public policy/ political process, this engaging virtual initiative, hosted by the Psychology PAC, spotlights colleagues who have made their mark in public service. The first of the 2026 series highlighted Representative Judy Chu (CA-28), who is currently the only psychologist serving in Congress. A graduate of CSPP (now Alliant University, as attested by attendee and fellow graduate Elaine Rodino), she is the first Chinese American woman ever elected to Congress and serves as a senior member of the House Ways and Means Committee, which is extremely important for a wide range of health care issues. She chairs the Congressional Asian Pacific American caucus advocating for the Asian American, Native Hawaiian and Pacific Islander community across our nation. Representative Chu is a long-time champion of psychology and has been recognized by APA and APA Services for her leadership.

Moderated by Stephen Gillaspay and CEO Arthur Evans, our colleague made it very clear that those concerned about the availability of quality mental health care

continued on page 52

for our nation should personally get involved and make their voice and underlying values heard (including addressing Diversity, Equity, and Inclusion)—especially during this Administration. An excellent first step would be to actively join an organization representing one's views and collaborating with colleagues who are equally concerned. She described a number of her successful legislative efforts, including those generating bipartisan and bicameral support. In response to Arthur's question, she concurred that her foundational psychology training was extremely relevant to the public policy process, especially learning how to really *live with and hear* what her constituents were saying, i.e., possessing emotional intelligence.

Graduate Psychology Education: During its deliberations on the Fiscal Year 2027 Appropriations legislation for the Department of Health and Human Services, the House Appropriations Committee again recommended \$25 million for the Graduate Psychology Education program. The interprofessional Graduate Psychology Education program increases the number of health service psychologists trained to provide integrated services to high-need, underserved populations in rural and urban communities. The Committee notes data from CDC demonstrating a rise in mental health issues for youth and adolescents and urges HRSA to strengthen investments in the training of health service psychologists to help address this population. This visionary initiative was the brainchild of former acting APA CEO and health psychologist Cynthia Belar and remains a very high legislative priority for APA.

Digital Tools For Youth Mental Health: In June, the APA joined with the American Academy of Pediatrics, the Children's Hospital Association, and the De-

partment of Health and Human Services as sponsors to the NASEM Forum for Children's Well-Being Leadership Summit *Defining Quality Together: Youth, Parent & Practitioner Perspectives on Digital Mental Health Tools*. The workshop (with APA's Vaile Wright actively participating) examined how to collaboratively develop quality measurement standards, assess the safety and efficacy of these tools, apply clinical and ethical considerations essential to responsible deployment, create sustainable financing models, and address implementation challenges. Building on an initial November 2025 workshop focused on youth mental health, the participants dove more deeply into defining quality measurement and clinical standards for digital tools aimed at youth mental health, explored how digital mental health interventions can be developed through authentic youth and family partnership, and sought to establish rigorous quality standards and appropriate clinical safeguards.

The first workshop examined frameworks for youth co-creation of digital tools for youth mental health; quality measurement approaches that balance speed with rigor; methods for incorporating lived experience into design, evaluation, and validation; and the clinical and ethical considerations essential to responsible deployment. How should one measure quality outcomes across the continuum of digital interventions and the safety and efficacy of these tools, from self-help tools to therapy extenders to virtual care platforms that meet the needs of various interested parties including youth, families, clinicians, child and adolescent mental health specialists, funders, and health systems? What is the current evidence base for digital mental health interventions in youth

continued on page 53

populations, the ethical considerations of deploying tools with limited validation data, and the role of clinical oversight in ensuring safety and effectiveness? A future workshop will focus on scaling what works, examining sustainable financing mechanisms (e.g., reimbursement innovations, and system-level strategies) as well as the mechanics of scaling up effective digital mental health tools. The behavioral/ mental health world is clearly rapidly changing. We would ask: Will interested and concerned visionary clinicians, scientists, and educators become personally involved in a timely fashion?

Slow But Steady Progress Towards Licensure Mobility: Alex Siegel, Director of Professional Affairs, ASPPB: iJust to let you know that I have been proven wrong about New York. When asked, I

always said I do not believe NY would adopt PSYPACT. Well, PSYPACT is on the NY Governor’s desk to be signed into law. In talking to folks from NY, even though there is opposition, they believe the Governor will sign the bill. The only other profession in NY to be part of a compact is nursing. Recently bills also passed the legislature in Iowa and Louisiana. When these three become law, this will bring the total to 46 jurisdictions. I guess I need to quit talking or retire. We are now down to the *Sleepy Six*: California, Oregon, Guam, New Mexico, Puerto Rico, and the U.S. Virgin Islands.i iMakin’ the same mistakes, we swear we’ll never make againî (Jerry Jeff Walker. *Pissin’ in the Wind*).

Aloha,
Pat DeLeon, former APA President —
Division 29 — July, 2026





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Beyond Symptom Management: Existential/ Humanistic Treatment for Combat Veterans

Michael Pica, PsyD



One observation of military veterans who served in Beirut, Afghanistan, and Iraq is their presentation and experience of persistent hypervigilance, avoidance, emotional constriction, and transitional forms of disillusionment. These symptoms may be part of a larger trauma response and mask unresolved affective states that should be addressed as a regular component of treatment.

The recommended treatment guidelines for veterans are predominately skill-based and symptom-focused in the form of cognitive-behavioral, cognitive processing, prolonged exposure, and eye movement desensitization and reprocessing therapies (Schnurr et al., 2024). Existential and Humanistic approaches (Guigno et al., 2017; Krippner & Pitchford, 2018; Vachon et al., 2016) have commented on the importance of collaborating with veterans to sort out the meaning of their experiences and develop acceptance of how these experiences have shattered many fundamental assumptions of their existence. Using deidentified and altered case examples, this article hopes to enlighten clinicians to the complexities and benefits that can arise when working beyond symptom management into the emotional and existential concerns that drive symptomatic behavior.

A Case of Persistent Hypervigilance

J served two duties in Afghanistan. He recalled not being sure of what he was getting into at the time and described a

lack of organization upon deployment with missions seeming to be conducted on the fly and with little preparation. His missions were primarily related to transportation. On two occasions, he was ambushed and attacked, then was significantly injured. Several of his troop members were mortally wounded.

Upon returning home, J was unable to feel a sense of ease in his daily life. He was distant from others at work, who nicknamed him “Mr. Serious.” At home, his need for safety and order led to obsessive routines which created tensions with his partner. He often felt she distorted his sense of reality and overreacted to her words and facial expressions. He started a bar fight after he thought a man was staring at and talking about him, which resulted in a battery arrest.

For J, the initial goal of treatment was to validate the experience of his service; unpredictable, mismanaged, and confusing. The focus became one of connecting his war trauma with active, real-world events. He slowly began to engage in grounding exercises and became more aware of his arousal levels by tuning into his body. Cognitive restructuring was used to challenge and correct the assumptions he was making about others, such as co-workers and his girlfriend.

What eventually surfaced was unresolved anger toward his military branch and the public. J reported feeling misled, taken advantage of, and misunderstood. He ultimately connected these feelings to an upbringing with an abusive, reality

continued on page 55

distorting parent. This childhood dynamic mirrored his experience in the service, which was exacerbated when he came home to civilians who did not understand what we went through. Civilians mirrored his classmates and family members, who also never understood what he went through at home. His foundational sense of self, he discovered, rested on feeling misunderstood. This became a driving force in his recovery.

A Case of Avoidance

B served in the second Iraq war. Like J, his service was confusing, the missions were not well-defined, and they were often wrought with danger and risk. In B's case, he was propelled to open fire and struggled with the knowledge of taking lives. Upon returning home, he found himself questioning his service and the hero status that was bestowed upon him. He did not want to talk to anyone about it, including his partner. Slowly, his life became one of going to work and doing basic home tasks before retreating to the basement for hours on end. He was reclusive at parties and sat far away from others at his child's sports games.

For B, his avoidance allowed him to manage his anxiety and the immense guilt he felt for his actions in service. In his mind, what he did was unforgivable and needed to make himself invisible. He felt like a fraud when people called him a hero. He unfairly compared himself to his father and grandfather who served in "real wars," which only perpetuated feelings of shame and inferiority that colored his childhood and foundational sense of self.

Sessions were focused on reframing his thinking about comparisons of war service and his struggle to accept the absence of purpose of his war service. With some relief and trust established, B began to process the events and feelings associated with his service roles and redefine

his lived-emotional-meaning. He began to set limits on isolating, and he started coaching his child's little league team. Spontaneity with his family was encouraged and he came to the realization that he did not owe any explanation for his service or his actions.

A Case of Emotional Constriction

M served in Beirut during a terrorist attack in the early 1980s. Upon returning home from service, M began exhibiting emotional constriction. Family members and co-workers described him as flat and unfriendly, which was significantly different from the warm and friendly person he had always been. For M, the flatness reflected a mistrust of others' intentions and served to keep him from getting angry in public, as he did not trust his ability to control it.

The author posited that M's emotional constriction served to psychologically shrink him and his feelings out of existence; the goal of which was to keep him from feeling vulnerable and keep feelings such as anger from becoming a problem. M's emotional constriction was consistent with a history of early childhood trauma by a violent and physically abusive parent. He learned to hide himself and constrict his emotions as a young boy. Similarities were noted between his childhood and military trauma responses which validated him and gave him clarity. Spatial referencing and bodily awareness exercises were implemented to facilitate a grounding and awareness of himself and his feelings which he began processing more frequently in session. He slowly worked on making himself more noticeable and expressive in safe places around safe people.

Transitional Disillusionment

As mentioned earlier, transitional disillusionment refers to an existential self-examination and questioning of others
continued on page 56

based on the subjective meaning veterans attach to their military service, how military service is portrayed by the media, and how they are received by the public upon returning home. Guigno et al. (2017) commented on the confusion and self-questioning that veterans experience when returning to civilian life. Quite often, there is a disconnect between what the veteran experienced, what has been portrayed by the media, and reactions from the public.

Take for example, the conflict in Beirut that occurred in the early 1980s. Beirut is an example of a military engagement that has been relatively ignored by the media and become less commonly known to the public. Beirut veterans, such as M, have reported feeling invisible upon their return from service and question whether it was equal to others who served in more formally recognized wars.

The same can be said for those who served in Bosnia, an extremely dangerous conflict of which many people remain unaware. Veterans who served in the second Iraq War, which revealed no weapons of mass destruction, have also questioned their service. Some have felt deceived into taking part in a war that as J once expressed, “meant nothing”. These mixed messages can make for complex feelings and existential questions about one’s service. This is exacerbated when the public responds with a simultaneous congratulatory, demeaning, or dismissive comments.

Managing transitional disillusionment requires opening a space to explore and reframe the most vulnerable thoughts and feelings that veterans resist sharing. Validation and normalization of these emotions, thoughts, and experiences can release some of the existential burden they carry.

A key to unlocking this material is paying close attention to more subtle entries into existential discussion; whether it is talking about being called a hero, people wanting to shake their hand at a party, or strangers wanting to thank them for their service. Engagement in these topics opens therapeutic windows. Though seemingly benign, they may have flooded the overly vigilant or emotionally constrictive veteran with a variety of unwanted thoughts and feelings. These examples provide opportunities to validate, explore, and begin the process of reorganizing and consolidating aspects of transitional disillusionment. Keep in mind that validation, a genuine curiosity, and appropriately timed humor go a long way when treating veterans providing the atmosphere needed to begin moving into more sensitive material.

Conclusion

Beyond nightmares and flashbacks, veterans return home with varying symptom presentations that include persistent hypervigilance, avoidance, emotional constriction, and struggles with transitional disillusionment. While symptom management has proven quite effective, it is important to consider the underlying emotional and existential concerns that drive symptomatic behavior. As evidenced in the cases described, pre-service psychological disruptions often play a role in the processing and manifestation of service-related trauma. For those returning home, the experiences can be complex and varying, that is, depending on the veterans’ missions and how they are portrayed by the media and received by the public. Paying close attention to what may seem a benign story may go a long way toward validating the veterans’ experiences and open the door to process more vulnerable unresolved vulnerable

continued on page 57

affective states that perpetuate symptomatic behavior and restore the veteran into a person-as-a-whole.

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Psychosocial Stage Theory as a Model for Treating Homeless Veterans

Michael Pica, PsyD



Erikson (1950) outlined eight stages of psychosocial development across the developmental lifespan. Within each stage arose a “crisis” that the individual needed to resolve before proceeding cleanly into the next. Unresolved resolution at any stage led to a psychological arrest that hindered the negotiation of the following stages: trust versus mistrust, autonomy versus shame, initiative versus guilt, industry versus inferiority, identity versus role confusion, intimacy versus isolation, generativity versus stagnation, and ego integrity versus despair. The first four stages are relative to infant, childhood, and adolescent development, while the last four are specific to adulthood.

Over 75 years later, psychosocial stage theory continues to be researched and cited in the literature and taught regularly in undergraduate and graduate programs (Maehler & Hernandez-Torano, 2025). However, Erikson’s theory has not been without its critics, who have pointed to limitations of conceptual stage models, his use of a naturalistic observational method, cross-cultural considerations, increases in marital infidelity, and generalizability to women (Cherry, 2025; Jung, 2019; Saachie, 2022; Sorell & Montgomery, 2009; Syed & Fish, 2018). In response to these and other contemporary developments, developmental theorists have expanded and refined aspects of Erikson’s framework by examining the impact of technology and social media (Cote, 2018) and the extension of adolescence into young adulthood (Kay, 2018). These revisions have

helped modernize Erikson’s (1950) conceptualization of identity development.

Homelessness Among Veterans

Nichter et al. (2023) reported that one in every 10 veterans has experienced homelessness post-service. They estimated that approximately 30,000+ homeless veterans seek nightly shelter. A recent analysis of the Ending Homeless Veteran’s Initiative Project revealed homelessness among veterans decreased by 55.3% compared to 8.6% among the general population during the same 16-year study period (O’Toole et al., 2024). The results point to the benefits of federal funding for housing homeless veterans and the need for continued attention and resources.

The Clinical Application of Psychosocial Theory

Orenstein and Kaur (2026) suggested that practitioners can use psychosocial theory to help clients work through difficult periods of adjustment. Karunarathna et al. (2024) pointed to the use of psychosocial theory as a conceptual guide to help clients work through significant life transitions, such as recovery from a psychotic break, trauma, substance abuse, or, for purposes of this paper, the treatment of homeless veterans.

Application of the Model to Homeless Veterans

What follows is a discussion of how the model can be applied to veterans participating in transitional housing and how therapy is adjusted to meet their evolving needs at each particular stage of development.

continued on page 59

Trust versus Mistrust

The initial stage of trust relates to the experience of becoming homeless after being enlisted in service. Veterans may feel the military and/or the veteran's administration system has created barriers that inhibit accessing consistent and effective services (Ein et al., 2024; Yok-Fong et al., 2025). This may result in a general skepticism of those who offer assistance, particularly in homeless or transitional living centers where veterans may have had prior negative experiences with mental health and social service providers.

Establishing a certain level of trust in the housing program is the first step toward effective treatment. The goal for the clinician is to build upon this foundation of safety and reliability to foster therapeutic engagement and connection. Trust may be difficult to establish as some veterans struggle to trust their own judgement, let alone that of a stranger. These challenges may be further amplified when veterans have experienced unresolved trauma before, during, or after military service.

A supportive, existential/humanistic approach may be most suited during the trust phase. The existential/humanistic perspective speaks to the development of a collaborative working relationship between the veteran and the therapist (Guigno et al., 2017). This makes the veteran an active participant in the process and may guard against treatment dropout (Wells, et al., 2022). The psychologist's role is to enter the veteran's unique lived experience, rather than imposing a predetermined therapeutic agenda on them. Central to this process is the psychologist's capacity to embody an empathic stance and to model emotion regulation, particularly for veterans who have served in combat. This creates a safe psychotherapeutic space to work through forms of

hypervigilance, avoidance, and resistance. Unresolved forms of trust create the basis for psychosocial maladjustment that carries into the next stages.

Autonomy versus Shame

The autonomy stage reflects a period in which veterans step from the basic structure of group home living and allow themselves to become vulnerable and open to opportunities including social service, individual, and supportive group psychotherapies. This is similar to the toddler stepping away from the primary caregivers to actively explore a new and uncertain world.

This is a big move for veterans who may have previously felt judged or misunderstood by a civilian therapist with no prior military experience. The therapist wants to avoid such pitfalls while promoting this vulnerable move to become active agents in their lives. At this stage, and in fact, at every stage of working with this vulnerable population, effort should be made to promote autonomous movement and guard against inadvertently shaming the veteran.

To avoid the potential for adverse interactions, clinicians should engage without drawing assumptions, let the veteran have a voice, recognize and respect the civilian/military differential, and seek consultation when needed during this vulnerable point in therapy.

Initiative versus Guilt

In this stage, the veteran begins taking more initiative in their therapies and tasks of daily living. This can be subjectively perceived as a series of small, successive wins (Orenstein & Kaur, 2026) that promote internalized feelings of self-efficacy. The current author refers to this period as the "I can do it" phase.

continued on page 60

As the veteran demonstrates greater initiative, the clinician may respond with a more active approach that matches the veteran's initiative. This might include the introduction of cognitive restructuring assignments, mindfulness exercises, and problem-solving training with a client who is now more actively working on themselves with a renewed sense of hope and vigor. Guilt may arise when veterans see others making the most of opportunities and realize they could have made more of the ones offered to them. The guilt may be related to squandering opportunities. Some may become motivated to seek out or re-engage in treatment and should be met with ongoing support and encouragement.

Industry versus Inferiority

In the stage of industry, the veteran is working actively within all aspects of the program. They are following through with appointments, job interviews, and potential long-term housing options, building more successive wins that lead to feelings of self-mastery and empowerment. Stated differently, the veteran is actively working toward independence.

