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The PRINCIPLES of CHANGE

to Personalize and Improve the Treatment of Suicidal Clients

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HOW TO BE AN ALLY TO TRANSGENDER PEOPLE

EMILY CULLIGAN, MA

You may know a friend, family member, or coworker who is transgender, or you may have seen a transgender person in the media. You might have questions such as what pronouns to use when referring to this person or wondering about how you can support them. Showing your support as an ally for transgender people is incredibly important due to the discrimination, stigma, and inequality they face. Transgender people encounter significant challenges, including heightened poverty, harassment, homelessness, unemployment, and suicide rates. Additionally, the transgender community lacks adequate legal protection. There can be increased challenges for transgender people who are also members of other minority groups, such as people of color (The Human Rights Campaign Foundation, n.d.; GLAAD, 2020). Family acceptance and support is particularly impactful on the wellbeing of transgender youth. Thus, it is crucial to support and advocate for transgender people.

The term "gender identity" refers to a person's internal knowledge of their own gender. "Sex assigned at birth" is determined as male, female, or intersex, based on the appearance of the body's physical anatomy when a baby is born. For some, gender identity matches the sex assigned at birth; this is referred to as "cisgender." However, in transgender people, gender identity and sex assigned at birth do not align. For example, a transgender woman is a woman who was assigned male at birth. Additionally, non-binary people hold gender identities that do not fit neatly into either of the two options of male or female (GLAAD, 2020).

Acting as an ally is important not only for transgender people who you know personally, but for the transgender community overall. Allies can contribute to social and cultural changes by creating a safer and better place for transgender people to exist. Being an ally at all times is important, not just when you are around a transgender person. Here are some tips for how you can act as an ally for the transgender community (GLAAD, 2022):

• Respect the terminology a transgender person uses: Not all transgender people use the same terminology to describe

themselves and their experiences. One person may use the term "transgender," another may use the term "non-binary," and others might use different terms. Make sure to respect the terms each individual person uses and do not make assumptions or tell them how you think they should refer to themselves.

• Be patient with people who are questioning or exploring their gender identity: Gender identity is each person's internal knowledge of their own gender, so do not impose a specific gender identity on someone. Instead, give them time to figure this out for themselves. It may take some time to determine what is true for oneself. This exploration may involve the use of one name or pronouns at first, then a change to a different name and/or pronouns at a later time. Try to be respectful of and use the name and pronouns requested at any given time. Gender identity, expression, name, and pronouns may be fluid and can shift over time.

• Recognize the diversity among transgender people: Everyone has unique preferences and experiences, including people within the transgender community.

Recognize that there is no single way to exist as a transgender person, just as there is no single way to live as a cisgender person. Some transgender people may undergo a medical transition involving hormone therapy and surgeries, while others may not. Accept transgender people in their gender identity regardless of whether or not they have medically transitioned. Also, be aware that there is not a certain "look" that indicates a person is transgender, so you cannot know who is or is not transgender just from looking around. Because of this, you may assume there could be transgender people around wherever you go. Do not assume that everyone is cisgender.

• Listen to others and introduce your own pronouns if you are uncertain about what pronouns to use: If you are unsure of what pronouns to use, listen to others who know the person to see what pronouns they use. If you need to ask which pronouns the person uses, start by introducing yourself with your own pronouns ("I'm Emily, I use the pronouns she and her. What pronouns do you use?").

• Apologize and be open to corrections if you misgender someone: Misgendering might occur by using the incorrect pronouns and/or name when referring to a transgender person. Have an openness to being corrected if you misgender a transgender person. If you accidentally do this, apologize to the person right away but do not belabor your mistake. Make conscious efforts to use their correct name and pronouns moving forward.

• Respect boundaries: Do not ask personal questions just because someone is transgender. Asking about a transgender person's birth name can be anxiety-provoking or upsetting, and their birth name may be something they want to leave behind. Avoid using or sharing their birth name if you know it. Additionally, avoid questions related to a transgender person's surgical status, sex life, or genitals. You likely would not ask these questions of people who are cisgender, so extend the same respect and boundaries to transgender people. If they wish to discuss these aspects of their personal life, allow them to bring it up first.

• Listen to transgender people, learn more, and recognize your limits as an ally: Recognize that transgender people are the experts of their own experiences. Be open to hearing them with an open mind and allow them to speak for themselves. Utilize social media, books, films, etc. created by transgender people to learn more about the community. Learn more about the history of transgender people as well. Also, acknowledge that you may not know everything and be willing to admit when you do not know something. Avoid making assumptions, which could be incorrect or hurtful.

Remember that you can also talk to someone. If you are a parent or friend of a transgender person and are struggling to accept, understand, or cope with their transition, seek out resources for yourself. You may choose individual therapy and/or support groups specifically for the loved ones of transgender people. You may benefit from talking to a psychologist or other mental health professional if you are struggling with mixed emotions surrounding a loved one's transition. Many providers are offering psychotherapy via secure internet video connection at this time. The Pennsylvania Psychological Association can assist you in finding a local psychologist by using the Psychologist Locator. You can also ask your health care professional or a trusted friend to recommend a psychologist or other mental health professional..

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USING PRINCIPLES OF CHANGE TO PERSONALIZE AND IMPROVE THE TREATMENT OF SUICIDAL CLIENTS

SAMUEL KNAPP, EdD, ABPP

When treating suicidal clients, psychologists strive both to prevent a client suicide and also to help clients to develop lives worth living. Psychologists can have better success in meeting these goals if they inform their interventions with research on suicide, use evidence-supported treatments, and personalize their treatments by considering their clients' unique preferences, needs, and characteristics (Norcross & Cooper, 2021). The vignette in this article illustrates how psychologists can supplement their knowledge of suicide and effective interventions with personalized recommendations found in the principles of change literature (Castonguay et al., 2019). Because client perspectives are so important in ensuring successful treatment, this article uses quotes from qualitative studies on clients who had received treatment for suicidal thoughts.

Clinical Vignette

Claire was a19-year-old college student who was seen following a suicide threat. Her parents had insisted that she come in for treatment. She was compliant but not enthusiastic in treatment.

Her psychologist intended to treat Claire with cognitive behavior therapy (Bryan & Rudd, 2018) which is an evidence-supported therapy for treating suicidal clients. During the initial interview, the psychologist assessed Claire for the immediate risk of suicide using a well-known screening measure and a non-judgmental and supportive interviewing style, and collaboratively developed a safety plan with her. Because of the importance of getting the safety plan completed, Claire's psychologist only had limited time in the first session to go over the informed consent information and intended to complete the rest of the informed consent process as early as feasible (as is permitted in the APA Ethics Code, 10.01; American Psychological Association, 2017).

Even though cognitive-behavior therapy is an effective treatment for suicidal clients, it is best implemented when psychologists balance adherence to the protocol with flexibility based on client preferences and needs. The treating psychologist noted three things about Claire that she wanted to consider when implementing the CBT protocol. Like a good scientist-practitioner, Claire's psychologist phrased these in terms of hypotheses that she needed to answer after gathering more information, considering different options, and discussing them with Claire. First, noting Claire's low or modest motivation for treatment, the psychologist asked herself, "How do I motivate Claire who says that she is here to appease her parents?"

Second, noting that Claire was introspective and prone to brooding about her problems, the psychologist asked herself, "How do I address Claire's internalizing coping style?" Third, the psychologist learned that the immediate precipitant of the suicidal crisis was the rejection from a young person with whom she had a romantic interest, but also that Claire lacked a strong social support network which could have buffered the impact of this rejection. The psychologist asked herself, "How do I help Claire build the social resources needed to protect her against the risk of suicide and to help her build a good life?" The psychologist intended to involve Claire in these decisions as much as she could.

Background Information

Fortunately, recent research has identified several treatments with strong evidence that they can reduce suicidal behavior (cognitive behavior therapy, dialectical behavior therapy, and the collaborative assessment and management of suicide), although other less researched treatments show benefits as well including attachment-based family therapy, mentalization therapy, interpersonal therapy, problem-solving therapy, schema-focused therapy, and others (Calati & Courtet, 2016). However, according to APA's definition of evidence-based practice, psychologist must not only consider the empirical support for a treatment, but also should use clinical judgment, and consider client preferences and needs when they implement the intervention (American Psychological Association, 2021). This is consistent with the conclusions of Norcross and Cooper (2021) who noted that clients had better outcomes when psychotherapists personalized their treatments. For example, clients who had their psychotherapy matched to their preferences dropped out of treatment half as often as their unmatched counterparts and were significantly more likely to have positive outcomes (Swift et al., 2018). One source that can guide psychotherapists on how to adopt psychotherapy to client preferences and needs comes from the principles of change literature (Castonguay et al., 2019; McAleavey et al., 2019).

Principles of change are brief, transtheoretical, and evidence-supported statements on what is effective in psychotherapy. Castonguay et al. (2019) derived these principles through a review of the outcome and process literature in psychotherapy and designed them to be user friendly. These principles are continually evolving as new literature is published, but this article relies on the latest 2019 version (Castonguay et al., 2019). McAleavey et al. (2019) identified 38 such principles and categorized them into five categories: client prognostic principles, treatment/provider moderating principles, client process variables, therapy relationship principles, and therapist intervention principles. Appendix A summarizes all the principles of change.

A review of evidence-supported treatments of suicidal clients (e.g., Bryan & Rudd, 2018; Jobes, 2016), qualitative studies of client perspectives (see for example Hom et al., 2021; Hom et al., 2020; Richards et al., 2017; Shand et al., 2018; Sheehan et al., 2019), and principles of change literature (McAleavey et al., 2019) show many similarities in what is effective with suicidal patients. They all acknowledge the benefits of focusing on a strong treatment relationship, empowering clients through collaboration, soliciting feedback from clients concerning their progress and experiences in psychotherapy, and helping clients to build skills to manage their life difficulties.

Some of these recommendations take on special importance with suicidal clients. For example, psychologists can achieve better outcomes if they regularly monitor

client progress regardless of the presenting problem (Norcross & Cooper, 2021; see also principle of change 31, McAleavey et al., 2019). Nonetheless, monitoring takes on special importance with suicidal clients because psychologists also need to monitor their clients' risk of suicide as well as their overall response to treatment. Psychologists can monitor their clients' risk of suicide by routinely asking clients to describe the frequency, duration, and intensity of suicidal thoughts, suicidal plans, and other risk factors for suicide, and by supplementing client self-reports by asking significant others or using brief survey instruments that measure suicide risk.