The goal of the therapist is to keep the momentum of the industrious veteran who is engaged in the process of becoming. As veterans assume greater responsibility for their lives, treatment may focus on cultivating awareness of personal choice and self-agency. This includes exploring how past decisions may have contributed to negative outcomes previously attributed to external circumstances, while also recognizing the choices that have facilitated progress toward their current goals. Role plays may be used to practice interpersonal situations involving employment, veteran administration assessments, and the reintroduction of estranged loved ones into their lives.

The therapist must work hard to guard against activating feelings of inferiority by inadvertently setting the veteran up for failure. This can be accomplished by carefully assessing the veteran's cognitive and emotional capacity, current level of readiness, and need for appropriate scaffolded challenges that foster mastery rather than reinforce self-doubt. Feelings of inferiority may emerge among veterans who see others reaching their goals and question why they are not; perhaps questioning themselves in the process. Such feelings may be intensified by prior experiences including trauma, homelessness, institutional barriers, stigma, or repeated setbacks that have undermined their confidence in their own abilities. Consistent with Erikson's conceptualization, clinicians can address these individual contextual dynamics to help veterans cultivate industry.

Identity versus Role Confusion

The stage of identity describes the process of homeless veterans redefining their identities. The development of an emerging identity is significant as it has been linked to higher levels of intimacy, generativity, and integrity across adulthood (Mitchell et al., 2021).

Veterans begin the process of rediscovering their authentic selves, which have long been mired in "default" identities, defined here as inauthentic or foreclosed identities developed to please, impress, or gain acceptance from others. Obtaining and maintaining employment might spur an identity based on their roles at work, meaningful relationships, community involvement, and other forms of community integration that foster a stronger sense of purpose and self. Rather than viewing themselves solely through the lens of homelessness or military service, veterans can begin to culti-

continued on page 61

vate a more integrated and authentic identity grounded in their strengths, aspirations, and personal values.

The therapist's role is to facilitate identity development. This might include a deeper emotional or existential examination of identities that were imposed upon them or adopted throughout their lives before, during, and after military service. The therapist gently challenges the use of previously identified default selves that may have served a functional purpose at one point but have since limited or become harmful to growth and development.

The veteran is encouraged to get in touch with their strengths, challenge prior self-narratives, and settle into their authentic selves. They may speak to their default selves through two-chair, or empty chair work. They may write letters to their default selves. Reflection on their journey through homelessness may lead to a redefinition of their military service, from a homeless veteran to a proud veteran. Those who do not participate in redefining their identities remain stuck living in and replaying outdated narratives.

Intimacy versus Isolation

The intimacy phase represents the newly defined veteran finding intimacy and meaning in relationships with co-workers, case managers, peers, and therapists. They have become intimately involved as active participants in their own lives, becoming genuinely connected to who they are and to their treatment.

Veterans may begin processing more vulnerable emotional concerns related to early family dynamics, trauma experienced during military service, or a deeper dive into their subjective emotional experiences related to substance use or homelessness. Within treatment, the therapeutic relationship may serve as a corrective emotional experience

through which veterans learn to tolerate vulnerability, develop trust, and engage more authentically with others. Without the development of intimacy, veterans may withdraw from opportunities for connection and support. Such isolation may contribute to the reemergence of developmental struggles related to shame, guilt, self-doubt, or role confusion that had previously been managed or partially resolved.

Generativity versus Stagnation

The generative veteran is one who renegotiated the prior developmental stages in a way that resulted in feeling confident, fulfilled, and settled within themselves. Compared to their potentially stagnant counterparts, they become eager to take on the role of mentor to those earlier in the process of transitional living. When invited or asked to speak at meetings and conferences, they are eager to share their stories of success. Generativity may also be expressed through meaningful community integration, including volunteer work, advocacy efforts, employment, caregiving, family roles, or other meaningful contributions.

Therapy at this phase may have moved into a maintenance phase for the generative veteran. The therapist takes a more supportive role, available to provide accountability and reassurance to maintain the confidence and direction needed to maintain treatment gains.

In contrast, veterans who continue to struggle with feelings of guilt, inferiority, isolation, and limited intimacy may lack the confidence, motivation, or emotional wherewithal to assume such roles. Their road ahead may feel bleak and colored with pessimism and regret, while their counterparts emerge with a newfound sense of hope and meaning.

continued on page 62

Ego Integrity versus Despair

Generative veterans may then transition into living with a sense of ego integrity. They served. They became homeless. They overcame the most difficult of obstacles. They learned to trust, became autonomous, and took initiative. They worked industriously, redefined their identities, and now live in their authentic selves with intimate relations. Some achieved meaningful community integration by forming relationships with members of the community that facilitated their growth and development. For example, this may have occurred by volunteering at a veteran's 5K or working in the commissary. Many derive purpose from continuing to share their experiences with other veterans, mentoring peers, or contributing to their communities.

Ego integrity emerges as veterans develop the capacity to look back on their lives with acceptance, integrating both successes and failures into a coherent life narrative. Through this process, they may find meaning in suffering, develop compassion for themselves and others, and experience a sense of fulfillment despite life's imperfections. Therapy for veterans achieving ego integrity may be terminated or moved to maintenance as the veteran transitions to permanent housing.

In contrast, those who fall into despair may remain isolated, stagnant, and stuck in group home living. They may become preoccupied with regret, resentment, or perceived failures. Rather than integrating their experiences into a meaningful narrative, they may experience hopelessness, bitterness, social withdrawal, or a sense that their lives have lacked purpose or value.

Concluding Remarks

The paper outlined a model to conceptualize, facilitate, and foster internalized behavioral change and community integration embedded within psychosocial

stage theory. It starts with a basic establishment of trust within the veteran and between the veteran, the therapist, and the housing program. Once established, the opportunity to negotiate a path toward independence comes into reach. The role of the therapist was discussed, highlighting the unique challenge of meeting the needs of the evolving veteran as he, she, or they progress from homelessness to ego integrity.

There are a couple of final points to note. First, psychosocial stage theory is not as sequential as originally developed (Cherry, 2025). At any point, the individual can revisit and resolve prior unresolved crises (Mitchell et al., 2021). As events evolve across the life span, opportunities arise to revisit unresolved feelings of isolation, guilt, inferiority, or stagnation. For veterans, this means that opportunities for growth and development remain available throughout the lifespan. Even when developmental conflicts have not been fully resolved, future life experiences, relationships, and therapeutic interventions may provide renewed opportunities for reflection, growth, and integration.

Second, just as the psychosocial stages are not definitively sequential, neither is the treatment outlined in this model. At any point, the veteran may be working on themes related to any of the stages, and the therapist must remember to adjust to meet the veteran where he, she, or they are during any given moment in the process of psychotherapy.

Ultimately, the model provides a framework for understanding how veterans may progress from homelessness toward greater purpose, connection, and psychological well-being. Veterans who invest in this process transform from feeling hopeless, uncertain, and helpless to becoming autonomous, taking initia-

continued on page 39

tive, developing into their authentic selves, and achieving meaningful community integration with a sense of ego integrity. Working from Erikson's psychosocial stage theory, clinicians can anticipate and adjust their approach to the ever-changing demands of treatment. In this way, the model offers clinicians a framework for supporting veterans as they move from homelessness toward greater purpose, connection, and psychological well-being.

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continued on page 40

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The Double Identity Crisis in Transgender Adolescent Development

Michael Pica, PsyD



The literature on transgender youth has primarily focused on neuroscientific and biological, etiological factors (Ghiassi et al., 2024; Levin et al., 2022), violence and victimization (Lombardi et al., 2002; Norris & Orchowski, 2022), gender identity models (Boskey, 2014; Doyle, 2022; Katz-Wise et al., 2017; Pleak, 2009; Spencer et al., 2021), hormonal treatment (Chen et al., 2023; Graham, 2023), transgender sports and athletics (Oberlin, 2023), gender dysphoria (Steensma et al., 2013), and the prevalence of suicidality (Austin et al., 2022). The unique and complex process of concurrently negotiating personal and gender identity in adolescence is rarely researched. This dual identity understanding is coined by the author as the “double identity crisis.”

The concept evolved from working with young transgender adults about a year after the onset of the COVID-19 pandemic. Newer to treating this population, the author began to speculate about the developmental demands on transgender adolescents. The author was particularly interested in how identity development is addressed in this group of individuals, who may already be feeling ostracized by their families and peers.

The “double identity crisis” finds its roots in Marcia’s (1966) theory of identity status. His original theory has received considerable support as noted in a large-scale systematic review by Maehler and Hernandez-Torrano (2025).

Marcia (1966) described adolescents as being faced with the challenge of identi-

fying oneself independent from one’s primary caregivers. Adolescents respond with one of four choices: diffusion, moratorium, foreclosure, or achievement. How adolescents negotiate identity depends on one’s level of exploration and commitment. Whatever path an adolescent chooses may become consequential to the following stages of life span development. Take for example, a middle-aged client who foreclosed to being the “party guy” in high school and remained emotionally arrested for most of his adult life; devolving into an alienated and depressed individual who became dependent on alcohol.

Marcia’s Theory Applied to Transgender Teens

Marcia (1966) described identity *diffused* adolescents as those who do not engage in identity exploration and do not commit to an identity. He believed that diffusion was more common amongst younger adolescents, representing the most immature level of identity formation. Relative to the transgender adolescent, awareness of gender incongruence may not have occurred. A South Korean investigation by Oh, et al. (2023) found that the age of first awareness was 10.6 years with a standard deviation of 5.1 years. One could speculate that it may have been subconsciously repressed due to a lack of emotional or developmental readiness to begin exploration in addition to cultural, religious, peer, or family pressure.

Marcia (1966) described identity *foreclosure* as a way of avoiding the identity crisis by foreclosing to the demands of caregivers and peers. Any exploration is

continued on page 66

limited. A commitment is made to the identity imposed on them by others. For transgender adolescents, this might refer to having growing awareness of gender incongruence, but foreclosing due to being raised in a more conservative family, cultural, or religious system. This may be due to hearing family, friends, and community members speak derogatively about the LGBTQ community.

Marcia (1966) described identity *moratorium* in terms of exploring or experimenting with identity but ultimately deferring to perceived or implied demands of the caregiver or caregivers, and friends. A transgender teen, with a more definitive awareness of gender identity, may begin exploring what it feels like to live in one's affirmed gender (i.e. experimenting with clothing), but succumbs, or commits to one's assigned gender due to the words, attitudes, and pressure from family, friends, religious affiliations, and the community.

Marcia (1966) described identity *achievement* as an adolescent showing full exploration and commitment to an identity that best suits oneself. Transgender teens who reach a level of achievement have explored, integrated, and committed to living in the gender that feels right to them.

Four Groups with 16 Combinations

The "double identity crisis" presumes that personal and gender identity co-occur as separate but co-equal processes that can influence one another. Exploring and committing to "who I am" is just as important as exploring and committing to "what gender I am." However, depending on the level of gender dysphoria, exploration of gender identity might take precedence.

What follows is a basic description of each of the four sets of groupings.

Group 1

Group 1 matches personal identity diffusion with four forms of gender identity crises. The result is diffusion-diffusion, diffusion-foreclosure, diffusion-moratorium, and diffusion-achievement.

Group 2

Group 2 matches personal identity foreclosure with the gender identity crises of diffusion, foreclosure, moratorium, and achievement. This group comprises the combinations of foreclosure-diffusion, foreclosure-foreclosure, foreclosure-moratorium, and foreclosure-achievement.

Group 3

Group 3 matches personal identity moratorium with the gender identity crises of diffusion, foreclosure, moratorium, and achievement. This group consists of moratorium-diffusion, moratorium-foreclosure, moratorium-moratorium, and moratorium-achievement.

Group 4

Group 4 matches personal identity achievement with gender identity crises of diffusion, foreclosure, moratorium, and achievement. This group comprises the combinations of achievement-diffusion, achievement-foreclosure, achievement-moratorium, and achievement-achievement.

Developmental and Psychological Considerations

How transgender teens negotiate the "double identity crisis" can weigh heavily on their mental health as they transition to young adulthood (Wanta, et al. 2019). In the healthiest case of double achievement, individuals who after thoroughly exploring and finding acceptance toward both their personal and gender

continued on page 67

identity, set themselves up for a successful transition. They have the confidence, drive, interpersonal savvy, emotional maturity, balance, and resilience to transition and achieve whether at work, college, a trade, or the military. They are primed to form the intimate relations needed to work through one of the more significant developmental tasks (Erikson, 1950) of young adulthood.

For the other 15 combinations, minor to significant longer-term consequences may follow into early adulthood. The most negatively impacted groups are those in the double-diffused, diffused-foreclosed, foreclosed-diffused, and double-foreclosed categories. This is due to the lack of exploration into who one really is and what gender makes most sense to them. These individuals may enter young adulthood experiencing higher levels of psychological distress, lack of self-direction, and less than sufficient relational intimacy. This may partly explain the higher percentage of drop-out rates among transgender college students compared to cisgender peers (Liss, et al., 2024). They become further compromised when criticized for not moving forward with their lives, dropping out of college, failing to launch, and characterized as lazy, immature, or choosing to live like a teen.

Case Examples

The following case examples have been included to illuminate the model and how it translates to treatment. The cases were specifically chosen because they show how the double identity crisis operates and affects the development of teens and young adults before being addressed in treatment; moving from different combinations of unresolved identity status to forms of double achievement. These cases show how the double identity crisis may not become resolved until well into adulthood.

G: A Case of Diffusion-Diffusion

Consider the case of “G,” a transgender male in his mid-20s. G was raised in a devoutly religious home with controlling parents. G was a quiet, unassuming kid who was discouraged from having a voice and pursuing his individual interests. He was socialized femininely and forced into activities which he never felt comfortable. As an adolescent, G felt a growing sense of confusion within himself; “a boy trapped in a girl’s body” which he did not express to anyone. He was particularly fearful of his parents finding out and disowning him.

G never explored who he was as most decisions were made for him. G quietly succumbed to his parents’ demands. G dated males, participated in soccer, and applied to college because that was expected, despite wanting to pursue a career in the trades. Social relations were kept to a minimum. G did not listen to music that his parents did not permit.

G showed a diffusion-diffusion response to the double identity crisis by suppressing any exploration and/or commitment to personal and gender identity. Into young adulthood, he struggled with anxiety and depression and felt like a “passenger in life”. Interpersonal relationships were few. Most often, G kept to his room missing the opportunity to engage in college life. In private, G began a tentative exploration by dressing in men’s clothing and working manual labor jobs.

G was asked to identify which combination of the double identity crisis fit most. G suggested moratorium/moratorium which after further processing admitted was more like diffusion-diffusion; though now on a trajectory of exploration and commitment. The earliest part of therapy focused on developing a voice, making decisions, socializing, and setting boundaries

continued on page 68

with his parents. This set the stage for personal identity development. G realized that he was funny and enjoyed dark humor and began visiting comedy clubs. He realized that he was more than crafty. He began woodworking. He began listening to the techno music he enjoyed and found himself dancing freely around his house. He took a break from church as he never felt this was part of his true identity.

Therapy helped G progress through the gender stage of the double identity crisis. He became assertive and developed a sense of empowerment. His relationships blossomed. G began exploring life as a man which led to joining support groups, starting hormonal treatment, and changing his name. Eventually, G let his parents know that he was hormonally in transition. The relationship remained delicate, but in process. At this point in his development, G entered a mode of moratorium/achievement-achievement.

Y: A Case of Diffusion-Achievement

Y, an early 20s transgender male, came to treatment due to anxiety and depression. He was introverted and had trouble making friends throughout his life. Y had some adolescent interests in graphic design which he never explored. Y spent much of his time playing video games but did not identify himself as “a gamer”. Y lacked self-direction. He was primarily home-bound after high school, neither working nor taking classes.

Despite Y’s lack of personal identity development, he explored his gender identity to the point of achievement. Y affirmed his gender as “trans-masculine” since the beginning of high school. He read and went on forums discussing gender identity. Through education and exploration, Y realized he was not comfortable living as a woman. He came out to the family and changed his name. His family was supportive. He became active in the trans-

gender community, completed top surgery, and began taking testosterone.

The diffusion-achievement dilemma created problems for Y’s entry into adulthood. Despite being settled in his gender, Y never explored who he was, or how he envisioned the future. Thus, Y remained unmotivated, depressive, socially withdrawn, and less than productive even while identifying confidently as man.

Y was instructed to select which of the 16 combinations best fit them. Y chose diffusion-achievement. Therapy focused on developing his personal identity which included having a voice and becoming a proactive participant in life. This included a focus on differentiating when he was acting in his more confident adult self with those around him, or regressing into his reactive or withdrawn adolescent self; particularly in relation to his parents and partners. After a year of treatment, Y was working and enrolled in school. Though still generally anxious, the anxiety became less debilitating and his depression alleviated. Y achieved an evolving personal identity to match his gender identity achievement.

Concluding Remarks

Personal and gender identity formation can either be deferred, explored, or accepted to produce our healthiest transgender youth. Treatment needs to address both aspects of the double identity crisis uniquely encountered by this cohort. Achieving gender identity alone is not sufficient as it may not fully address one’s personal identity development; though it can help promote it by alleviating gender dysphoria.

From the perspective of the “double identity crisis”, an over emphasis on gender affirmed care can become detri-

continued on page 69

mental when gender-achieved adolescents have foreclosed the development of their personal identities to their gender identity development. This may be due to believing that gender achievement will solve all their psychological distress. This individual might compromise the personal identity by taking on aspects of the transgender community, some of which may not speak to who they really are but achieve a sense of belonging. This is not any different than the adolescent who bases his, her, or their identity solely around the sport team, or the cannabis using crowd.

Stated differently, short-sighted therapists who overly emphasize gender identity to the neglect of personal identity development might be doing this population a disservice. This is not to suggest a minimization of gender affirming care; in fact, becoming more comfortable in one's gender identity may alleviate the dysphoria needed to pursue one's personal identity development as previously noted. The reminder pertains to the treatment of both aspects of identity development to maximize growth of the person-as-a-whole.

Likewise, personal identity development in absence of gender identity development is just as problematic. It cannot overcompensate for a diffused or foreclosed gender identity, or a gender identity that remains in moratorium and evokes pervasive feelings of gender dysphoria.

In conclusion, those who do not resolve the "double identity crisis" experience isolation, low self-esteem, a lack of self-direction, shame, anxiety, and depression that affects their long-term development. Those who can find achievement of their personal and gender identities are most suited for relational success and emotional well-being.

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Childhood Adversity and Suicide

Samuel Knapp, EdD, ABPP



What Childhood Events Are Especially Problematic?

Suicidal patients often report adverse childhood events (O'Connor, 2021; Thompson & Kingree, 2022). Consequently, psychotherapists working with suicidal patients need to consider how these experiences impact their current functioning and how they contribute to their suicidality.

Adverse childhood events could involve a wide range of serious and upsetting stressors or events, including being the victim of child abuse, witnessing violence in the household or community, having a parent who has a serious mental illness or who has been incarcerated, being the subject of bullying, or experiencing parents' divorce. Approximately two-thirds of American adults reported experiencing at least one adverse childhood event, and 17% reported having four or more such events (Swedo et al., 2023). The risk of psychological harm increases as the number of adverse childhood events increases (Tang et al., 2025). Notably, individuals who identify with a sexual and/or gender minority status reported higher rates of adverse childhood events (Solberg, 2024). Additionally, individuals who experience adverse childhood events demonstrate an increased risk for poor physical and mental health as adults, increasing their risk for depression, substance misuse, non-suicidal self-injury, and suicidal behavior (Tang et al., 2025).

Experiencing maltreatment from a caregiver is one of the most disruptive events a child can experience. Even after

controlling for other environmental conditions, child maltreatment is associated with an increased likelihood of developing psychiatric disorders and making suicide attempts (Grummitt et al., 2024). In addition to experiencing child abuse, several other factors are associated with an increased risk for suicide, including younger maternal age at birth, low parental education, low birth weight, the death of a parent in childhood (Vidal-Ribas et al., 2024), or a traumatic brain injury in childhood (Dougall et al., 2024). Some of these factors are associated with living in poverty, such as food or housing insecurity, and others are related to a minoritized status, such as discrimination or social exclusion.

Circumstances, such as the duration or context of the stressors, may exacerbate or mitigate their impact (Liu et al., 2025). The harm from adverse events is greater when children have an inconsistent or unsupportive social network. The harm is reduced when children have a supportive social network (Srivastav et al., 2022).

Why Do Adverse Childhood Events Matter?

The mechanisms by which adverse childhood events make someone vulnerable to suicide are not well understood. Nonetheless, evidence suggests that adverse experiences in early life may alter brain structure, thereby increasing difficulties with emotion regulation. The prenatal and early childhood periods are characterized by heightened plasticity and exposure to stressors, which can have consequences that last into adulthood. These stressors may alter the hypothalamic-pituitary-adrenal

continued on page 72

axis, a neuroendocrine system, and reduce its threshold for a stress response (Giotakos, 2020).

Additionally, adverse childhood events may increase the risk that an individual will develop maladaptive responses to life circumstances, such as poor executive functioning (Rogerson et al., 2023), a limited ability to regulate emotions (Wong et al., 2024), and a lack of trust in social relationships (Flechsenhar et al., 2024). These maladaptive responses may influence an individual's dissatisfaction with their life and contribute to their desire to die.

Finally, adverse childhood events may increase an individual's capability to kill themselves, although the research on this remains inconsistent (Serebriakova et al., 2025). According to ideation-to-action theories of suicide, a suicide attempt occurs when an individual has the desire to die and has also acquired the capability to kill themselves (Joiner, 2010). A person acquires the capability for suicide when they have overcome the natural urge for self-protection and the general desire to avoid harm to oneself. The capability for suicide is hypothesized to be multidetermined. It involves dispositional factors, such as one's genetic endowment, access to lethal means to kill oneself, and life experiences that habituate an individual to pain and suffering and reduce their fear of death. These life events include experiences that provoke pain or fear, such as exposure to violence as either a victim, perpetrator, or witness (O'Connor, 2021).

How Should Psychotherapists Address Adverse Childhood Events?

Psychotherapists should ask patients about adverse childhood experiences as part of the social history component of an initial intake or clinical interview. However, psychotherapists should go beyond counting the number of stressors or traumas

and instead ask about the circumstances and context of these events to better understand their impact on the patient. For example, the effect of an assault on a child may vary according to whether the assault caused temporary pain or a long-term disability, if the physical assault was a one-time event or part of abuse, and the degree of support the child received from the family and community following the assault.

Psychotherapists should be curious from the beginning about their patients' childhood experiences. The following questions should be considered when initially starting this conversation:

- Can you describe your home life growing up?
- Did you have any experiences in childhood that were especially upsetting?
- Did you have any experiences in childhood that appear linked to the reason you are seeking therapy?
- Did any experiences in childhood appear especially important in making you the person you are today?

If patients describe salient adverse events or experiences, psychotherapists may proceed by asking open-ended questions as follows:

- How did you feel about it at the time?
- How do you feel about it now?
- How does it impact you today?
- How did it impact you in the past?
- Is it linked to behaviors that keep you from reaching your goals?
- Does it impair your relationships with your family?
- Have these experiences changed how you interact with others?

continued on page 73

If patients report suicidal thoughts, psychotherapists should consider whether the patient has developed an acquired capability for suicide. If a patient with suicidal thoughts has an increased habituation to pain and suffering and a decreased fear of death, psychotherapists need to be especially alert to suicidal plans (i.e., time, location, means), past attempts, backup plans (i.e., plans to fall back on if the primary plan is not feasible), partial plans (i.e., plans that have not been created thoroughly), and any dormant plans (i.e., plans made in the past that are not currently considered). This information is important when developing a plan to restrict easy access to lethal means of suicide (Knapp, 2023).

The discussion of childhood events can focus on how they affect patients' day-to-day functioning, including their ability to regulate their emotions and to develop trusting relationships with others. For example, adults who were maltreated as children were more likely to use unproductive emotional regulation strategies, like emotional suppression, and less likely to use productive emotional regulation strategies, like cognitive reappraisal (Ion et al., 2023). In addition, the experience of maltreatment may lead to a general pattern of distrust that makes it more difficult to develop close and meaningful relationships with others. This information can guide the treatment plan for suicidal patients because of some emotions or beliefs, such as a sense of entrapment (i.e., my life is intolerable and there is no way for the pain to end), perceived burdensomeness (i.e., people would be better off if I were dead), and thwarted belongingness (i.e., no important social group values me) are linked to an increased risk of suicide (O'Connor, 2021).

Practice Pointers

Adverse childhood events may lead to the development of maladaptive responses to life circumstances, increase a patient's capability of suicide by reducing their fear of death by habituating them to pain and suffering, contribute to ineffective emotion regulation strategies, and increase distrust of others. Psychotherapists should ask about adverse childhood events as part of their routine social history. These events increase the risk of later psychological problems, including a heightened risk of suicide. Psychotherapists should also explore the nature of the event, the circumstances in which it occurred, and the patients' perception of how it has influenced their later lives. This information may influence how psychotherapists perceive their patients' capability for self-harm and their approach to psychotherapy, to the extent that these events started a chain of events or a pattern of thinking that diminished the patients' ability to fulfill their life goals.

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FEATURE

Considerations for Adolescent Mothers: Trauma-Informed and Integrated Care

Emma Jalili, MA

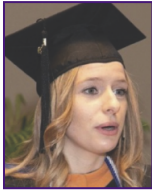
Lavita Nadkarni, PhD

Carly Perlmutter, RN, BSN



Considerations for Adolescent Mothers: Trauma-Informed and Integrated Care

Adolescent pregnancies and teen birth rates are shown to be correlated with significant physical, emotional, and social risks in the United States (Mickler & Tellestrup, 2025) and in many countries across the world. In 2019, 21 million pregnancies were reported in women aged 15 to 19 years worldwide with approximately 50% of the pregnancies reported to be unintended and resulting in an estimated 12 million births



(World Health Organization, 2024). Out of these unintended pregnancies, 55% of them ended in abortion (Sully et al., 2019). While abortions are generally safe, risks of complications increase in low and middle-income countries, along with U.S. states that prohibit and criminalize abortion. This presents a critical issue for adolescents who often experience limited access to reproductive education and healthcare, exposing the vulnerabilities of unintended pregnancies during teenage years. While research has indicated that adolescent pregnancies can increase the risk of physical and psychological trauma, clinical practices have not yet shifted to prioritize an integrated healthcare model that addresses these risks (Jeha et al.,

2015). As a result, adolescent mothers are almost three times more likely to develop depressive symptoms during pregnancy and postpartum compared to adult mothers (Figueiredo et al., 2007). It is imperative for healthcare professionals to address the specific challenges that exist for this population while establishing an integrated healthcare model that supports both the mother and infant during the postpartum period. As such, this article advocates for a trauma-informed framework when treating adolescent mothers in medical and behavioral healthcare settings.

Adolescent Shifts with Pregnancy

Adolescent motherhood presents a unique set of psychological, social, and developmental considerations that require a distinguished model of care. It's important for healthcare providers to be cognizant of the developmental shifts that influence how adolescents respond to prenatal treatment and to interactions in clinical settings. Adolescents undergo significant cognitive changes, including the emergence of advanced abstract thinking, improved decision-making skills, and heightened egocentrism, all of which facilitate identity formation and increased self-awareness (Erikson, 1959/1980). They are also highly sensitive to physical appearance and body image. For adolescent mothers, the rapid physical changes of pregnancy can exacerbate body image concerns, potentially trigger disordered eating habits and impact overall wellbeing (Janas-Kozik et al., 2021; Przybylowicz &

continued on page 77

Danielewicz, 2021). These developmental changes are crucial in the transition into adulthood, and stunted growth or delays during this period because of pregnancy can amplify stress reactivity, increasing the risk of postpartum mental health concerns and maladaptive behavioral patterns later in life (Adepegba, 2025).

A key social transition that takes place in adolescence involves the shift of reliance on validation and support from parents/caregivers to greater dependence on peer relationships (Erikson, 1959/1980). This process may be interrupted as a result of pregnancy, as adolescent mothers often experience a disruption in education and limited social support (Fontoura-Matias et al., 2024). Pregnancy in adolescence is also associated with a history of trauma and high levels of comorbid traumatic experiences, including interpersonal violence (IPV), physical violence, emotional adversity, loss of caregivers or siblings, and community violence (Killian-Farrell et al., 2020). The combination of traumatic experiences and insufficient social support can increase a mother's vulnerability to postpartum mental health concerns, further compromising maternal and infant wellbeing. Specifically, adolescent victims of IPV are at an increased risk for adverse health outcomes for infants, including premature birth, low birth weight, and inconsistent access to regular primary care for both the child and mother (Madkour et al., 2013). Without adequate understanding of the specific stressors faced by adolescent mothers and proper intervention, these challenges can perpetuate intergenerational trauma by negatively influencing attachment bonds and infant developmental outcomes, further cultivating mistrust in the healthcare system (Graf & Schechter, 2024). These developmental, physical, social, and psychological risks demonstrate the necessity for an integrated healthcare model and

trauma-informed care when treating such a vulnerable population.

Methodology

To better understand how the issues identified in the literature are observed in medical practice, a semi-structured interview was conducted with Ms. Carly Perlmutter, a registered nurse currently working at an outpatient integrated healthcare clinic for complex family planning and adolescent gynecology specialties in New York City. Ms. Perlmutter's clinic is an academic institution that treats patients with diverse socioeconomic backgrounds that are typically referred to by general practitioners (e.g., primary care physicians and hospital staff) across the tri-state area. Interview questions consisted of open-ended prompts designed to understand present trauma-informed clinical practices when treating adolescent mothers. In reviewing the interview responses, Ms. Perlmutter offered challenges in her role and that of the clinic as well as recommendations to provide better care for this population.

Challenges Faced by Adolescent Mothers

Ms. Perlmutter revealed that the most significant barriers to treatment that many of her adolescent patients' face is their limited health literacy and inconsistent follow-up care. Rapid developmental shifts combined with unexpected life events like an unplanned pregnancy can create an internal conflict for many adolescents, making acceptance difficult. The distress of these experiences undermines health awareness and leads to noncompliant care. Research has indicated that mental health concerns and attitudes surrounding pregnancy in adolescent mothers has led to negative mental health outcomes and feeling unsupported or disempowered in caretaking postpartum (Osok et al., 2018).

continued on page 78

Outside of developmental considerations, social and environmental factors can shape how pregnant adolescents interact in healthcare settings. Ms. Perlmutter stated that many of her patients have histories with interpersonal violence, relating to a tendency to experience strong physical and/or emotional reactions during gynecological exams (i.e., clenching, yelling, moving to the top of the exam table to avoid being touched). Additionally, she highlighted the systemic barriers present within the healthcare system that disproportionately effect pregnant adolescents. Existing research has underscored the significant impact of lacking access and/or having limited awareness of available resources (i.e., transportation, mental health treatment, prenatal and postpartum care services) on pregnant adolescents and their ability to be an active participant in their healthcare. One study found that limited knowledge of mental health treatment, lack of trust in healthcare, internalized stigma, and limited social support prevented pregnant adolescents from seeking help and maintaining treatment adherence (Oladeji et al., 2025). This is even more impactful for low and middle-income socioeconomic statuses and minority patients, as mothers from these populations are more likely to experience complications related to pregnancy (Joseph et al., 2021).

Clinical Implications and Recommendations

Challenges specific to the treatment of pregnant adolescents can be addressed by implementing an integrated healthcare model that builds on existing principles and incorporates various modalities to further strengthen care and support positive outcomes in the postpartum period. Ms. Perlmutter engages with adolescent patients using a trauma-informed approach that emphasizes trust, safety, and collaboration while rec-

ognizing the unique challenges faced by this vulnerable population. She encouraged providers to engage with patients in a manner that promotes accountability and autonomy by helping the patient develop a greater understanding of their health. This can be achieved by implementing the teach back method within extended appointment times, where patients are encouraged to explain their health information or treatment plan in their own words (Mahmoodi, 2025). Ms. Perlmutter indicated that adolescents are more likely to self-disclose victimization than adult patients, likely due to the environment created by their practitioners. Positive encounters such as these in healthcare settings can offer validation and support from trusted providers, fostering prosocial identity development to provide an easier transition into adulthood and motherhood.

When working with pregnant adolescents, medical professionals, like Ms. Perlmutter, are typically the first to acknowledge and recognize the effects of systemic barriers to prenatal mental health treatment. Ms. Perlmutter noted that her practice maintains a strong relationship with the institution's social work network to manage and provide safety to our patients while they are in our care and beyond (C. Perlmutter, personal communication, September 13, 2025). Standard of care practices for maternal care clinics should expand toward partnerships with mental health professionals, behavioral health facilities, pediatrician offices, schools, and other community agencies to provide additional opportunities for continuous care. Medical professionals should receive annual, trauma-informed, culturally competent training that discusses these barriers and explores ways to address them with adolescent patients in treatment settings. This should include training on

continued on page 79

mental health screening instruments tailored to adolescents. These tools should assess a variety of mental health concerns – including anxiety, trauma, and risky social behaviors – as well as their impact on functioning. Commonly used screening measures such as the Edinburgh Postnatal Depression Scales (EPDS) or the Patient Health Questionnaire (PHQ-9) may not fully encapsulate the unique mental health struggles that adolescents face. Furthermore, mental health screenings should be a continuous process implemented throughout treatment, especially considering the intense, fluctuating emotions associated with both adolescence and pregnancy.

Ethical considerations arise when a medical provider screens a pregnant adolescent for mental health concerns without a clear, developmentally appropriate plan for care, especially if the patient reports worsening mental health symptoms in relation to pregnancy. Given the complexity of informed consent, providers must be aware of local laws and best ethical practices regarding minor consent for medical and mental health treatment and the intricacy of parental/guardian involvement. At Ms. Perlmutter's practice, patients within the age bracket of receiving sexual health care without parental consent are asked if they wish to involve a caregiver in their appointments and treatment planning. Additionally, patients within this age range are given access to an electronic health record system that allows them to communicate patient autonomy and allows practitioners to engage in patient-centered care while maintaining ethical and legal practices.

When adopted correctly, healthcare professionals can uniquely enhance treatment for adolescent mothers through an integrated healthcare model rooted in trauma-informed care, ethical practices,

and continuous emphasis on mental wellness that extends into the postpartum period.

Discussion

Given the prevalence of adolescent pregnancies, it's impossible for medical and mental health professionals to ignore the unique vulnerabilities that exist within this population. Ms. Perlmutter's clinical observations highlight the real-world challenges pregnant adolescents face, reinforcing the influence of developmental factors, emotional processes, and traumatic events during this period. She stated that her practice strives to create an environment that is nonjudgmental, compassionate, and a safe place for adolescent patients establishing autonomy in their healthcare (C. Perlmutter, personal communication, September 13, 2025). The enactment of a trauma-informed, integrated healthcare model grounded in ethical and legal practices can promote continuity of care and overall trust in the healthcare system, reducing the risk for postpartum depression and fostering health adjustment for mother and child.

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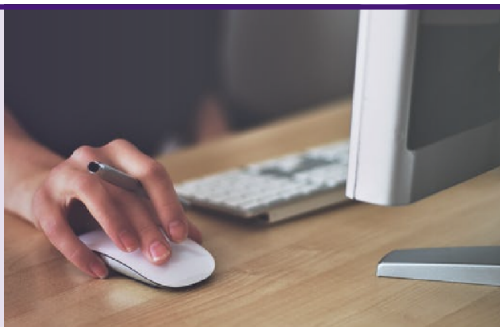
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FEATURE

Social Nutrition or Social Malnutrition: Addressing Loneliness in Ourselves and Others

Samuel Knapp, EdD, ABPP

Jeff Sternlieb, PhD

Sandy Kornblith, PhD



As social animals, we all require *social nutrition*, which involves regular and meaningful interactions with others (Kornblith et al., 2022). The absence of this vital nourishment can lead to *social malnutrition* or loneliness,



a profoundly personal experience that arises from the gap between our desired and actual social connections. Loneliness is not the same as social isolation. While isolation can be measured objectively, loneliness is a subjective feeling (Holt-Lunstad, 2018). One can have a small social circle and not



feel lonely. Conversely, one can have many social contacts and still feel lonely.