Addressing Client Needs

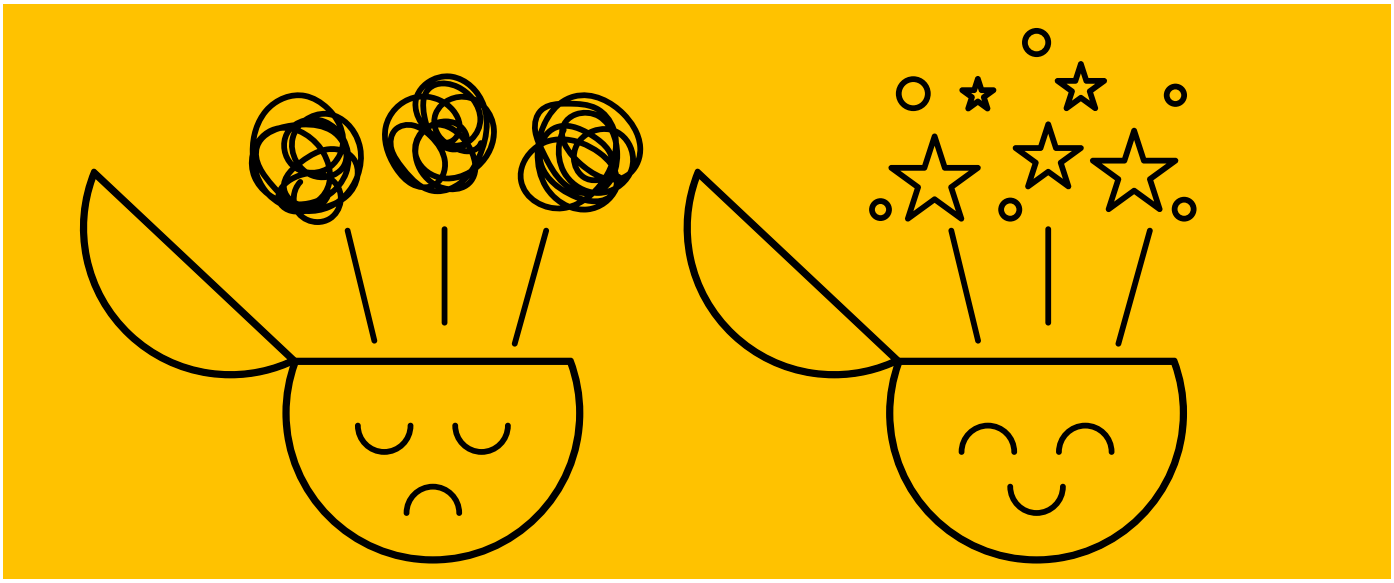
While considering the treatment plan, Claire's psychologist noted that Claire may lack the internal motivation needed for success in psychotherapy, had an internalizing coping style characterized by brooding, and had few social supports. The article first describes some common themes found in the literature on suicide, evidence-based practices, and client reports of their experiences that can guide Claire's psychologists. Then the article describes some options from the principles of change literature that could supplement those recommendations.

How Can Claire Increase Her Motivation?

During the first meeting Claire did not appear fully engaged in treatment and reported that she attended the first session upon the insistence of her parents, prompting her psychologist to ask herself how to motivate Claire for treatment. This had major implications for the effectiveness of treatment. Reluctant patients have a higher risk of dropping out of or failing to benefit from treatment. According to principle 5 of the principles of change literature, "Clients who are more intrinsically (or autonomously) motivated to engage in psychotherapy may benefit more from it than clients who are less intrinsically (or autonomously) motivated" (McAleavey et al., 2019, p. 14). Claire's psychologist can consider several factors relevant to motivation for change commonly found among suicidal clients, including the possibility that Claire feared that her psychologist would force intrusive interventions on her, judge or criticize her, minimize her concerns (Sheehan et al., 2019), or be unable to help her.

Many suicidal patients may fear that their psychologists will force unwanted interventions on them (Hom et al., 2021; Hom et al., 2020). They may fear, for example, that their psychotherapist will put them in a hospital, disclose sensitize information about them to others without their consent, force them to have their movements closely monitored, or force them to take medication. These fears of coerced treatment may limit the willingness of suicidal clients to participate in psychotherapy, or, if they do participate, may limit their willingness to disclose their thoughts or feelings. Sometimes this reflects a misunderstanding on the client's part as to what constitutes a criterion for hospitalization or other coerced treatments (Hom et al., 2021). Unfortunately, many suicidal clients have experienced or have been threatened with unwanted and intrusive interventions. One client describing her experiences said, "Everybody just freaks out and wants to get you hospitalize, and acts like you're a danger, and that doesn't really make me feel better. I don't like that as soon as I say that they want me to be monitored or closely watched. I don't want my privileges taken away" (Richards et al., 2017, p. 42).