Author Gail Honeyman depicts loneliness through the protagonist's internal dialogue in her novel *Eleanor Oliphant Is Completely Fine*.

Most people's absence from the world would be felt personally by at least a handful of people. I, however, had no one. I do not light up a room when I walk into it. No one longs to see me or to hear my voice. I do not feel sorry for myself, not in the least. These are simply statements of fact (2017, p. 225)

Social nutrition promotes good health (Office of the U.S. Surgeon General,

2023). Those with strong social relationships tend to live longer, have better health, and report better well-being. In contrast, those who are lonely have an increased risk of all-cause mortality (Leigh-Hunt et al., 2017), heart disease, stroke (Valtorta et al., 2016), and dementia (Sutin et al., 2020).

The link between psychological well-being and loneliness is not a one-way street. Psychologically healthy people are more likely to create meaningful relationships; however, "the casual arrow flows more strongly from relationships to mental health than vice versa" (Braithwaite & Holt-Lunstad, 2017, p. 120). This bidirectional relationship underscores the complexity of the issue and the need for comprehensive solutions, as addressing loneliness is not straightforward.

The link between loneliness and health is plausible in light of human evolution. Being part of a social group meant protection from predators and greater access to shared resources, such as food and shelter. Although being connected to others is less essential for immediate survival today, individuals who lack social contact may feel easily threatened, potentially triggering physiological responses of alarm or danger.

The link between social support and health is likely multidetermined (Holt-Lunstad, 2018). Social support can lead to instrumental support (access to re-

continued on page 83

sources through the provision of concrete material aid), informational support (the provision of helpful information), or emotional support (the provision of empathy and understanding, which reduces physiological arousal and produces a sense of calm and well-being; Cohen, 2004). Additionally, individuals with social support tend to exhibit better healthcare habits (Farrell et al., 2022). Perhaps social support reduces stress, which can lead people away from unhealthy habits, such as smoking or drinking alcohol to excess. Perhaps those with social support have others around them who encourage healthy living habits.

Social Malnutrition

Not all social relationships are healthy, however. Some social contacts may be considered the equivalent of social junk food because they are not nourishing. They may not provide instrumental or informational support; instead, they may cause emotional distress.

Negative or highly ambivalent social relationships can harm a person's health. In their analysis of data from the National Social Life, Health, and Aging Project, Bookwala and Gaugler (2020) found that negative relationship quality, particularly criticism from one's partner, increased the risk of mortality among older adults. Those who live in ambivalent social relationships have higher blood pressure and shorter life spans for a variety of reasons, including cardiovascular disease, cancer, and infectious diseases (Holt-Lunstad & Clark, 2014).

Social media has a mixed impact on social relationships. It allows contact between friends and family from a distance that was previously not possible. It can also afford marginalized groups, such as transgender individuals, a means of offering and receiving mutual

support and a validation of their rights and emotions across geographical boundaries. Social media also enables individuals to feel connected through a common theme (e.g., sports fans) with people from different cities or states, even if they do not know their actual neighbors in the house next door.

However, a downside of social media is that it makes it possible to prioritize virtual contact over in-person contact. This can easily prevent individuals from associating with people of diverse backgrounds and viewpoints (Dunkelman, 2014). According to Dunkelman, losing a sense of community erodes tolerance for people in our neighborhood, promoting phobic avoidance and, ultimately, indifference. What remains is a narrow form of interaction, both in our homes and on our phones, outside our immediate community, with only those selected because they are family, close friends, or share similar beliefs and experiences (Thompson, 2025).

Also, many social media contacts are unproductive, and heavy involvement in social media among adolescents is associated with poorer mental health (Azagba et al., 2024). Although the reasons for this correlation with poor mental health are not fully understood, social media contacts may result in a devalued sense of self when one compares themselves to an often hyped-up, misleading, and/or false representation of others' lives in their social media posts.

Participation in divisive hate groups is another form of social malnutrition. Although participation in such groups could increase a sense of belonging and meaning, such acceptance comes at a cost. Participation in such groups requires adherence to ideologies of racial or in-group superiority, which reduces

continued on page 84

their empathy for, and alienates them from, many of their neighbors who could have been a source of social support (Rein, 2025). Furthermore, acceptance is not unconditional; it is contingent on adherence to false ideologies. The authors speculate that thinking for oneself or questioning the dominant ideology could lead to alienation and targeting of the individual, thereby increasing fear of non-conformity.

Healthy social contacts promote prosocial values, bring people together, establish bonds of mutual trust, and embed individuals in a protective and reciprocal social network in which they can express love or actively promote the growth and well-being of others (Fromm, 1963).

Promoting Social Nutrition Among Ourselves

In addition to maintaining social contacts in their personal lives, psychotherapists function more effectively when they are connected to and part of a vibrant professional community. Psychologists who labeled their peers as exemplary had solid social relationships with peers, spouses, friends, and others (Coster & Schwebel, 1997).

Johnson et al. (2012) have promoted a socially embedded work life and used the term *competence constellation* to refer to “a consortium of individual colleagues, consultation groups, supervisors, and professional association involvements that is deliberately constructed to ensure ongoing multisource enhancement and assessment of competence” (p. 566). These connections can provide up-to-date information on emerging trends in the field, provide an informal source of monitoring in which colleagues could speak up if they saw someone engaging in dangerous or less-than-optimal practices, be available for emotional support when things are stressful, and also offer instru-

mental support in the form of sharing information on local resources (e.g., an excellent psychiatrist to refer to or loaning psychological assessment materials). It could be a network of lifelong learners who continually stretch their knowledge base and challenge their assumptions. Consequently, it is not surprising that socially embedded psychologists are less likely to experience burnout (Yang & Hayes, 2020).

It can be challenging for professionals with independent practices to establish a positive professional network. They can start by making relationships a priority by:

- Keeping up with their colleagues from graduate school/internship and offering to meet for lunch, Zoom get-togethers, or other social engagements.
- Joining a local, state, or specialty psychological association and offering to participate in a committee/workgroup or present their ideas at a workshop or continuing education presentation.
- Volunteering or accepting a consulting position at a local agency where they can connect with others and learn about local resources.
- Creating ongoing connections with colleagues through consultation groups, Balint groups, journal clubs, or other venues.

These activities require some initial investment in time and energy. Nonetheless, these connections will pay off in terms of the quality of one’s work and work satisfaction.

Promoting Social Networks Among Our Patients

Some causes of loneliness can only be addressed at the macro level, such as through policies that reform the practices of social media companies or through

continued on page 85

political leaders prioritizing national unity over division.

Other causes of loneliness may be addressed at the micro level. Of course, developing a strong therapeutic alliance with patients is a crucial element of effective treatment. Additionally, psychotherapists may help patients who feel lonely build healthy relationships within their natural social networks. Because loneliness does not have a single cause, psychotherapists should consider multiple intervention options based on individual needs. Sometimes, interventions can be basic, such as providing a hearing aid, ensuring transportation for those who cannot drive, or creating opportunities to participate in social groups. Joining a community choir or other forms of volunteering, for example, may alleviate loneliness for some individuals and confer significant health benefits to specific patients.

At other times, individuals may hold maladaptive beliefs about their relationships, which can hinder their ability to interact easily with others. For example, some patients may focus so much on their negative thoughts or become so hypervigilant for rejection cues that they are unable to maximize the quality and quantity of their social relationships.

Finally, other interventions may help patients maintain and preserve existing relationships. Sometimes, this involves learning basic communication skills, such as listening attentively to others or respectfully expressing one's needs. Of course, relationship attitudes and behaviors may be influenced by an individual's attachment style, experiences in social modeling (observational learning), value system, social opportunities, or temperament. Psychotherapists may need to combine two or more interventions to benefit some patients.

Practice Pointers

The quality of an individual's life depends, to a large extent, on the quality of their relationships with others. Therefore, the best psychologists strive to maintain strong relationships with their peers and patients. They recognize that the quality of their work-life depends, in part, on the extent to which they receive feedback, support, and information from others in the field. In addition, they recognize the importance of assessing and intervening to address loneliness in their patients.

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FEATURE

Partner-Involved Approaches to Insomnia and Sleep Apnea: Integrating Sleep Science into Psychotherapy with Individuals and Couples

Bruce D. Forman, PhD



Sleep complaints are among the most common issues that present in psychotherapy with growing evidence demonstrating that insufficient or disrupted sleep contributes to a broad range of physical, psychological, and public-health concerns. Further, epidemiologic and meta-analytic findings show that insomnia is an independent risk factor for cardiovascular disease, hypertension, and type 2 diabetes even when controlling for depression and other health behaviors (Cappuccio et al., 2010; Laugsand et al., 2011; Leproult & Van Cauter, 2010). Chronic sleep disturbance disrupts metabolic functioning, elevates inflammation, increases sympathetic activation, and alters endocrine rhythms, mechanisms directly tied to long-term health risk (Irwin, 2019).

Additionally, poor sleep is integrally connected to mental health and wellness. Longitudinal research indicates that insomnia predicts the onset and persistence of depression and anxiety disorders (Baglioni et al., 2011). Importantly for psychotherapists, insomnia is one of the most consistent and modifiable risk factors for suicidal ideation, suicide attempts, and suicide death, independent of daytime mood symptoms (Pigeon et al., 2012; Woosley et al., 2019). When clinicians treat suicide risk without addressing sleep, they may overlook a major driver of dysregulation.

Beyond mental and physical health, inadequate sleep has serious safety consequences, contributing to workplace er-

rors, home accidents, and motor-vehicle crashes. The cognitive and psychomotor impairments associated with sleep deprivation approximate those associated with alcohol intoxication (Stutts et al., 2003; Watson et al., 2015). For many clients, these risks also affect partners, family systems, and their broader community.

Despite the profound impact of poor sleep on daily functioning, most psychotherapists receive minimal training in sleep disorders, including insomnia and obstructive sleep apnea (OSA). The clinical impact of limited training on sleep disorders is that many clinicians unknowingly treat individuals with comorbid insomnia and sleep apnea (COMISA), a highly prevalent and impairing condition associated with more pervasive symptoms, increased daytime dysfunction, and reduced overall treatment adherence (Ong et al., 2012; Sweetman et al., 2019).

Because sleep unfolds within interpersonal environments, especially within couples dynamics, relational processes often influence the trajectory of insomnia. Partner responses to nighttime awakenings—like providing emotional reassurance, co-ruminating, engaging in conflict cycles, attempting to help—can inadvertently intensify conditioned arousal (Troxel et al., 2007; Gordon & Chen, 2014). Conversely, supportive and structured partner involvement can enhance treatment adherence, reduce distress, and strengthen relational well-being (Gordon et al., 2021).

continued on page 88

This article synthesizes research on partner-involved treatment for insomnia and COMISA and offers practical, evidence-informed guidance for psychotherapists. These strategies do not require formal cognitive behavioral therapy for insomnia (CBT-I) training; rather, they help clinicians integrate sleep-health principles into psychotherapy while leveraging relational strengths.

Insomnia Is a Relational Problem

Studies consistently show that insomnia is influenced by interpersonal dynamics, especially among co-sleeping couples. Rogojanski, Carney, and Monson (2013) demonstrated how partner reassurance, in-bed conversations, emotional caretaking, and co-rumination reinforce nighttime arousal and sleep-interfering behaviors. These patterns mirror relational dynamics common in anxiety treatment: well-intentioned partner efforts reduce short-term distress while maintaining long-term avoidance and dependence.

Ellis and colleagues demonstrated that perceived partner alliance, defined as patients' perceptions of partner support, collaboration, and alignment with treatment goals, is associated with adherence and outcomes in cognitive behavioral therapy for insomnia (CBT-I). When patients perceive their partners as supportive of sleep-promoting behaviors such as stimulus control and consistent wake times, treatment engagement improves and insomnia severity decreases (Ellis et al., 2015; Ellis et al., 2017). Building on this work, conceptual and emerging empirical literature has highlighted the role of partner accommodation behaviors, including alterations to routines, sleep environments, or expectations intended to reduce distress. While such behaviors may enhance perceived closeness or reassurance in the short term, they may inadvertently interfere with adherence to CBT-I behavioral prescriptions and per-

petuate insomnia-maintaining processes through interpersonal pathways (Rogojanski et al., 2013; Ellis et al., 2021). Together, these findings underscore that insomnia is rarely an individual disorder in isolation, but rather unfolds within a dyadic system shaped by emotion regulation, communication patterns, and shared nighttime behaviors.

Partner-Assisted CBT-I:

What the Evidence Shows

The first structured partner-assisted CBT-I protocol was evaluated by Mellor et al. (2019). Couples were assigned to either partner-assisted CBT-I, individual CBT-I, or sleep-management training. The findings from this research include improved insomnia severity in all CBT-I conditions, increased adherence to core behavioral components in partner-assisted CBT-I, reduced accommodation behaviors with partner involvement, and greater confidence addressing nighttime challenges together. A review by Xie & Feeney (2024) found strong evidence in support of the mediating effects of emotional/ affective mechanisms (e.g. emotions and mood states) in explaining associations between various aspects of romantic relationships (e.g. relationship satisfaction, partner conflicts, and attachment orientation) and sleep quality.

COMISA: When Poor Sleep Has Two Sources

Co-morbid insomnia and sleep apnea, also known as COMISA, affects a substantial portion of clients with chronic insomnia. Research shows a bidirectional relationship: OSA-related arousals worsen insomnia and insomnia-related hyperarousal reduces continuous positive airway pressure (CPAP) tolerance (Ong et al., 2012; Sweetman et al., 2019). Partner involvement is especially important because partners often witness snoring, gasping, apneas, and CPAP dif-

continued on page 89

difficulties. Research has demonstrated that supportive partner involvement predicts improved CPAP adherence (Baron et al., 2011; Ye et al., 2017), critical or coercive partner involvement predicts reduced adherence (Baron et al., 2011), and couples-based CPAP interventions show good feasibility and satisfaction (Kelly et al., 2020).

Screening for OSA in Psychotherapy

Because psychotherapists are often the first point of contact for clients with sleep complaints, clinicians can play a critical role in screening for sleep apnea.

The STOP-Bang questionnaire is a validated, easy-to-administer tool assessing snoring, tiredness, observed apneas, high blood pressure, BMI, age, neck circumference, and gender. Higher scores correlate strongly with moderate-to-severe OSA (Chung et al., 2016). Psychotherapists can integrate STOP-Bang at intake, particularly when insomnia is chronic, treatment-resistant, or accompanied by high-risk indicators such as loud snoring, witnessed apneas, excessive daytime sleepiness, obesity, hypertension, cardiometabolic disease, or poor response to prior behavioral or pharmacologic sleep interventions.

In addition to that questionnaire, clinicians can direct clients to a free and validated online screening tool (Sleep-HealthScreen.com) that will send the results via email and can be shared with the clinician to inform treatment. This resource screens for insomnia, apnea risk, restless legs, circadian disturbance, and other sleep-disorder symptoms and generates a printable summary for providers. Though screening is not diagnosis, it can provide a basis for making a referral to a sleep medicine specialist or primary care physician for further evaluation and potentially prevent living with untreated apnea.

Clinical Guidelines for Psychotherapists: Integrating Partner Work into Sleep Treatment

These strategies are designed for clinicians without specialized CBT-I training but who have strong skills in psychotherapy, systems work, and/or relational dynamics.

1. Conduct a Dyadic Sleep Assessment

Assess the following:

- Bedtime/wake-time routines for each partner
- Partner responses to nighttime awakenings
- In-bed emotional conversations or conflict
- Patterns of reassurance, co-rumination, or avoidance
- Environmental or behavioral accommodations
- STOP-Bang indicators and apnea symptoms
- Feelings about sleeping separately when clinically indicated

2. Provide Relational Psychoeducation

Explain insomnia as a conditioned hyperarousal disorder rather than a willpower failure. Help couples understand:

- Why in-bed wakefulness reinforces insomnia
- Why reassuring or comforting the partner in the middle of the night often maintains symptoms
- Why independent coping promotes long-term improvement
- How partners can support—not control—behavioral changes

This psychoeducation can be framed using attachment, emotion-focused therapy, cognitive behavioral therapy, and systemic concepts.

continued on page 90

3. Modify Nighttime Interaction Patterns

Therapists can help couples establish:

- Connection rituals outside the bed
- A structured night plan for awakenings
- Reduced in-bed conversation and problem-solving
- Partner scripts that minimize emotional escalation (i.e., “I’m here with you. Let’s follow the plan we agreed on.”)

4. Facilitate Sleep-Schedule Negotiation

Many couples encounter tension around:

- Differing sleep needs
- Sleep-restriction schedules
- Fear of losing intimacy
- Childcare responsibilities

Psychotherapists can support collaborative problem-solving, boundary-setting, and communication around these issues.

5. Reduce Partner Accommodation

Using a graded approach, take the following steps:

1. Identify accommodation behaviors
2. Rank them by difficulty
3. Reduce one or two at a time
4. Support partners in managing guilt or worry
5. Reinforce shared competence

This mirrors exposure work and builds resilience.

6. Integrate Partner Work into COMISA Treatment

When sleep apnea is diagnosed or suspected:

- Normalize CPAP challenges
- Address relational fears or

frustrations

- Reduce coercive “pressure tactics”
- Support collaborative, curiosity-driven problem solving
- Encourage CPAP desensitization processes
- Emphasize the health benefits for both partners

Partner involvement often determines long-term adherence.

7. Develop Dyadic Relapse-Prevention Plans

Plans should include:

- How to address schedule drift
- What to do when accommodation returns
- How to manage episodes of increased nighttime anxiety
- How to support CPAP adherence over time
- Monthly “sleep check-ins”

What Psychotherapists Can Do

Even without delivering a formal CBT-I approach to treatment, psychotherapists can:

- Screen for sleep conditions using the STOP-Bang questionnaire and SleepHealthScreen.com
 - Integrate sleep assessment into intake and couples sessions
 - Identify relational maintenance factors
 - Support behavior change through emotionally focused, systemic, or CBT frameworks
 - Collaborate with behavioral sleep medicine clinicians and sleep physicians
 - Normalize temporary co-sleeping adjustments
 - Encourage dyadic coping strategies
- continued on page 91*

These actions enhance therapeutic outcomes and promote client well-being.

Conclusion

Insomnia and COMISA are not only individual challenges, they but they are also relational phenomena influenced by interpersonal patterns, emotional responses, and nightly interactions. Psychotherapists are uniquely positioned to address these patterns, strengthen partner collaboration, and integrate sleep-health principles into treatment. By including tools such as STOP-Bang and [SleepHealthScreen.com](https://www.sleephealthscreen.com) and by targeting relational processes that maintain insomnia, clinicians can help clients achieve better sleep, enhanced mental health, and greater relational satisfaction.

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FEATURE

A Fat Positive Framework for Beginning Body Image Work with Plus Size Clients

Sofia Siraj-Wu MS, LPC



Two-thirds of the United States population of women are considered plus size, but weight stigma in healthcare spaces is as pervasive as ever and has long lasting mental health implications for plus size clients (Flint et al., 2025, Christel & Dunn, 2016). With anti-fat bias on the rise, plus size clients who are seeking therapeutic services to work on body image issues are at risk of receiving inadequate care from clinicians who may hold their own biases or feel ill-equipped to empathetically hold space for plus size clients with body image concerns (Wang et al., 2025).

As plus size clients often enter counseling, at least in part, for addressing body image issues, a framework for ethically and empathetically beginning this work feels vital. Not all plus size clients are interested in weight-loss or even experience negative body image issues. However, most if not all, have likely experienced microaggressions or prejudice due to weight stigma and systemic fatphobia. Learning to approach each client's body image needs with accurate empathy is essential to developing a strong therapeutic alliance. Using a fat positive framework with all clients, and more crucially with plus size clients, ensures an appropriate level of humility and respect that is often lacking in healthcare spaces (Philip et al., 2025). The framework proposed in this article is based on modern Health at Every Size (HAES) research regarding anti-fat bias and body image, my work as a Licensed Professional Counselor who works specifically with queer, BIPOC,

plus size clients experiencing body image issues, and my own lived experience as a fat-identified, queer, plus size woman of color (Suarez et al., 2024). I created this framework after receiving a highly positive response from participants of my course on fat positive approaches to counseling who said they agreed with the concepts of fat positivity, but did not know it could be applied clinically. Wanting this concept to be as easily applicable as possible, I designed the FRIENDS framework to be utilized as a supplement to the clinician's existing theoretical approach(es) and coping strategies. The FRIEND framework, introduced in detail below, aims to provide a structure for competently and empathetically beginning body image work and is specifically designed for clinicians who support plus size clients in improving their body image.

FRIEND

Explore the first time they felt shame in their body. In the context of this framework, I utilize the following definition of shame, "the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging" (Brown 2012). Clients who are plus size will typically be able to identify this moment easily as it is often a core memory for them. It may be conceptualized, by the client, as the beginning of their issues with their body and often takes place in early childhood.

Help the client vividly recreate this moment by:

- identifying who was present,
- naming what was said,

continued on page 94

- describing the environment they were in during the moment,
- defining what was happening somatically for them during the moment,
- exploring what were they thinking,
- and recounting any other relevant details that can help them process this pivotal moment wholly.
- Can they remember additional context like what was happening the moment before the first moment of shame took place and what happened for them in the moments immediately after?

This first part of the proposed framework may take at least one if not a few sessions. As it can reduce the impact of particularly traumatizing memories, Eye Movement Desensitization and Reprocessing (EMDR) would be an ideal companion processing method for this memory if the client finds the moment particularly distressing to recall.

FRIEND

Reflect on every core memory related to body shame from that moment to now. Pay particular attention to intersectionality of being plus-size in combination with additional marginalized identities. The second part of the framework builds on the first by asking the client to walk through the most salient memories from the first moment of body shame to present day. This may mean exploring a handful of memories in session, or it may mean journaling or otherwise expressing memories outside of session and bringing their discoveries back to process. It is important to convey that these memories must have impacted how client related to their body in a new and negative way. For example, I was often told that “outfits should always be flattering” in order to make you appear as small as possible. This opinion be-

came a core belief of mine for many years and shaped how I dressed and showed up in public spaces until I learned that I am allowed to wear whatever makes me feel personally great. These moments are important and powerful to name for the client as it allows them to name and externalize the harm they were caused and how it negatively impacted their body image and self-concept.

Additionally, it is particularly important to hold intentional space for the client to identify how the intersectionality of each of their marginalized identities (i.e. race, cultural background, socioeconomic status, gender, sex assigned at birth, sexual and/or relational orientation, ability status, etc.) impacted these moments and to allow the client to reflect on this as well.

This work can be painful as it asks the client to identify moments of complex trauma and label them as such—possibly for the first time. It may be slow work because identifying one memory may unintentionally unearth multiple additional memories. Meeting the client where they are in their unique journey is important for allowing them to internalized their significance. Having a plan to “cope ahead” by engaging in grounding nervous system regulation strategies can help clients feel safe and restored after engaging with this framework in session.

FRIEND

Identify internalized negative body image messages received and who/what/ where they came from. Unfortunately, most of the internalized negative messages clients receive begin in childhood and come from trusted family members. Naming this can identify complex trauma patterns that you as the clinician and the client may have been unaware of because this type of repeated and constant messaging is so

continued on page 95

normalized by society today. It is important to remind yourself and the client that receiving negative messaging consistently and constantly about one's body from loved ones, teachers, doctors, friends, strangers, social media, television, movies, and anywhere else where body shaming is normalized, is **not normal**, is in fact deeply **harmful**, and **not their fault**.

Navigating the complexities of internalized negative body image messages can take time. It is vital to meet the client where they are emotionally and cognitively in order for this work to have the most impact for the client. It may be necessary to go slow or to pause using the framework to address other issues that arise. Identifying these negative messages may also unearth other internalized negative messaging, so creating space for processing the client's unique intersectionality is crucial.

FRIEND

Externalize and explore the impact fatphobia and diet culture have had on the client's life from the first moment of shame until now. This part of the framework requires the clinician to have a foundational understanding of systemic fatphobia, diet culture, and its impact on plus size people. While still somewhat rare, there are resources to help clinicians understand the massive and systemic impact of fatphobia and diet culture on clients. These resources will be listed at the end of this article.

Once the clinician has sufficiently addressed their own weight bias and has acquired a baseline level of knowledge about systemic fatphobia and diet culture harm, then they can begin to help the client explore the impact these systems have had on the client (Philip et al., 2025; Robinson et al., 2025). Fatphobic rhetoric is embedded into every facet of our culture and is internalized as early

as childhood for many. It cannot be stated enough how essential the "unlearning" of fatphobic societal norms is for competently and compassionately working with plus size clients. This externalization part of the framework is important for expanding the client's worldview and providing vital psychoeducation about the racist and patriarchal origins of the anti-fat "beauty standards" that are pervasive today (Strings, 2019).

Externalizing the impact of the client's experience with dieting and diet culture can help them understand that their body is not an inherent problem to be fixed (Bacon, 2014). Helping the client understand that the problem lies within capitalistic diet industries profiting from the public's sustained and severe insecurity in their body image can alleviate clients' misplaced body shame. Psychoeducation about the deeply racist origins of modern "beauty standards", can also help externalize shame and guilt clients may feel for not meeting these fabricated standards that are unachievable for the majority of the world. (Strings, 2019)

This step in the framework may include the client naming the times they have experienced weight/size-based discrimination in the workplace, healthcare settings, or in their personal lives. It may also include the client naming and processing any diets or diet industry products they have tried and how it impacted their relationship with their body.

FRIEND

Name current feelings and thoughts about your present body image and how past messages and experiences inform those current feelings. This part of the FRIEND framework aims to encourage the client to gently and honestly acknowledge and take ownership of the current state of their body image. It al-

continued on page 96

lows them to acknowledge how they came to be, where they are currently in their body image journey, and what external sources led them there.

Gentle reflection on what this feels like and how their current body image impacts their activities of daily life is an important component of the framework. Naming the past messages and experiences that inform their current body image may feel redundant here, but it is essential to continue to reflect that the client's negative body image is not inherent—it was projected onto them by external sources and is not their fault. A major theme that will likely arise from this stage is a need to release shame about their body. This is long-term work and may take many multiple sessions to achieve progress. It is important to acknowledge that navigating body image issues is also a lifelong journey which makes setting accurate expectations for coping even more imperative.

FRIEND

Client Decides to change the way they relate to their body with a renewed empathetic lens and define how they would like to think and feel about their body. This stage in the FRIEND framework is where the client can begin to conceptualize how they would like to relate to their body in a more positive way—and on their own terms. It empowers them to take ownership of their own thoughts and feelings about body image and decide how they would like to perceive themselves and their body.

The client may be able to easily and eagerly define what they want for their new body image, or they may struggle to even identify what is possible for an improved body image. The “magic question” technique can help the client begin to define this for themselves. In this context, the “magic question” could

be stated as follows, “If you waved a magic wand and woke up in the body you have now with the exact relationship you have always wanted to have with your body, what would it look like?”. If they need more help, the below examples may be a comforting starting point for them:

- *Body Neutrality*
You don't have to love your body—you just don't have to hate it. Your body is allowed to simply exist without constant judgment.
- *Body Acceptance*
Acknowledging your body as it is right now, even if you have mixed feelings about it.
- *Body Respect*
Treating your body with care and dignity—feeding it, resting it, moving it—regardless of how you feel about it.
- *Body Positivity*
Actively challenging harmful beauty standards and affirming that all bodies are worthy, visible, and valuable.
- *Body Love*
Feeling appreciation, gratitude, or affection toward your body—not because it's perfect, but because it's yours.

Considerations and Conclusion

Reminding the client that body image will ebb and flow day to day (which is normal and okay), is important to ensure the client understands that the goal is not to have an unrealistically positive relationship with their body. The overall goal is to reduce the level of distress and harm caused by their negative body image.

Using the FRIEND framework as a supplemental support system to the clinician's existing theoretical approach(es) will benefit plus size clients seeking support with their body image. It provides a

continued on page 97

framework for clinicians to reference when questioning how to competently support plus size clients on their body image journey and will also help build rapport and enhance the therapeutic alliance between client and counselor.

Additional resources are listed below.

Podcast:

Maintenance Phase by Aubrey Gordon

Books:

Fearing the Black Body: The Racial Origins of Fatphobia by Sabrina Strings

What We Don't Talk About When We Talk About Fat by Aubrey Gordon

Reclaiming Body Trust: Break Free from a Culture of Body Perfection, Disordered Eating, and Other Traumas by Hilary Kinavey MS, LPC, and Dana Sturtevant MS, RD

Health at Every Size by Lindo Bacon, PhD

National Board for Certified Counselors (NBCC) Approved Continuing Education Course:

Becoming a Fat Positive Counselor: An Unlearning and Relearning Guide for Competently Working with Clients of Size By Sofia Siraj-Wu MS, LPC

<https://ondemand.modernpath.net/p/becoming-a-fat-positive-counselor-an-unlearning-and-re-learning-guide-for-competently-working-with-clients-of-size>

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Why the Health of Americans Will Decline and What Psychotherapists Should Do About It

Samuel Knapp, EdD, ABPP



Compared to Peer Countries, Americans Are Sicker

One metric of a country's overall health is its citizens' life expectancy from birth. Life expectancy in the United States peaked at 79.3 years in 2024, with only negligible increases in recent decades. In contrast, life expectancy in other high-income countries has increased significantly over the same period and now averages 80.3 years, with two-thirds of the Organization for Economic Cooperation and Development (OECD) countries having a life expectancy that is over 80 years (OECD, 2025).

Life expectancy in the United States is the lowest among all English-speaking nations, 3 to 4 years lower than most high-income countries, and almost 6 years lower than countries with the highest life expectancy. The United States ranks 43rd in life expectancy worldwide, placing it near Albania and Cuba (World Population Review, 2025). Additionally, 11 U.S. states have a life expectancy below 75 years (Arias et al., 2022), placing them behind 70 other countries, including Bangladesh and Vietnam. This occurs despite the United States spending much more per capita on healthcare than most other countries, including an average of 30% more than high-performing peer countries (Blumenthal et al., 2024).

The excess mortality in the United States compared to other high-income countries occurs across all age groups and for all the leading causes of death (Dehry &

Krueger, 2023). However, compared with other countries, the United States has significantly more deaths due to drug overdoses, homicides, suicides, and traffic accidents (Wilkie & Ho, 2024). Also, infant mortality in the United States is double that of many other high-income countries (Dehry & Krueger, 2023). Although life expectancy varies considerably across racial and ethnic groups within the United States, the life expectancy of non-Hispanic white Americans (close to 80 years old) is still lower than the life expectancy found in most other high-income countries (OECD, 2025).

The Health of Americans Is Likely to Decline

Current administrative policies will likely lead to a decline in Americans' health. An increase in deaths and disability rates can be anticipated as a result of direct cutbacks in healthcare funding (Basu et al., 2025), reductions in worker and public safety programs (e.g., School of Public Health, 2025), decline in living conditions for low income Americans (such as reduced availability of food stamps; One Big Beautiful Bill Act, 2025), and decreased funding for research to improve treatment approaches and interventions (U.S. Department of Health and Human Services, 2025). While some of these factors will take effect immediately, others will take effect when the Medicaid cuts are implemented after the 2026 election cycle. Some of these factors will take longer to be noticed and felt, although

continued on page 99

their impact is likely to be just as significant. Even though a vast majority of Americans will suffer in one way or another from these changes, the harm disproportionately impacts those who are economically and socially marginalized. This article outlines several policies that could harm public health.

Reductions in Healthcare Funding

The recently enacted One Big Beautiful Bill Act (2025) will remove an estimated 12 million people from Medicaid coverage, which is expected to significantly contribute to declines in health among those losing coverage (Basu et al., 2025). Medicaid is also a major payer for addiction treatment in the U.S. (Counts, 2025). The loss of treatment options for individuals formerly on Medicaid is likely to contribute to increased substance overdose deaths, which would then undo the recent decline in opioid-related deaths in the United States (Johnson et al., 2025).

As a result of cuts to Medicaid funding, many rural hospitals are likely to close entirely or to eliminate less financially viable programs, such as obstetrics or behavioral health services (American Hospital Association, 2025). 600 nursing homes are also expected to close due to funding reductions, and federal assistance for community supports for older adults has also been cut (Marseles, 2025). Moreover, the One Big Beautiful Bill Act (2025) reduces subsidies for patients covered under the Patient Protection and Affordable Care Act (2010), with the American Hospital Association (2025) estimating that one-third of individuals currently enrolled in the program will lose their coverage.

Lastly, the One Big Beautiful Bill Act (2025) will significantly increase the national debt (Congressional Budget Office, 2025). Medicare reimbursement is tied to the federal budget deficit, and

provider fee reductions will automatically take effect when the deficit reaches a specified threshold. However, Congress has the authority to waive these decreases. If implemented, this will increase healthcare professionals' reluctance to accept Medicare patients. As healthcare systems lose revenue due to cuts in Medicaid, Medicare, and the Affordable Care Act, they may attempt to cover their costs by increasing the fees charged to commercial insurers or private payers.

Reductions in Protections for Workers and the Public

There has also been a reduction in staff and in the enforcement at the National Institute for Occupational Safety and Health (School of Public Health, 2025) and the Food and Drug Administration (Tin, 2025), which may lead to an increase in deaths, injuries, and illnesses among the workforce and the public. Additionally, the U.S. Department of Labor has proposed removing many worker safety standards, thus increasing the risk of occupational disabilities and deaths (Bussewitz, 2025).

Reductions in Federal Emergency Management Agency (FEMA) funding will result in reduced staffing of critical positions responsible for issuing early warnings of severe weather, potentially increasing fatalities from natural disasters. Some deaths occur directly as a result of the disaster itself; however, more deaths occur after the immediate disaster ends due to disruptions in access to health care services or medications (Chu et al., 2025).

Additionally, executive orders have been issued to curtail the federal government's enforcement of anti-pollution laws. Incentives have been introduced to favor the use of coal and oil, which are

continued on page 100

more polluting than clean energy sources. This will lead to declines in public health as pollution levels continue to rise (Nilsen & Marsh, 2025).

Lastly, a recent presidential executive order instructed the Attorney General to review all federal firearm safety laws. It is believed to be the first step in the federal government's failure to defend firearm safety laws in court (Schascheck, 2025). If so, deaths from firearms (either from suicide, homicide, or accident)—which are already more than 11 times higher in the United States compared to other high-income countries (Grinshteyn & Hemenway, 2019)—may increase even more in the near future.

Social Determinants of Health

Health is about more than health care (Woolf, 2019, p. 196). The social and physical environments in which people live (e.g., stress levels, access to food) also significantly influence their health. As one example of the decline in support for healthy living environments, the federal government has imposed limitations on the Supplemental Nutrition Assistance Program (SNAP) and tightened eligibility requirements for school lunch programs (One Big Beautiful Bill Act, 2025). This is likely to significantly increase the rate of malnutrition, particularly among children and older adults, increasing the risk of disease and premature death.