Some psychologists may overemphasize coercive interventions because they feel overly anxious about a client suicide, fear an increased risk of professional liability, or because they do not know about the effective outpatient evidence-based treatments. Because of the long-term risk of reducing client motivation to participate



in treatment, psychologists may only justify coerced interventions if they determine that their clients have an imminent risk of killing themselves, they have exhausted or found other less intrusive and more accessible options unfeasible to save the life of the clients, and they strive to minimize the negative impact of the coerced interventions (Knapp, 2020).

Other suicidal clients may fear that their psychologists will judge, criticize, or denigrate them. Perhaps these clients have internalized some of the negative societal stereotypes (self-stigma) about suicidal persons. Unfortunately, sometimes clients acquired these fears of being judged based on previous treatment experiences. As one person with lived experience said, "They [the other people] use words like coward, selfishness. . . all those clichés that are associated with suicide" (Sheehan et al., 2019, p. 20). Another former client stated that the staff, "Treated me like dirt. When I went in, the doctor was talking down to me" (Hom et al., 2020, p. 178).

Still other suicidal clients may fear that their psychologists will minimize or dismiss their concerns. Some patients have been told that if they were really suicidal, they would have tried a more lethal way of killing themselves. Another former client stated that the staff told her, "You just want attention. You don't need help" (Hom et al., 2020, p. 178).

Instead of threatening clients, more effective psychotherapists will try to engage their clients more fully into treatment. Clients show more satisfaction with treatment and lower dropout rates when their psychologists shared decision-making with them (Norcross & Cooper, 2021). Almost three-fourths of former clients said that involving them in decisions about treatment planning was "helpful" or "very helpful" while only 6% said it was "unhelpful" (Shand et al., 2018). When asked about how to improve their treatment experiences, several clients noted the importance of discussing treatment options including the nature of the treatment and why treatments were selected (Hom et al., 2020). Conversely, the failure to involve clients in treatments is associated with poorer outcomes or patient dissatisfaction. One survivor with a poor experience stated, "Nobody asked me my thoughts. Nobody asked me my opinions. Nobody asked me what was or was not working" (Hom et al., 2020, p. 178).

Psychologists can discuss the importance of collaboration during the informed consent process. For example, while no psychologists should promise that they would never use coerced interventions, they can state that they only use such interventions under extremely limited circumstances to protect the client from imminent death. In addition to stating that they rely on collaboration in their informed consent process, psychologists can demonstrate collaboration in how they develop the safety plan, counsel clients on lethal means safety, or otherwise engage in treatment. From the description in the vignette, it appears that Claire's psychologist has already taken some steps to foster motivation by being nonjudgmental and supportive in the initial interview and developing a safety plan collaboratively.

Recommendations from the principles of change literature can give Claire's psychologist additional options. She may also increase motivation by respecting Claire's opinions concerning the nature and type of psychotherapy as recommended in principle 13 of the principles of change literature which states, "Clients who are matched to their preferred therapy role, therapist demographics, or treatment type may benefit more from psychotherapy than clients unmatched on these preferences" (McAleavey et al., 2019, p. 17). Also, Claire's psychologist can tell Claire that she wants to personalize psychotherapy to meet Claire's preferences and needs. Claire's psychologist may ask about any previous psychotherapy that Claire might have had and what in that psychotherapy she found helpful. Although Claire's psychologist may have ideas on what Claire needs and have a preferred method of psychotherapy, she needs to initiate the discussion with an open mind and a willingness to show flexibility (Norcross & Cooper, 2021).

This vignette does not mention the client or psychologist's race, ethnicity, or sexual orientation. If Claire's psychologist was in an independent practice, then Claire might have learned or inferred the race, sex, or age of her psychologist based on what was on a website before treatment began and had chosen her psychologist, in part, based on those factors. On the other hand, if Claire went to an agency she might have been randomly assigned to a psychotherapist.

However, clients receive better results if their psychotherapists fit the demographic profile that they prefer (principle 13). According to one client, "Talking to people that are people of color or people who understand that, that would help a lot because I feel more open to them if they can relate on a similar ethnic or racial level" (Richards et al., 2017, p. 45). If Claire received treatment at an agency, that agency could have addressed preferences proactively by asking prospective clients in the initial phone call if they had a preference on the demographics of their psychotherapists (Norcross & Cooper, 2021).

Principle 14 identifies the importance of deferring to client preferences for religiously or spiritually informed psychotherapy. "Clients whose preference for religiously or spiritually oriented psychotherapy is accommodated may benefit more from treatment than clients whose preference is unmet" (McAleavey et al., 2019, p. 17). Therefore, Claire's prognosis will be improved if her psychologist respected any request from Claire to have spiritual or religious perspectives integrated into psychotherapy. Some psychologists include a simple question on their intake forms such as "Do you wish to integrate your religious or spiritual perspectives into psychotherapy?" which opens the door for further discussions.

Furthermore, it may be worthwhile to ask Claire about what outcomes she expects from psychotherapy. According to principle 4, "Clients with higher initial expectations for benefiting from psychotherapy may benefit more from it than clients with lower initial outcome expectations" (McAleavy et al., 2019, p. 16). Some suicidal clients may engage in help-negation because they believe that nothing can help them or that they have no reason for hope (Hom et al., 2021). Claire's psychologist can address any low expectations for psychotherapy by summarizing the outcome literature with evidence-supported treatments for suicide and giving Claire disguised examples of formerly suicidal clients who have gone on to live good lives. Other clients have

benefited from participating in peer support groups where they may meet others who have successfully managed their lives despite having a history of suicidal thoughts or attempts.