Reductions in Research Funding

The current administration has halted funding for scientific projects at several private universities for reasons unrelated to the scientific merit of those projects. Additionally, the proposed budget for the National Institutes of Health has reduced its funding by 40% (U.S. Department of Health and Human Services, 2025). The withdrawal of federal funding for healthcare research will

slow the development of more effective medications and scientific innovations intended to reduce mortality and improve health.

Conclusions and Recommendations

The opportunity for a long and healthy life will be even more out of reach for many Americans. Due to space limitations, this article had to omit dozens of other ways new policies will harm public health; such as, appointing anti-vaccination activists to oversee vaccination policy within Health and Human Services (American College of Physicians, 2025), withdrawing the United States from the World Health Organization (Park, 2025), discontinuing the data collection on public health measures (Salmon, 2025), cutting funding for local public health agencies, eliminating funding for Planned Parenthood, reducing or eliminating student loans available for future health care workers, and reducing funding for programs to address domestic abuse (One Big Beautiful Bill Act, 2025).

To push back against these changes, psychotherapists should support efforts by the American Psychological Association (APA), state and territorial psychological associations, and other organizations to expand access to high-quality, affordable health care, advance research, and address social determinants of health. Psychotherapists can do this by:

- Responding to action alerts from these organizations.
- Contributing to the political action committees of the APA and state and territorial psychological associations.
- Meeting directly with public officials to express concerns.
- Promoting dialogue and public awareness of health care issues.

continued on page 101

Also, psychotherapy educators should educate students on their significant role in public health by adding advocacy (Singh et al., 2023), public health perspectives (Patel et al., 2023), social determinants of health (Woods-Jager et al., 2024), and skills in communicating healthcare findings to the public (Panthagani et al., 2025) into their curriculum.

In these discussions and presentations, psychotherapists should remember that promoting public health involves technical expertise (being able to explain scientific findings to a lay audience, avoiding jargon, being transparent about how conclusions were reached, acknowledging relevant limitations to their data) and social skills (listening carefully to the concerns of others, treating them with respect, building relationships, and searching for common ground). Shaming or attacking others does not work well in psychotherapy and is equally ineffective when discussing public policies.

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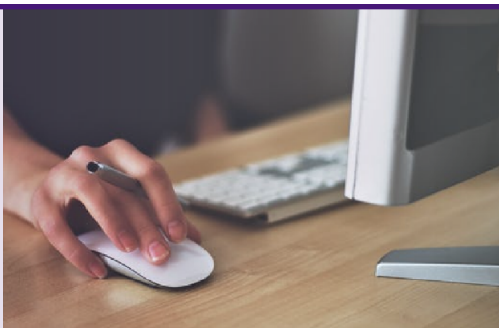
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continued on page 102

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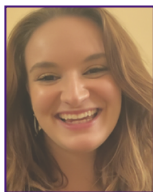
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From Misconception to Meaning: A Trauma-Informed Understanding of BDSM

Sophia Gamez, MS



Defining BDSM

BDSM, commonly referred to as kink, S&M, or leather, is an abbreviation of bondage and discipline, dominance and submission, and sadism

and masochism. It refers to a physical, psychological, and sexual practice often involving consensual power exchange. Within the community, it is mainly considered within four categories: practices (“play” or “scenes”), a lifestyle (“kinkster”), an orientation (“kinky”), and a subculture. Some common terms within the community to designate an individual’s role or status include dom, top, switch, bottom, sub, sadist, pup, little, daddy/mommy, or master and slave (Nichols, 2006). Consciously or unconsciously, many people interact with these practices without a specific label. Whether engaging in light impact play—such as spanking—or eroticizing being bossed around by a dominant figure, BDSM offers something for interested participants without pressure to engage in more extreme behaviors.

BDSM Stigma by Mental Health Clinicians

Client reports of discrimination and tendency to pathologize

The National Coalition for Sexual Freedom (NCSF) Violence & Discrimination Survey (2008), which surveyed over 3,000 individuals involved in BDSM and kink communities, found that approximately one-third of participants reported experiencing discrimination or persecution within medical, mental health, legal, and governmental systems. Within men-

tal health settings specifically, approximately 40% of participants who disclosed their kink-related behaviors to a clinician reported discriminatory experiences. These negative experiences extended beyond pathologizing BDSM practices and included breaches of confidentiality, assumptions of abuse or trauma without adequate assessment, pressure to discontinue consensual kink behaviors, loss of child custody concerns, employment discrimination, and clinicians viewing consensual BDSM dynamics as inherently dangerous or indicative of pathology.

Importantly, many BDSM behaviors exist on a broad spectrum of intensity and risk. Some activities, such as spanking or roleplay, involve relatively low physical risk, whereas others, such as knife play, breath play, or intense impact play, may carry greater potential for harm if performed without adequate negotiation, informed consent, safety precautions, skill and aftercare. Therefore, the clinical concern should not automatically center on the presence of kink behaviors themselves, but rather on whether these activities are consensual, informed, safely practiced, and free from coercion or abuse.

Distress surrounding BDSM behaviors also requires nuanced clinical assessment. In some cases, distress may stem from internal conflict, shame, trauma, compulsivity, impaired functioning or nonconsensual dynamics. However, distress may also arise from minority stress, stigma, fear of disclosure, social

continued on page 105

rejection, or discrimination from health-care providers and broader society. As such, clinicians must avoid assuming pathology solely based on the presence of consensual kink interests and instead conduct comprehensive, nonjudgmental assessments that distinguish consensual BDSM practices from abuse, coercion, or clinically significant dysfunction.

Recent research indicates only one-fifth of individuals feel comfortable speaking to their partners about their kink activities and preferences (Bowling et al., 2024). There is ongoing controversy surrounding the inclusion of Sexual Sadism Disorder and Sexual Masochism Disorder in the current DSM-5-TR, particularly regarding criteria that define these disorders as involving, “intense, recurrent sexual arousal from the physical or psychological suffering of another person.” While the diagnostic manual states the behaviors must cause clinically significant distress or impairment, the DSM-5-TR continues to view these behaviors as pathological or potentially retraumatizing, even though current research suggests otherwise. However, when distress is present, clinicians must carefully assess its source, as it may reflect genuine impairment or trauma-related concerns, but may also stem from shame, minority stress, or societal stigma surrounding consensual BDSM practices.

Prevalence

Many people engage in BDSM in some way. De Neef et al. (2019) found that 69% of individuals report having BDSM-related fantasies and nearly 47% of people have engaged in BDSM at least once. This is supported by broader scoping reviews confirming that kink interest and behaviors are common, normative variations of human sexuality rather than marginal anomalies (Brown et al., 2019). The National Coalition for Sexual Freedom (2024) conducted a survey in the U.S.

about adult engagement in kink practices, which found that: 30% of adult Americans engage in spanking, 22% in roleplay, 20% in bondage, and almost 13% in playful whipping. Less than 4% have attended a BDSM party—defined as a social gathering or organized event where individuals interested in BDSM engage in consensual kink-related activities, socialize within the community, observe scenes, and participate in negotiated power exchange dynamics within established community rules and consent practices (Newmahr, 2011). Lehmillier (2018) conducted a U.S. survey on sexual fantasies that, although not nationally representative, found that fantasies involving erotic force are common. When asked about their favorite fantasy, 61% of women, 54% of men, and 68% of nonbinary participants cited being “forced,” to have sex, while 20% of women, 38% of men, and 38% of nonbinary participants cited “forcing,” someone. Most who fantasized about forcing someone emphasized it was consensual in context (e.g., “they secretly want it”).

A common, misinterpreted concept within mainstream media is engaging in consensual nonconsent (“CNC”) or “rape fantasy.” CNC refers to pre-negotiated scenarios where individuals consent to engage in activities that mimic nonconsensual acts (Szpilka, 2023). While this may sound jarring to many, this act can be healing. Another study discusses how BDSM practices, including CNC, can serve as a pathway for some childhood abuse survivors to process and heal from past traumas (Gerwitz-Meydan et al., 2024).

BDSM vs. Abuse

BDSM is not inherently abusive, as it is grounded in consensual, negotiated and mutually agreed-upon dynamics between participants. However, because

continued on page 106

some BDSM practices may involve pain, restraint, power exchange, humiliation or intense emotional experiences, it can sometimes be difficult for both clinicians and kink practitioners to distinguish consensual BDSM activities from coercion, manipulation, or interpersonal abuse. This distinction becomes especially complex when consent is unclear, boundaries are violated, or harmful behaviors are minimized under the guise

of “kink.” Therefore, clinicians must carefully assess factors such as informed consent, communication, negotiation, mutual respect, and the ability to safely withdraw consent when evaluating whether a relationship dynamic reflects consensual BDSM or abuse. Stigma increases the stress of reporting behaviors both consensual and nonconsensual. Distinguishing between consensual BDSM and abuse involves:

Consensual	Abuse
● You have clearly discussed how to stop what is happening. ● You negotiate as equals prior to the beginning of the exchange. ● You have enough information to know what you’re agreeing to do. ● You set your own limits, and your partner(s) set theirs. ● Your limits are respected. ● You can express your feelings. ● You can speak to whomever you choose. ● You understand and agree to the risks involved.	● You can’t stop what’s happening even if you want to. ● You have no understanding of what will happen and no chance to agree or refuse. ● Your questions aren’t answered truthfully. ● You are tricked, coerced or pressured into doing things. ● You are forced to drink or take drugs, or necessary medication is withheld. ● You are afraid to be honest about what you think and feel. ● You are isolated and cut off from outside support, information or counsel. ● You are threatened or can’t leave.

Using a wheel of power and control (or LGBTQ+ version) may help identify harmful uses of power. (Domestic Abuse Intervention Programs, n.d.; Love is respect, n.d.)

continued on page 107

Safety: SSC, RACK, Safe Words, & Sexual Scripts

BDSM emphasizes safe, consensual practices using mottos such as: SSC (safe, sane, & consensual) and RACK (risk-aware consensual kink). Safe words allow partners to slow down, check in or stop a scene. The spotlight system is common: “green” = safe/continue; “yellow” = near limit/slow down; “red” = stop). Furthermore, not all safe words are verbal. Non-verbal signals—like tapping—can also be used, which may be especially helpful for those with traumatic experiences who may have difficulty using language to express needs. Sexual scripts are planned outlines for scenes, allowing communication and preventing unsafe or nonconsensual play.

Common Clinical Themes and Considerations

BDSM & Trauma

1. *Processing Trauma Through Play*: Some survivors use BDSM (“trauma play”) to safely revisit and transform traumatic experiences (Cascalheira et al., 2023; Thomas, 2020). Scenes may offer healing by reenacting trauma in a controlled way (Dripchak, 2007; Lindemann, 2011), with physical engagement helping rework memories (Hammers, 2014).
2. *Consent and Safety as Healing*: Consent distinguishes BDSM from abuse. Clear boundaries help survivors regain control, and trust enables experiences like “subspace” (Cascalheira et al., 2023; Dunkley & Brotto, 2020; Pitagora, 2017).
3. *Psychological Coping and Benefits*: Masochism may regulate emotion or reduce overwhelm. BDSM is not seen as pathological; benefits include release, altered states, and intimacy (Baumeister, 1988; Hammers, 2014; Ten Brink et al., 2021).
4. *Acknowledging Trauma Without Pathologizing*: BDSM can be empowering and reparative (Sandnabba et al., 2002; Ten Brink et al., 2021).
5. *Therapeutic and Identity-Affirming Aspects*: Scenes can be symbolic and healing, not just trauma repetition (Dripchak, 2007; Hammers, 2014; Lindemann, 2011).
6. *Pain, Power, and Transformation*: Pain and power can be redefined, bringing meaning, pleasure, and healing (Baumeister, 1988; Hammers, 2014).

BDSM and Sexual Satisfaction

1. *BDSM and Sexual Satisfaction*: BDSM practitioners report equal or higher sexual satisfaction than non-practitioners, often linked to open exploration, intentionality, and trust (Botta et al., 2019; Carty & Davidson, 2024; Strizzi et al., 2022).
2. *Sexual Functioning and Psychological Health*: Studies find no increased sexual dysfunction in BDSM populations. In fact, many report better functioning, lower distress, and greater sexual self-efficacy (Cesur & Sancak, 2024; Pascoal et al., 2015).
3. *Role, Gender, and Satisfaction*: Role and gender can shape experiences—dominant men and submissive women often report higher arousal and satisfaction, though outcomes vary (Botta et al., 2019; Cesur & Sancak, 2024).
4. *Relationship Closeness*: BDSM does not harm relationship satisfaction; instead, it often enhances emotional intimacy and trust (Carty & Davidson, 2024; Strizzi et al., 2022).
5. *Communication as a Strength*: Clear communication about desires, limits, and aftercare contributes to both sexual and relational satisfaction (Carty & Davidson, 2024; Strizzi et al., 2022).

continued on page 108

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6. *Stigma vs. Reality*: Despite stereotypes, BDSM participants are not more sexually or psychologically impaired (Cesur & Sancak, 2024; Pascoal et al., 2015; Strizzi et al., 2022). In fact, BDSM often involves intentional, health-promoting practices.

Kinksters: Maladaptive? Pathological? Violent?

1. *Mental Health and Psychological Functioning*: Compared to non-practitioners, kink practitioners show equal or healthier levels of depression, anxiety, self-esteem, distress, sexual functioning, attachment security, and lower rates of borderline traits, paranoia, and compulsivity (Connolly, 2006; Cross & Matheson, 2006; Powell, 2010; Richters et al., 2008; Sandnabba et al., 2002; Wismeijer et al., 2013). Some even report fewer family dysfunction histories. According to the Sexual Health Alliance, BDSM practitioners experience higher well-being and lower psychological distress than the general population—often attributed to the emphasis on trust, consent, and embodied self-awareness. Melavc et al. (2024) also finds that BDSM can promote psychological well-being and pleasure, particularly through safe, consensual exploration of pain.
2. *Aggression and Psychopathology*: Kink practitioners score equal or lower on measures of pathological sadism, masochism, hostility, authoritarianism, and psychopathy (Connolly, 2006; Cross & Matheson, 2006). They are not more prone to violence than non-practitioners.
3. *Trauma and Coping*: While many BDSM practitioners have histories of victimization (NCSF, 2015), they report low aggression, sexual violence, and rape myth endorsement. Crucially, research does not support

the idea that BDSM is a maladaptive response to trauma or early life dysfunction (Ten Brink et al., 2021).

Kink Affirming Therapy (KAT): Guidelines

The work of Margaret Nichols (2006), Kolmes et al. (2006), Stefani Goerlich's (The Leather Couch, 2020) and the Kink and Polyamory Aware Clinical Training (KPACT) program (2026) have led to the development of what we now call kink affirming therapy. The major guidelines are highlighted below:

1. Adopt a Sex-Positive, Non-Pathologizing Approach
2. Center Consent Over Content
3. Differentiate Kink from Abuse
4. Build Cultural Competence in Kink
5. Let Clients Define Relevance
6. Acknowledge Kink's Healing Potential
7. Foster a Stigma-Free Therapeutic Space
8. Practice Cultural Humility
9. Honor Client Autonomy

Trauma-Informed KAT

Both emphasize the principles of non-judgment, client autonomy, informed consent emphasizing safety and trust, cultural humility, collaborative therapeutic relationships, and being aware of the power dynamics. Some key differences are that KAT centers on sexual diversity, consent culture and stigmatization of BDSM while trauma-informed therapy focuses on the impacts of trauma on the nervous system, behavior and relationships.

Diversity

1. *Gender, Identity, and Kink Roles*: Masochistic roles can be misunderstood as pathological or self-harming. BDSM both reinforces and challenges gender norms. Focus on individual meaning, consent, and

continued on page 109

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- normalization of diverse gender expressions (Warkentin et al., 2025).
2. *Sexual Orientation, Queerness, and Intersectionality*: BDSM can affirm LGBTQ+ identities. Avoid fetishization and heteronormative assumptions (Dunkley & Brotto, 2018; Schiff, 2023; Sprott & Randall, 2023).
 3. *Race, Culture, and Representation*: BDSM spaces often lack racial/cultural diversity. Cultural stigma may increase shame or isolation, and racialized kink experiences are underrepresented. Clinicians should aim to use culturally informed, curious inquiry. Avoid imposing Western norms on dominance, submission, or shame (Schiff, 2023).
 4. *Trauma, Healing, and Fantasy*: For some trauma survivors, BDSM (e.g., CNC play) can be healing and empowering, especially when safety and consent are upheld. Trauma-related fantasies are not inherently pathological. The goal is to differentiate between therapeutic reenactment and retraumatization. Normalize and support client-led meaning-making and boundaries (Casalheira et al., 2023; Gewirtz-Meydan et al., 2024)
 - a. When Scenes Go Wrong
 - i. Harm may occur through boundary violations, injury, lack of aftercare, or power imbalance—not the kink itself. When these violations occur, community stigma can complicate how practitioners process the resulting distress or seek support (Holt, 2018).
 - ii. Kink affirming clinicians aim to affirm client experiences without shame. Explore consent, aftercare, and renegotiation needs. Educate on frameworks like RACK/SSC and exit strategies (Gewirtz-Meydan & Opuda, 2021; Kratzer et al., 2022; Schiff, 2023).
 5. *Mental Health, Diagnosis, and Stigma*: Kink practitioners often have equal or better psychological functioning. Yet those with BPD or PTSD face diagnostic overshadowing. Avoid assuming kink is symptomatic. Attune to consent and distress levels, not deviance. Use psychoeducation to reduce internalized stigma (Dunkley & Brotto, 2018; Warkentin et al., 2025).
 6. *Consent, Power, and Harm*: Harm generally results from nonconsensual practices or power misuse. Consent norms differ across communities. Make sure to educate on consent types (SSC, RACK). Routinely assess safety and respect diverse understandings of power.
 7. *Risk and Suicide Vulnerability*: Due to the compounding effects of societal stigma, shame, and systemic marginalization, BDSM practitioners experience elevated minority stress that can translate to a suicide risk two to three times higher than the general population. Clinicians must therefore screen for risk factors sensitively, focusing on reducing internalized shame through affirming care and fostering community connectedness (Cramer et al., 2017; Roush et al., 2017).
 8. *Community, Belonging, and Healing*: BDSM spaces can offer crucial support, identity validation, and resilience—but may also exclude marginalized voices. Affirm chosen family and subcultural belonging. Explore the client's inclusion, exclusion, and community needs (Dunkley & Brotto, 2018; Schiff, 2023).
 9. *Minority Stress, Marginalization, and BDSM*: A trauma-informed approach to BDSM must account for how marginalized individuals—
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continued on page 110

especially people of color, LGBTQ+ folks, and others—face stigma and discrimination, even within kink spaces (Meyer, 2003). The Minority Stress Model helps conceptualize how chronic stress from prejudice, internalized oppression, and systemic inequities affects mental health. A 2018 to 2019 U.S. study of 398 BDSM practitioners found that people of color were 16 times more likely to report discrimination and 17 times more likely to report fetishization at BDSM events. Experiences included overt racism, microaggressions, and social isolation (Erickson et al., 2022).

Clinical Implications:

1. Ask about experiences of marginalization within kink communities.
2. Explore how this impacts clients' safety, identity, trust, and relationships.
3. Provide culturally competent, trauma-informed care that validates these harms and addresses both micro- and macro-level aggressions.

Take Away Points

1. Many individuals engage in BDSM, which involves consensual power exchange and role-play. Therefore, it is important for clinicians to understand BDSM practices without assuming pathology.
2. Consent, negotiation, and clear communication distinguish BDSM from abuse. Clinicians should assess these factors when exploring client sexual behavior.
3. Safety practices such as SSC, RACK, safe words, and sexual scripts help prevent harm. Therefore, discussing safety norms can improve therapeutic understanding and client trust.
4. BDSM can support sexual satisfaction, emotional regulation, and empowerment. Clinicians should con-

sider the potential positive effects of kink on mental health and coping.

5. Stigma and discrimination remain common in healthcare and society. Therefore, creating a non-judgmental, kink-affirming, and culturally competent space is essential for effective care.

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continued on page 113

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Integrating Mindfulness into Psychotherapeutic Practice

Anne Bello, PhD MSW, HBSW, CAMC, CPPP



A client once described conflict at work “came out of nowhere.” Meetings would escalate quickly, leaving them feeling overwhelmed and reactive. When we slowed the moment down in session, something different emerged. As the client spoke about a recent disagreement, my favorite question to ask clients is: “What do you notice in your body right now as you recall that moment?”

After a pause, the client noticed chest tightness and shallow breathing. Then came rapid thoughts about being criticized, followed by a surge of anger. These sensations also appeared moments before the client spoke defensively during the meeting. For the first time, the client recognized that their reaction did not occur suddenly; it unfolded through a sequence of internal experiences. This moment illustrates a fundamental aspect of mindfulness in psychotherapy. While mindfulness is often presented as a therapeutic technique, it can also function as a way of being in the therapeutic encounter. Mindfulness is a shared practice of paying attention to internal experiences as they arise (Shapiro & Carlson, 2009). When integrated in this way, mindfulness becomes not only an intervention but also a valuable component of assessment and therapeutic discovery.

Mindfulness as Awareness in the Present Moment

Mindfulness is commonly defined as the practice of intentionally paying attention to the present-moment experience with openness and without judgment (Kabat-Zinn, 2003). Within psy-

chotherapy, this approach helps clients observe the interplay between thoughts, emotions, and bodily sensations as they occur in real time. Many clients enter therapy confused by their own reactions. They ask questions such as, “Why do I keep doing this? Why do I respond this way?” These questions reflect an intuitive awareness that their reactions have deeper roots. Mindfulness helps illuminate these processes by shifting the focus from simply describing events to noticing the internal experiences that accompany them.

In my practice, mindfulness often begins with small invitations to awareness:

- What are you noticing in your body as you talk about this?
- What thoughts arise when this memory comes up?
- Where do you feel that emotion right now?

Such questions move therapy from narrative recounting to experiential awareness. In this way, mindfulness becomes part of the assessment process itself, revealing patterns of emotional and physiological responses that might otherwise remain outside conscious awareness.

Research Supporting Mindfulness-Based Interventions

Mindfulness has become a foundational component of contemporary psychotherapy, particularly through various mindfulness-based interventions (MBIs) such as Mindfulness-Based Cognitive Therapy (MBCT; Segal et al., 2002), Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1990), Acceptance and Commitment Therapy (ACT; Hayes et al., 1999),

continued on page 115

and Dialectical Behavior Therapy (DBT; Linehan, 1993). These approaches emphasize present-moment awareness, non-judgmental attention, and psychological flexibility, processes associated with improved emotional regulation and reduced psychopathology (Goldberg et al., 2022; MacKenzie & Kocovski, 2016; Gu et al., 2015). Research shows that MBIs enhance psychological well-being and are effective across various clinical populations.

Mindfulness Based Interventions for Various Clinical Populations

Healthcare Professionals

A recent meta-analysis demonstrated that MBIs significantly reduced burnout and improved resilience and sleep quality among healthcare professionals (Dou et al., 2025). As transdiagnostic interventions, MBIs prove effective for conditions including depression, anxiety, trauma-related disorders, and stress-related issues, highlighting their role not only in symptom reduction but also in fostering broader psychological resilience (Alkan et al., 2025). Neurobiological studies further suggest that mindfulness practices are associated with functional and structural changes in brain regions implicated in attention regulation, emotional processing, and self-referential thinking (Tang et al., 2015).

Psychiatric Populations

Mindfulness-based approaches have also shown promise in more complex psychiatric populations. A systematic meta-review examining mindfulness and acceptance-based interventions among individuals with schizophrenia spectrum disorders found evidence suggesting these approaches can reduce psychological distress and improve coping with symptoms (Meinhart et al., 2025). Although additional research is needed, these findings highlight the growing scope of mindfulness-based approaches.

Additionally, MBCT has been widely studied for relapse prevention in depression, with evidence suggesting it helps individuals develop a different relationship with their thoughts, recognizing them as mental events rather than facts that require immediate reaction (Segal et al., 2013, p. 69).

Addressing Unanswered Questions in Mindfulness Practice

As mindfulness-based interventions continue to gain traction in therapeutic settings, several questions remain concerning their optimal use and efficacy. One critical area of inquiry is identifying which specific mindfulness techniques are most effective in different therapeutic contexts. Techniques such as body scans, mindful breathing, and observing thoughts and feelings yield varying results depending on individual client needs and circumstances. For instance, body scans may particularly benefit clients with anxiety by fostering awareness of physical sensations, while mindful breathing can offer emotional regulation during distress (Hofmann & Gómez, 2017; Siegel, 2012; Treleaven, 2018).

Moreover, integrating mindfulness practices into existing therapeutic frameworks raises additional considerations. Therapists can incorporate mindfulness by initiating sessions with short mindfulness exercises, thus centering both themselves and the client. Additionally, introducing mindfulness concepts during discussions allows for exploration of thoughts and feelings through a mindful lens. Facilitating this process often involves training that equips therapists with the necessary skills to blend mindfulness into diverse therapeutic approaches while ensuring alignment with overall treatment goals.

continued on page 116

Integrating Mindfulness More Deeply into Clinical Practice

Despite the strong research foundation, mindfulness is sometimes applied narrowly in therapy, often limited to brief breathing exercises or guided meditations. While these practices are useful, mindfulness can be integrated more effectively when viewed as a broader therapeutic approach.

Several principles support this deeper integration. For example:

Mindful Therapist Presence: Mindfulness starts with the therapist's own awareness. Attentive listening, emotional attunement, and curiosity about the client's present-moment experience create a relational environment that fosters exploration.

Awareness Before Change: Behavioral change rarely happens without awareness. Mindfulness helps clients recognize the gap between stimulus and response, allowing them to notice automatic patterns before reacting.

Embodied Awareness: Mindfulness encourages attention not only to thought processes but also to bodily sensations. This somatic awareness often provides vital information about emotional states and stress responses.

Extending Mindfulness into Daily Life. Finally, it is essential to acknowledge the limitations of mindfulness-based interventions, especially for individuals facing severe mental health challenges. Such interventions may not be suitable for everyone, particularly those with a history of trauma, acute psychiatric conditions or personality disorders, as the practice of non-judgmental observation may provoke distress (Treleaven, 2018). While mindfulness offers valuable coping mechanisms, it is crucial to recognize that it should complement, rather than replace, other evidence-based treatments

for individuals requiring more intensive support.

The most meaningful shifts often happen when mindfulness moves beyond formal exercises and becomes part of everyday experiences, such as conversations, stressful moments, and relational interactions (Kabat-Zinn, 1994).

Mindfulness Beyond Technique

As psychotherapy evolves, mindfulness provides a compelling link between evidence-based techniques and personal self-awareness. When practiced authentically, mindfulness transforms therapy from merely analyzing issues to fostering a deeper understanding of internal experiences. Therefore, mindfulness is not just a skill we teach clients; it embodies an approach to psychotherapy itself, emphasizing curiosity, present-moment awareness, and attentiveness to the unfolding of human experience. In this sense, mindfulness becomes both the medium and the message of therapeutic work, a way of being present with others that, in itself, is healing.

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Practical Tips for Using Social Media to Promote Your Professional Practice

Amanda Conway, MS



Creating professional social media accounts across multiple platforms can increase both business traction and community outreach and contact. By using your professional

knowledge to inform the public about your mental health expertise and areas of specialty, you can help strengthen the relationship between mental health care and the communities it serves; destigmatizing various facets of mental health, promoting positive coping skills, and providing access to resources, all while growing your professional brand and business. Whether you are a social media expert in your personal life or you are brand new to social media altogether, using social media to represent your professional brand can present unique challenges for everyone. This article will review strategies to consider when using social media to promote your professional practice.

1. Decide on a brand you love and that is relatable to your audience.

With 72.8% of internet users using social media as a primary source of information when researching brands (Nyst, 2023), it is important to know your target audience and brand in a way that is specifically appealing to them. Knowing your audience is the first step in creating your business brand. Knowing this will help you decide what type of content to create. Part of branding is creating an image people will remember; choose a color scheme or pattern that people can see and immediately associate with your brand. Is it going to be colorful and bright? Or is using neutral tones with simple and bold fonts more relevant to your brand? Whatever you

decide, it's important to keep it relatively consistent. If you are just starting out, play around when posting and see which posts receive the most engagement from viewers; this can help inform future decisions about branding and marketing toward your target audience.

2. Utilize a social media platform that caters to and aligns with your content and audience.

Social media platforms cater to specific audiences and content. For example, TikTok and YouTube are primarily used for video content, while BlueSky and X are primarily used for sharing information and photos. Each platform uses a variety of media forms; however, each one typically prioritizes certain media forms over others. Additionally, social media platforms are often used more predominantly by individuals in certain age groups. For example, 59% of 18- to -29-year-olds use TikTok, while only 25% of 50- to 64-year-olds adults use the platform (Pew Research Center, 2025). These types of demographic and statistical data are important to understand and consider when deciding which platform(s) to utilize and the type of content to create. Overall, YouTube, Facebook, and Instagram are the most widely used social media platforms among adults, with 84% reporting YouTube use, 71% using Facebook, and 50% using Instagram (Pew Research Center, 2025).

3. Use engaging captions.

Creating engaging captions and content allows for more opportunities for your audience to Interact with your content initially and regularly in the future, building an engaged following over time. Using

continued on page 119

specialized characters in your caption can help capture the eye of the audience and can create enough attention for someone to stop scrolling and engage their full attention in your post. Below is an example of the visual differences between a caption that does not use emojis to engage the audience and the same caption that utilizes emojis.

Without emojis

Unlock the power of dreams in therapy. Join us for Working with Dreams in Psychotherapy. Friday, October 24, Free registration, 3 free CE credits.

With emojis

🌟 Unlock the power of dreams in therapy! 🌟 Join us for Working with Dreams in Psychotherapy 📅

Friday, Oct 24 | 12–3 PM EST

📄 Free registration for all

✅ 3 FREE CE credits for APA

✅ Division 29 members

While both captions contain the same information, the second caption catches the eye, is easier to read, and provides quick information for the audience to swiftly decide if they are interested enough to take action. Another way to build a following is by creating polls to engage the audience by asking interactive questions and allowing followers the opportunity to provide feedback on what they are seeking information on. This can also be included in your captions by asking the audience a question about the content.

4. Don't be afraid to use templates.

If you are just starting your professional social media accounts, creating posts can be daunting. Luckily, many apps and sites, such as Canva, Adobe, and Fotor provide free templates to help you get started. Templates allow creators to

focus more on the information being shared since the formatting and overall aesthetic of the template are already created. Once you become more comfortable with designing the content in templates, it's encouraged to play around with the plethora of fonts, colors, and presentation styles and adapt them to your personal, professional style.

5. #Use the Hashtag.

Hashtags boost your reach and visibility by making your profile more searchable. It connects similar content and provides a quick way to see posts relevant to your interests. Each social media platform has its own hashtag strategy. For example, you want to use more hashtags on Instagram, whereas you want to keep the tags minimal on X for maximum engagement (Heaslip, 2025). Focus on the relevance of the hashtag to your topic, be specific, and avoid overly competitive or broad hashtags (i.e., #therapy).

Overly broad and competitive

Psychotherapy plays a vital role in supporting mental health, personal growth, and well-being.

#therapy #mentalhealth #health
#wellness #selfcare #business
#psychology #healing

Why this doesn't work well:

These hashtags are broad making it difficult for the post to surface to a targeted audience interested specifically in psychotherapy.

Relevant and targeted hashtag

Psychotherapy plays a vital role in supporting mental health, personal growth, and well-being.

#Psychotherapy #Psychotherapy-
Research #EvidenceBasedTherapy
#TherapeuticAlliance #Clinical-
Psychology #MentalHealthEquity
#APADiv29

continued on page 120

Why this works better:

These hashtags are directly tied to psychotherapy, research, and professional practice, helping the content reach a more specific and engaged audience.

When creating a hashtag, ensure there are no spaces between words- and focus on utilizing letters and numbers only and not special characters/symbols. Users can follow specific hashtags to discover new content related to topics they care about. Hashtags function as discovery tools, helping posts reach an audience beyond your account’s followers. When relevant hashtags are not used—or are too broad—content may be less visible to intended audiences, limiting reach, engagement, and overall outreach potential. Strategic hashtag use allows posts to connect with users actively

seeking information on that topic. If you’re wondering which hashtags to use, go check out some of your own favorite accounts to gain some inspiration. Be thoughtful and be strategic.

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FEATURE

The Projective Assessment Integration System (PAIS): A Guide for Student Clinicians in Training

Michael Pica, PsyD



When administered, scored, and interpreted correctly, remain pivotal in assessing emotional functioning, problem-solving, interpersonal style, and linearity of thought.

Critics of projective testing point to problems with validity, inter-rater reliability, and subjective preconceptions that may limit the generalizability of the results (Lilienfeld et al., 2000). However, there are a plethora of valid and reliable studies identifying object-relational (Westen, 1991), personal problem-solving (Ronan et al., 1993), and dissociative scoring systems (Pica et al., 2001) for the Thematic Apperception Test (TAT), along with standardized scoring systems for the Rorschach using Exner (2003) and the Rorschach Performance Assessment System (R-PAS; Meyer et al., 2011). Karon (1995) commented that a problem with questions about inter-rater reliability rests on the fact that not all clinicians administering and interpreting projective data have the same level of experience and training, which can impact this form of reliability.

The Projective Assessment Integration System (PAIS) is comprised of six triads used to formulate an integrative interpretation of the projective assessment. These triads include the depression triad, cognitive rigidity/defensive triad, obsessive triad, compromised thinking triad, interpersonal triad, and the dissociative triad. The system can be used by trainees and licensed clinicians who may be looking for ways to organize their thoughts and identify similarities and

differences across measures and the assessment at large.

Foundation of the System

The concept for the PAIS developed when the author began wondering how Rorschach scoring determinants might translate to or appear in TAT stories and the projective drawings when administered together in a comprehensive assessment. For instance, might shading responses on the Rorschach correspond with depressive TAT stories and/or shaded drawings of houses and trees?

The PAIS centers on sound clinical observation and starts with an analysis of Rorschach responses scored per Exner (2003) and/or more recently, the R-PAS (Meyer et al., 2011). The interpretive process begins with an examination of popular scores, human content/movement, form responses, achromatic responses, texture, shading, and special scores. An analysis of this data is compared to responses on the TAT and projective drawings to identify similarities between them.

Depression Triad

The depression triad begins with an examination of Rorschach responses suggestive of dysphoric affect, primarily associated with shading, texture, achromatic, and morbid responses. This might include a dead animal, a furry coat, or a shadowy monster identified in the performance proper and elaborated upon in the inquiry to identify the appropriate determinant.

continued on page 122

If such variables are present, how do they correlate with the TAT? Joo & Park (2021) found that TAT stories of depressive individuals showed a negative emotional tone. This may include responses indicative of sadness, hopelessness, irritability, pessimism, exhaustion, morbid thoughts, and suicidality embedded within the stories.

Corresponding data on the projective drawings might display use of heavy texture or shading by pencil and/or crayon, or a predominant and/or unusual use of black or brown crayon. This might include drawing a black sun. If the examinee is instructed to tell a story about the drawing, it might include depressive themes similar to those found on the TAT.

Corresponding data across all three measures increases evidence for the presence of a dysphoric affect, which can then be analyzed alongside subjective data from the clinical interview, any collateral information obtained, and any significant historical data from chart and/or report reviews. The goal from integrating all the data obtained about the individual is often to arrive at a diagnosis to further inform and improve the treatment plan. Regarding the depression triad, this could potentially inform and suggest the diagnosis of an affective/mood disorder.