In addition, a clients' level of change readiness may influence their motivation. Readiness for change refers to a continuum of client attitudes ranging from precontemplation which is the lowest level of change readiness (no awareness of a problem or willingness to change) to higher levels of change readiness such as action (clients are ready to change) and maintenance (clients intend to prevent relapses; McAleavey et al., 2019). Treatment will be more difficult if Claire has a low level of change readiness. Principle 6 states that, "Clients in advance stages of change readiness (i.e., they are actively preparing for or currently taking action toward healthy behavior) may benefit more from psychotherapy than clients at lower levels of change readiness" (McAleavey et al., 2019, p. 16). If Claire is in a low stage of change readiness, then Claire's psychologist might consider a more person-centered approach as recommended in principle 12 which states that, "Clients with lower motivation for, or higher ambivalence about, change may benefit more from psychotherapy when their therapist is responsive and person-centered versus more directive and change oriented" (McAleavey et al., 2019, p. 17). One of the key components in the stages of change involves considering steps to resolve the issues. The fact that Claire at least showed up for one appointment suggests at least some awareness that a problem exists and can be the foundation for getting Claire to commit to more change related actions.

How Can Claire Reduce Her Brooding?

Claire reported an internal coping style characterized by brooding (a tendency to perseverate on one's problems and the negative consequences of one's distress and having difficulty disengaging from that perseveration). This prompted her psychologist to ask about the optimal manner of addressing this brooding. Brooding or perseverating on one's suicidal thoughts is associated with an increase in suicide risk (Rogers et al., 2021).

Principle 18 states that "Clients with internalizing coping styles may benefit more from psychotherapy that is more focused on fostering insight and self-awareness than behavior change and symptom reduction (McAleavey et al., 2019, p. 17). Therefore, Claire's psychologist might consider mindfulness exercises and other interventions such as identifying reasons for living, identifying the link between antecedent events, beliefs, and emotional or behavioral consequences of those beliefs, or other activities that focus "on strengthening the patient's awareness of his or her internal states, and the context within which these states are experienced" (Bryan & Rudd, 2018, p. 167). Other psychologists working from other therapeutic orientations could similarly focus on strategies that foster self-awareness as opposed to symptom reduction and behavior change.

How Can Claire Strengthen Her Social Networks?

Finally, Claire's psychologist noted Claire's weak social support network. Loneliness, perceptions that one burdens others, or alienation from others predisposes people to suicide (Calati et al., 2019). In addition, disruptions in relationships such as a romantic break up or the death of a loved one may precipitate a suicide attempt. Conversely, strong social networks protect against suicide attempts. Clients with suicidal ideations often described their commitments to family members and others as a reason that they will not attempt suicide.

Claire's psychologist could consider principle 19 which states that "Clients with moderate to severe impairment and/or fewer social supports will benefit more from psychotherapy when their therapist helps them address their social or medical needs" (McAleavey et al., 2019, p. 17). Claire would benefit more from treatment if she strengthened her social network. Loneliness can occur for varied reasons. Sometimes client lack social skills, have dysfunctional interpretations of social interactions, or simply the lack of opportunities to make or nurture friendships. Claire's psychologist can recommend interventions appropriate to the reasons for Claire's lack of a social network.

Claire's psychologist should monitor Claire's progress in psychotherapy to determine if Claire is responding to accommodations, in accordance with principle 31 which states that, "Clients whose therapist receives feedback on a routinely delivered outcome measure may benefit more from psychotherapy than clients whose therapist does not receive feedback" (McAleavey et al., 2019, p. 18). Finally, Claire's psychologist can give Claire feedback on how she is doing as a client in therapy including any improvements in her motivation, consistent with principle 32 which reads, "Clients who receive feedback from their therapist on their performance in treatment may benefit more from psychotherapy than clients who do not receive feedback" (McAleavey et al., 2019, p. 19).

This vignette did not identify Claire's race or ethnicity. However, research with ethnically diverse clients shows that social connectedness and suicide may have an especially close relationship. A lack of sense of belonging (e.g., family conflict, rejection by family members) and perceived burdensomeness on family members are associated with suicidal ideation among Asian-Americans to a higher degree than among European Americans (Yip et al., 2021). Familismo, or family cohesion, is an important protector from suicidal thoughts for Hispanic Americans (Yip et al., 2021). Ethnic identity (salience of one's race, connection to members of one's race, and the regard which the persons feel for their race) is associated with a lower risk of suicide among African Americans. When developing interventions for African American clients, it may be appropriate to consider how external social pressures, such as discrimination, disadvantaged socio-economic status, and marginalization contribute to the feelings of isolation and hopelessness that are associated with suicide (Robinson et al., 2022).

Conclusions and Lessons Learned

The knowledge of the principles of change literature alerted Claire's psychologist to factors to consider when tailoring the treatment to Claire's

preferences and needs. Several of the principles of change reinforce what psychotherapists already know from evidence-based literature and client reports concerning what helps their clients. However, psychologists can integrate other principles of change into their treatment to enhance treatment outcomes.