Rigidity/Defensive Triad

A rigid or defensive Rorschach might be marked by an over-abundance of pure form responses which has historically and more recently been linked to perceptual rigidity, a guarded test-taking style, and observable defensiveness as noted by Exner (2003) and Mihura, et al. (2015).

Corresponding TAT data, as discussed by Schlesinger (2021), might find an ex-

aminee providing short, innocuous descriptions of the cards versus elaborative stories even after the instructions are re-read after administration of the first card; in most cases card one. For example, a card descriptor might read, "that is a boy, that is a violin, he is sitting at the table." This might correlate with the Rorschach pure form response, "it's a bat." Upon inquiry, the examiner asks, "what made it look like a bat?". The examinee responds, "just looks like a bat."

Corresponding projective drawing data might include attempts at stick figures, or simple drawings of human figures and structures that are noticeably stiff and rigid. The examinee may provide little elaboration when queried by the examiner.

If all three components are met, the examinee might hold a rigid cognitive set, have trouble with ambiguity, struggle with creativity, and/or may become more easily threatened, and/or rely on the use of intellectualization or primitive denial as a way to withhold sharing vulnerabilities.

Obsessive Triad

The Rorschach response set for this triad may be overly detailed with multiple time-consuming responses per card, and/or using very small parts of the card to generate responses as reported by Meyer et al. (2011). The term "obsessive" is used to describe an approach to this ambiguous task that goes beyond what may be encountered with a typical examinee. In this case, the examinee "covers all bases" by scanning the card to make use of every detail without reference to the amount of time he, she, or they are taking to complete the task.

Similarly, TAT responses might be lengthy and overly elaborate making

continued on page 123

use of very small parts of the card, or including images not present in the card into the stories. The author has found these examinees often asking for reassurance, that is, wondering if they are performing as asked, or if their stories are right.

Corresponding projective drawings include overly detailed, time-consuming drawings coupled with lengthy responses to inquiries and an increased need for reassurance.

Corresponding data across the triad might lead the examiner to consider an anxious, self-conscious, or obsessive thought process. An important caveat about this triad is that it is not meant to diagnose obsessive-compulsive disorder, or obsessive-compulsive personality disorder, but rather a generally obsessive style, or way of coping with anxiety generated during ambiguous situations.

Compromised Thinking Triad

Rorschach indicators for this triad include fewer popular responses in comparison to established normative data (see Exner 2003; Meyer et al. 2011), deviant responses, or verbalizations indicative of strained or peculiar reasoning, such as a bunny with wings flying to another planet.

Corresponding TAT data might show an absence, or limited number of popular responses, such as not seeing the violin in card one, or not describing people on a farm for card two. Peculiar responses would be another indicator. For instance, the author tested one examinee who stated that the man working on the farm is in a blizzard and then is going to do a handstand and walk to his neighbor's home in a foot of snow.

Projective drawing data indicative of a peculiar or strained thought process

might include peculiar representations of people, houses, or trees, and the peculiar use of color, such as drawing orange tree bark or a purple person. Peculiar responses when queried about their drawings are another indicator; for example, "this is a palm tree by a home in Alaska."

Corresponding data across all three measures may suggest a peculiar, non-conventional, or less than linear way of perceiving the world, but not necessarily a diagnosis of psychosis.

Interpersonal Triad

Rorschach indicators of the interpersonal triad might include a lack of human content or human movement responses. Corresponding TAT data might display a lack of interpersonal interactions in the stories, the main character, perhaps alone in thought and not thinking about others, or statements about characters not liking or not wanting to be around people, or feeling alienated, isolated, or lonely.

Similar themes would likely be noted in the projective drawings, if queried. One might also see a lack of other people being incorporated into the drawings, the characters not interacting with one another, or the main character not thinking about others in the stories.

Corresponding data across all three categories might be suggestive of someone who lacks interpersonal awareness, is avoidant of relationships, does not think relationally, or may struggle with social skills.

Dissociative Triad

Research on the Rorschach with dissociative clients (Leavitt & Labott, 1998) has pointed to empirical support for patterns of hidden images, images denied

continued on page 124

or forgotten during the inquiry, images seen through obscured media (e.g., mist, fog, clouds, smoke, shadowy, ghost-like figures, figures seen from an extreme distance), stimuli reported to be rapidly shifting or being blown apart, and/or human figures being pulled apart.

Relative to the TAT, one might find stories with similar figures or themes of distance or being viewed through some kind of dissociative or obscuring media. Projective drawing data might show similar ghost-like or shadowy figures, figures drawn or described from a distance, through a cloudy, smokey, or foggy mist, or they describe on inquiry shifting figures or figures being pulled apart.

Pica et al. (2001) found dissociative clients to respond to the TAT cards most notably with spontaneous trance states, intra-interview amnesias, and volatile emotional reactions. These behavioral observations are consistent with the denial finding during the Rorschach inquiry noted above; that is, the original response named in the performance proper was forgotten during the inquiry as it may have been given during a dissociative state or forgotten in a dissociative state at a later point in time. Behavioral observations of this sort that cut across the assessment might be suggestive of a dissociative process to be considered alongside the rest of the assessment data.

Report Writing

Before closing, it is worth noting that this system can be used to write an integrated projective section in a formal assessment report. Most often, the results obtained from the projective measures are written under each specific test, which lends itself to a less integrated presentation of the findings. Though beyond the scope of this article, it may be beneficial to give some consideration to completing a com-

prehensive presentation of the results utilizing a PAIS framework.

For instance, a report might read, "When looking at the data as a whole, the examinee meets four of the six triads suggesting a peculiarity or lack of linearity to his thinking, the potential for a dissociative process, a rather rigid and obsessive way of perceiving the world and/or approaching his environment and showing little interest in others or not being someone who may readily think in relational terms." This is something that can be placed in a concluding paragraph after presenting the various results from each of the projective tests.

Summary and Conclusion

This article presented the PAIS system that students-in-training, novice clinicians, and more experienced licensed psychologists can use to integrate projective assessment data from the Rorschach, TAT, and projective drawings when administered as part of a psychological assessment battery. The system is ideal for training purposes and can be easily implemented into individual and group supervision. While the goal is to include all three measures in a full assessment, this may not always be possible for many reasons. Even if only two measures are chosen, the system can be used to make for a more confident integration and interpretation of the projective data within the context of the full assessment. Research is currently underway examining archival data to determine how accurately this system can match the diagnosis of completed assessments. The ultimate goal is to standardize the system with the validity and reliability needed to support it empirically and tie together projective assessment data that to this point may be perceived as less than integrated at best.

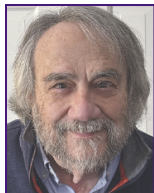
continued on page 125

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2026 SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY DISTINGUISHED PSYCHOLOGIST RECIPIENT



Les R. Greene, Ph.D. has held a joint appointment at the VA Connecticut Healthcare System and in the Department of Psychiatry of Yale University School of Medicine for more than four decades where he has taught, supervised and mentored Yale psychiatry residents, clinical psychology interns and graduate students individual, couples and group psychotherapy. He has published extensively in the areas of psychodynamic theory and group psychology, has served as editor-in-chief of the *International Journal of Group Psychotherapy*, and is a former President of the American Group Psychotherapy Association. He currently co-edits the AGPA Group Therapy Training and Practice Series and maintains an independent practice of psychotherapy in Hamden Connecticut.

2026 SAP/APF EARLY CAREER AWARD RECIPIENT



Alayna Park





2027 NOMINATIONS BALLOT

Dear SAP (Division 29) Colleague:

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

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

The offices open for election in 2027 are:

- President-elect
- Director for Psychotherapy Practice
- Director for Education & Training
- Treasurer
- Director for Membership
- Director for Diversity

All persons elected will begin their terms on January 2, 2028

A Director is a voting member of the Board of Directors, responsible for initiatives and oversight of the Society's portfolio in the respective specialty areas. Candidates should have demonstrated interest, expertise, and investment in the area for which they are running. Candidates should review the Society's fiduciary duty and conflict of interest policies and must complete the fiduciary questionnaire prior to being included on the slate. Detailed descriptions of the duties and responsibilities for each position are available on request from the Society's central office: assnmgmt1@cox.net.

The Society's eligibility criteria for all positions are::

1. Candidates must be Regular Members, or Voting Associate Members or Fellows of the Society.
2. Non-APA Member Affiliates may be elected to Director positions, but not to officer positions
3. No member may be an incumbent of more than one elective office.
4. A member may only hold the same elective office for two successive terms.
5. Incumbent members of the Board of Directors are eligible to run for a position on the Board only during their last year of service or upon resignation from their existing office prior to accepting the nomination. A letter of resignation must be sent to the President, with a copy to the Nominations and Elections Chair.
6. All terms are for three years, except President-elect, which is one year (and then proceeds to President for one year and Past President for one year).

The deadline for receipt of all nominations ballots is December 15, 2026.

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

If you would like to discuss your own interest or any recommendations for nominations, please contact the Society's Chair of Nominations and Elections, Dr. James Boswell at jboswell@albany.edu

Sincerely yours,

Joshua Swift
President

Rayna Markin
President-elect

James Boswell
Chair, Nominations Committee

----- NOMINATIONS -----

President-elect

Treasurer

Director for Membership

Director for Diversity

Director for Education and Training

Director for Diversity

Name (Printed)

Signature

Fold Here

Division29
Central Office
6557 E. Riverdale St.
Mesa, AZ 85215

APA 2026 CONVENTION – HONORING DR. CHARLES GELSO

At the 2026 APA Convention, the Society sponsored a symposium honoring the late Charles Gelso and his impact on the field of psychotherapy. His seminal work on the therapy relationship and, specifically, the tripartite model and the real relationship, left an unerasable footprint on our field. This symposium brought together friends and colleagues to reflect on the impact and legacy of Dr. Gelso's work and takeaways for the future.



PLEASE JOIN US IN CONGRATULATING THE 2026 SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY GRANT RECIPIENTS!

Norine Johnson Psychotherapy Research Grant



The 2026 winner received \$20,000 for her psychotherapy research project

Dr. Friederike Winter is a postdoctoral researcher at the University of Mannheim in Germany, where she also teaches clinical psychology in the Master's programme in Psychology and Psychotherapy, alongside her work in clinical practice. ■



Charles J. Gelso Psychotherapy Research Grant

This year, the Society provided three \$5000 grants



Lihi Cohen, M.A., is a doctoral candidate in psychology at Bar-Ilan University, supervised by Prof. Dana Atzil-Slonim and Dr. Sharon Naparstek. Her research focuses on psychotherapy process and outcome, with particular interest in how therapists adapt their interventions to patients' moment-to-moment needs and in how computational methods, including large language models, can support the study of clinical processes at fine-grained resolution.

Her broader interests include cognitive and mental flexibility, and the methodological challenge of linking micro-level therapeutic interaction to treatment effectiveness and applying it in therapist training. Cohen trained as a rehabilitation psychologist at Bar-Ilan University, with practica at Sheba Medical Center and the Bar-Ilan University Community Clinic. ■



Eleanor Wu is a postdoctoral fellow and clinical psychologist at Johns Hopkins School of Medicine. Her research focuses on observational measurement of youth psychotherapy process and studying the mechanisms through which mental health providers and service systems promote treatment engagement for youth and families from historically underserved backgrounds. She seeks to apply this research to advance the personalization of youth psychotherapy in publicly funded service settings. ■



Joshua K. Swift, Ph.D. is a Professor in the Psychology Department at Idaho State University and a licensed psychologist. At Idaho State University, he teaches courses on professional ethics, clinical supervision, psychotherapy skills, and self-care and well-being. He is also a psychotherapy process and outcome researcher with a specific focus on client factors that impact treatment initiation, dropout, and outcomes. ■

Diversity Research Grant – Pre-Doctoral Student



Nan Zhao (she/her) is a doctoral candidate in Counseling Psychology at Iowa State University. Nan earned a B.A. in Psychology and an M.S. in Clinical and Health Psychology from Peking University, China. Her research focuses on self-compassion and mental health, with a particular emphasis on understanding cultural barriers to mental health care. The Diversity grant will support Nan to develop an indigenous measure of self-compassion for

East Asian heritage populations grounded in dialectical thinking and establish the psychometric properties of the scale. The project aims to enhance to cultural validity of psychological assessments and serve as a foundation for developing culturally responsive interventions to cultivate self-compassion for individuals of East Asian heritage. ■



Diversity Research Grant – Pre-Doctoral Student



My name is Kriti Jain (any pronouns) and I am a PhD student in the Counseling Psychology program at the University of Tennessee, Knoxville, supervised by Dr. Kirsten Gonzalez. I earned my Bachelor's degree in Psychology from Ashoka University in India, followed by a Master's degree in Clinical Psychology with a specialization in Spirituality and Research Methods from Teachers College, Columbia University. I also currently serve as a Tri-Chair

on the APA Student Affiliates of Seventeen Executive Board.

My research focuses on the positive psychology of LGBTQ+ and BIPOC communities, utilizing both quantitative and qualitative methodologies to explore and support positive identity development and radical healing among individuals with intersecting marginalized identities. Currently, I am working with Dr. Gonzalez to develop a strengths-based and liberation-focused group intervention for QTBIPOC (queer and trans Black, Indigenous, and other People of Color). With the support of the Diversity Research Grant, I hope to conduct a randomized controlled trial to evaluate the efficacy of the intervention, with the eventual goal of disseminating this intervention across community and clinical settings to support the needs of this underserved population. ■



Diversity Research Grant – Early Career



Dr. Yue Li is a licensed psychologist and Assistant Professor of Psychology at Roosevelt University. She obtained her Ph.D. in Counseling Psychology at Indiana University in 2020. Through feminist and liberatory lenses, she primarily employs qualitative methods to analyze the impact of systemic oppression, sociopolitical environments, and colonial history on marginalized peoples' mental health. Dr. Xiang Zhou is a licensed psychologist and an

Associate Professor of Counseling Psychology in the College of Education at Purdue University. He received his Ph.D. in Counseling Psychology from the University of Minnesota in 2019. His work seeks to understand etic and emic

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Dr. Yue Li, continued

factors underlying health disparities and minority youth development, and in turn, develop culturally responsive interventions, particularly among Asian and Asian diasporic communities.

Our Diversity Research Grant study, titled “Indigenizing Psychotherapy in the Chinese Context,” aims to use qualitative and ethnographic methods to document how local Chinese mental health practitioners adapt, integrate, and transform Euro-American psychotherapy to be responsive to the cultural expectations of Chinese clients, indigenous philosophies (e.g., Confucian, Daoist, communal values), and sociopolitical realities. We attempt to further construct the psychology of decolonization in the Chinese context by attending to epistemological diversity: whose knowledge counts, whose healing traditions are centered, and how global mental health can move beyond one-size-fits-all frameworks. ■



International Research Grant – Graduate Student



I am Jiwei Wu, a doctoral candidate in Counseling Psychology at the University of Kansas. My research focuses on therapeutic encouragement, self-efficacy, resilience, and culturally responsive counseling practices. My dissertation involves the development and validation of the Chinese Therapeutic Encouragement Scale, a measure designed to assess clients’ perceptions of encouragement within counseling relationships.

I have provided counseling services in university, community mental health, and substance use treatment settings in the United States. My clinical approach is grounded in person-centered and strengths-based principles, with integration of cognitive behavioral therapy, acceptance and commitment therapy, and motivational interviewing. I am also committed to clinical supervision, teaching, and improving mental health services for culturally diverse and international populations. ■



PLEASE JOIN US IN CONGRATULATING THE 2026 SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY STUDENT PAPER AWARD WINNERS!

Lillian Comas Diversity Student Paper Award



Angelina Conrow is currently an incoming 4th year PhD student in clinical psychology at Idaho State University. Her research interests center around social factors that may impact psychotherapy process and outcomes such as stigma, although she has worked on projects ranging from social media and mental health to investigating re-search practices in the field of psychotherapy research. Clinically, she works with individuals of a variety of ages, providing psychological assessments and psychotherapy. She enjoys traveling, cooking, playing guitar, reading books, and playing tennis. ■

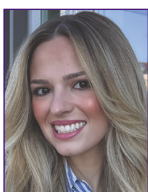


Mathilda Canter Education and Training Student Paper Award



Yejin (“Evelyn”) Hong is a Counseling Psychology doctoral student at the University of Illinois Urbana-Champaign. Her research focuses on psychotherapy process and outcomes, particularly therapist characteristics and interpersonal dynamics between the therapist and client. She is currently involved in projects examining therapist–client synchrony in working alliance judgments, therapist personality traits, and the application of the Truth and Bias Model to psychotherapy research. Her broader research interests include multicultural aspects of psychotherapy and psychotherapy training. ■

Jeffrey E. Barnett Psychotherapy Research Student Paper Award



I am Daniela Pasquarello, a rising third-year doctoral student in the Clinical Psychology Ph.D. program at Adelphi University and currently live on Long Island, New York. This fall, I will complete my externship at Nassau University Medical Center across both inpatient and outpatient settings. My clinical and research experience has primarily focused on the treatment of individuals with eating disorders through a range of research, assessment, and therapeutic experiences. Since beginning graduate training, I have conducted fidelity ratings of evidence-based treatments for eating disorders and process ratings of psychodynamic and behavioral therapy sessions. These experiences have deeply informed both my clinical work and research interests. Outside of work and academics, I enjoy spending time with my Labrador retriever, Junior, and exploring Long Island in search of the best sunsets. ■

Donald K. Freedheim Student Development Paper Award



Sondra Tiab, M.A., is a clinical psychology doctoral student at the University at Albany, SUNY. Her research interests focus on the integration of science and practice in psychotherapy, with a particular focus on the implementation of evidence-based treatments for sleep and circadian problems. Broadly, she is interested in understanding how treatments that are well-supported in research settings are experienced, adapted, and delivered in routine clinical care, and how these processes influence engagement and outcomes. Her work has primarily examined these questions within the context of cognitive-behavioral therapy for insomnia. ■

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



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

We'd love to hear from you!



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

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

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

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