In this vignette, the principles of change literature suggested considering a more non-directive approach to psychotherapy if Claire continues to show low motivation for treatment, focusing on reducing her brooding by fostering insight and self-awareness as opposed to symptom reduction, and building Claire's social networks and reducing her isolation. Of course, Claire's psychologist can best integrate the principles of change into psychotherapy if she involves Claire in these decisions. Finally, Claire's psychologist should monitor her progress to ensure that she is benefitting from treatment and that the risk of suicide continues to decline.

Culturally informed treatments may improve outcomes. Culture includes race, ethnicity, language preference, religion, and other factors and how they interact with a client's age or socioeconomic status. Culturally adapted psychotherapies improve outcomes (Norcross & Cooper, 2021). However, research has not found any advantage in matching clients and psychologists on gender or ethnicity or in providing religious or spiritually integrated psychotherapy unless clients express a strong preference for it (Norcross & Cooper, 2021).

Culture includes other facets besides race and ethnicity and it can refer to any group with a defined set of values, beliefs, assumptions, or modes of living that separate it from other groups. Thus, culture, when so broadly defined, is relevant for lethal means counseling (also called means safety counseling). Lethal means counseling deals with ways to motivate clients to remove easy access to their preferred means of suicide, such as keeping lethal amounts of medication away from clients who plan to kill themselves by poisoning. Because Claire had not developed or revealed a plan to kill herself or the means to do so, Claire's psychologist did not engage in lethal means counseling. But psychologists may have to conduct lethal means counseling with other clients, and should show especially heightened concern if their clients have access to firearms because firearms account for more than half of all suicides in the United States. Some firearm owners view discussions of firearm safety by medical personnel with suspicion under the belief that these are just subterfuges to get people to give up their firearms. Effective work with firearm owners requires its own type of cultural competence wherein the intervention considers the worldview, traditions, and social connections that guide their manner of handling or storing firearms and the way that firearm ownership is a part of the owners' identity. Fortunately, culturally appropriate lethal means interventions have had success in increasing safe firearm storage (see for example, Anestis et al., 2020). Motivational interviewing may be indicated with some firearm owners with low motivation to adopt safe means of storing their weapons.

The principles of change literature also suggests that some clients may need additional time, services, or interventions if psychotherapy will benefit them. For example, clients may be less likely to benefit from psychotherapy if they have a primary problem complicated by a co-existing personality disorder (principle 2), have less secure attachment (principle 3), have low socioeconomic status and unemployment (principle 7), experienced adverse childhood events (principle 8), or are anxious and have more negative self-attributions (principle 9). Therefore, psychologists may have to address co-existing personality disorders, work harder to establish a good treatment relationship with clients with less secure attachments, accommodate psychotherapy to factors associated with lower socioeconomic status, deal with the sequalae of adverse childhood events, or address negative self-attributions in anxious clients. These complications alert psychologists that they may need to invest extra resources, time, or support to facilitate meaningful change.

As much as they may want to accommodate clients' preferences, psychologists may not always be able to do so or want to do so. Some clients may strongly prefer modalities that the psychologist is not trained to offer, or clients may prefer some treatments that would not be indicated for their presenting problem. In such cases psychologists can share with their clients the reasons why they cannot or do not want to match the client's preferences and hopefully come to a resolution.

Key Clinical Considerations

Evidence-supported treatments and qualitative studies of client experiences can guide psychotherapists on how to intervene with suicidal clients. Psychologists may further improve their outcomes with suicidal clients if they consider the following:

• Outcomes with suicidal patients improve when psychologists rely on collaboratively informed treatments and when psychologists accommodate client preferences and needs, including adaptions based on culture or religion (spirituality).

• The principles of change literature can help psychologists to tailor treatments to their clients' needs.

• Monitoring patient progress helps ensure that the accommodations are benefitting clients as intended..

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APPENDIX A: SUMMARY OF PRINCIPLES OF CHANGE

Client Prognostic Principles

1. Clients with a higher baseline of impairment may benefit more.
2. Clients with co-morbid personality disorders may benefit less.
3. Clients with more secure attachment may benefit more.
4. Clients with higher initial expectations may benefit more.
5. Clients with more intrinsic motivation may benefit more.
6. Clients in an advance stage of the stages of change may benefit more.
7. Clients with low socioeconomic status and unemployment may benefit less.
8. Clients with adverse childhood experiences may benefit less.
9. Anxious clients with negative self-attributions may benefit less.

Treatment Provider Moderator Principles

10. Clients may benefit more when treatments are consistent with their level of problem assimilation.
11. Clients with resistance may benefit more from nondirective techniques.
12. Clients with lower motivation and higher ambivalence about change may benefit more from person-centered interventions.
13. Clients who are matched to their preferred therapy role, therapist demographics, or treatment type may benefit more.
14. Clients may benefit more when accommodations are made for their preference for religiously or spiritually integrated psychotherapy.
15. Clients with poorer interpersonal functioning may benefit less from a high proportion of therapist transference interpretations.
16. Clients with high baseline impairment may benefit more from long-term or intense treatments.
17. Clients with external coping styles may benefit more from therapy focused on behavior change and symptom reduction.
18. Clients with internal coping styles may benefit more from therapy that fosters insight and self-awareness.
19. Clients with moderate to severe impairments and fewer social supports may benefit when therapists address their social needs.
20. Clients with substance misuse problems benefit equally if their therapist had or had not a history of substance misuse.

Client Process Variables

21. Clients who actively participate in the treatment process may benefit more.
22. Clients who are more resistant to therapists may benefit less.

Therapist Relationship Principles

23. Clients who have a high quality of therapeutic alliance in group therapy may benefit more.
24. Clients may benefit more when therapists show regard and affirmation.
25. Clients may benefit more when therapists show congruence.
26. Clients may benefit more when therapists show empathy.
27. Clients may benefit more when therapists repair alliance ruptures.
28. Clients may benefit more when therapists use supportive self-disclosures.

Therapist Intervention Principles

29. Clients may benefit more when therapists use a higher proportion of psychodynamic interpretations.
30. Clients may benefit more when therapists use high quality psychodynamic interpretations.
31. Clients may benefit more than they give routine feedback to their therapist.
32. Clients may benefit more when they receive feedback from their therapist.
33. Clients may benefit more when therapists are flexible in implementing treatments.
34. Clients may benefit more when therapists foster adaptive interpersonal change.
35. Clients may benefit more when therapists foster self-understanding.
36. Clients may benefit more when therapists foster emotional experiencing or deepening.
37. Clients may benefit more when therapists use nondirective interventions skillfully.
38. Clients may benefit more when therapists foster behavior change.

PSYCHOPHARMACOLOGY IN PENNSYLVANIA

STEPHEN A. RAGUSEA, PSYD, ABPP

We now have 42 sponsors for our psychopharmacology bill in the Pennsylvania legislature. It's only one step in what will be a long and challenging governmental journey. Approximately a dozen other states are now pursuing the same goal, an effort with 50 years of history behind it.

It was way back in 1972 when Nick Cummings, first proposed to the American Psychological Association that APA pursue training in psychopharmacology for psychologists in pursuit of prescription privileges. An APA committee deliberated for a year but decided against the initiative. Of course, one must remember that, within the academic psychology community of the era, the very idea of psychologists being licensed for independent practice was still very controversial and many psychologists considered licensure to be both inappropriate and unethical. After all, some reasoned, psychologists had no medical training and weren't real doctors. I'm old enough to remember those days.

This issue died at APA for a time, but just a few years later, in 1977, I was completing my PsyD program at Baylor University when I wrote a paper arguing that psychologists should seek the authority to write prescriptions. I reasoned that with a little additional training, psychologists would certainly be able to do as good a job of prescribing psychoactive medications as physicians, who typically had little or no training in mental illness or human psychology. And I reasoned that doctors of psychology would be better overall providers of mental health care because they were much more appropriately trained than were doctors of medicine. As I recall, my professor at Baylor was aghast and suggested that I might be very, very wrong. I may have been premature, but I sure wasn't wrong.

In 1989, the APA Board of Professional Affairs, under the leadership of Norma Simon, strongly endorsed the development of appropriate curricula in psychopharmacology so that psychologists might more effectively meet the mental health needs of society. And it was recommended that this be made APA's highest priority. But, the really big break came from Pat Deleon's brilliant 1989 initiative, wherein he and Senator Daniel Inouye helped advance a Department of Defense pilot program permitting psychologists to prescribe in the military. Five years later, in June 1994, Navy Commander John Sexton and Lt. Commander Morgan Sammons became the first graduates of the Department of Defense Psychopharmacology training program at Walter Reed Army Medical Center. Once that program was operational, it was only a matter of time before psychologists would have prescription privileges all over the country. Certainly, the glacial movement we have sometimes experienced has been frustrating, but I always believed it was just a matter of time before the fruit of that pilot program dropped into the hands of Psychology.

Well, the fruit has ripened now in five states, Louisiana, New Mexico, Iowa, Idaho, and Illinois. In addition to the hundreds of psychologists already prescribing in these states, there have been approximately psychologists prescribing safely and effectively in the military and on Native American reservations for over 20 years now! There is no longer any doubt that psychologists, with some additional training, can safely and effectively prescribe -- or un-prescribe -- psychoactive medications within the context of good psychological practice. It's not theoretical. It's not even debatable; it's simply a matter of fact. Indeed, during legislative debate, even the Illinois Medical Board didn't contest that point!

Yes, there is still some debate within the body politic of Psychology, but I remind everyone that this is the same pattern we experienced when psychologists first sought to be independently licensed professionals. Georgia was the first state to pass a psychology licensing law in 1951 and the last state was Missouri in 1977. That's 26 years from start to finish. Just as we gradually achieved the ability to practice independently in all 50 states, we will eventually be prescribing in all 50 states. The only question now is, "When?"

"When will psychologists be prescribing in Pennsylvania?" Many among our members and in PPA leadership are excited by this challenge and newly motivated by the successes in other states. When will psychologists be prescribing in Pennsylvania? The answer is, "Soon, sometime soon."

THE ETHICAL IMPLICATIONS OF ADVERTISING: "I DON'T TREAT SUICIDAL PATIENTS"

SAMUEL J. KNAPP, ED.D., ABPP[1]

Some psychologists delivering health care post on their websites that they do not treat suicidal patients and will screen out such patients early in the intake process. When asked about their policy they might say, "I don't have the training with suicidal patients to do an adequate job," or "I only have a part-time practice and I do not have the time it would take to treat a suicidal patient." Psychologists posting these statements may have strong fears that a patient will die from suicide, or that the quality of their services may come under question. Psychologists fear a patient suicide more than any other professional event (Pope & Tabachnik, 1993). On a 5-point scale, 32% of PPA members reported elevated levels of distress when treating suicidal patients (Leitzel & Knapp, 2021).

Nonetheless, psychologists who attempt to exclude suicidal patients from their caseload may paradoxically increase the likelihood of a patient suicide. No one can completely exclude suicidal patients from one's caseload. First, patients who never had suicidal thoughts may develop such thoughts later. Also, patients who once had suicidal thoughts but did not have suicidal thoughts at the time they sought treatment, may have them return later. They might say to themselves for example, "I had suicidal thoughts last month, but I have not had them since, therefore I qualify for treatment from this professional." They may not appreciate how quickly suicidal thoughts can reoccur.

Furthermore, between almost one-third (Blanchard & Farber, 2016) and one-half (Hom et al., 2017) of patients lied or misled their psychotherapists about their suicidal ideation at least once. These patients may seek treatment from a "do not treat" professional because they do not expect to reveal their suicidal thoughts. But often they may feel ambivalent about disclosing and will make vague or indirect statements about death or suicide (e.g., "Sometimes I wish the Lord would just take me to heaven.") to determine how their psychologist would respond and whether further disclosures would be welcomed.

Finally, other patients with suicidal thoughts may not consider them sufficiently important to raise as an issue. The Center for Collegiate Health (2022) found that 9% of the patients at cooperating college mental health centers had suicidal thoughts, but only 1% considered them to be the primary reason for treatment. This opens the possibility that some patients with suicidal thoughts may ignore the "do not treat" statement and seek services because they intend to focus on their primary area of concern and not their suicidal thoughts. But suicidal thoughts fluctuate in intensity, frequency, and duration over time, and they may assume greater importance for the patients later in treatment.

Unfortunately, the "do not treat" statement may dissuade patients with new, revived, or newly disturbing suicidal thoughts from revealing them, and may keep ambivalent patients from eventually disclosing their thoughts because they fear that doing so may mean the loss of their treatment relationship. Therefore, psychologists who say that they do not treat suicidal patients are likely treating suicidal patients; they just do not know who they are. The "do not treat" statements may increase the risk of a patient suicide because these psychologists will have suicidal patients in their caseload who are not receiving appropriate interventions. For example, collaboratively developed safety plans reduce the risk of a suicide attempt by 43% (Nuij et al., 2021), but psychologists would only implement this potentially lifesaving intervention if they knew that a patient had suicidal intentions.

Of course, psychologists can tailor their advertisements to solicit patients who are less likely to have suicidal thoughts, such as advertisements that focus on adjustment disorders or problems in living or that state that they offer short-term treatments only. But these tailored advertisements only

reduce the likelihood of excluding suicidal patients. We have all known patients who presented well in the first session and stated that they only wanted support who turned out to be quite disturbed and dangerous.

Also, any psychologist may refer patients who have problems outside of their competence although psychologists continue to have obligations to the patients until a referral is made. For example, if a patient discloses in the same session that they have suicidal thoughts and a gender dysphoria issue (and the psychologist does not have the competence to treat patients with gender dysphoria issues), then the psychologist can stabilize and monitor the patient and simultaneously initiate the transfer to a qualified professional. But it would be a disservice for psychologists to falsely present the "out of my area of competence" argument just to get rid of patients with suicidal thoughts.

In summary, psychologists who deliver health care services may reduce the likelihood that suicidal patients will seek treatment from them, but they should not attempt to exclude all such patients. They should create an environment where patients feel free to share their suicidal thoughts, and should acquire the competence necessary to assess, manage, and treat suicidal patients. Psychotherapists with good training in the treatment of suicidal patients feel more comfortable working with them (Mitchell et al., 2020). In addition, psychologists may seek consultations when necessary or collaborate closely with other professionals with demonstrated proficiency when working with suicidal patients.

[1]*The author thanks Drs. John Gavazzi and Rachel Ginsburg for their review of this article.*

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Learning objectives: The articles in this issue will enable readers to (a) assess and explain current issues in professional psychology and (b) describe and act on new developments in Pennsylvania that affect the provision of psychological services

1. The APA definition of evidence-based practice includes
- a. Empirical evidence on the effectiveness of treatments
- b. Clinical judgement
- c. Client needs and preferences
- d. All the above

2. Norcross and Cooper (2021) found improved outcomes when psychotherapists
- a. Personalized treatments for their clients
- b. Adhered very strictly to the treatment manuals
- c. Used longer, as opposed to shorter, treatments
- d. All the above

3. Which of the following are TRUE concerning principles of change? The principles of change are:
- a. Brief, evidence supported statements from cognitive behavior therapy on what is effective in psychotherapy
- b. Lengthy, evidence-informed articles on what is effective in psychotherapy
- c. Brief, clinical pearls of wisdom that rely primarily on their face validity for what is effective in psychotherapy
- d. Brief, transtheoretical, and evidence-supported statements on what is effective in psychotherapy

4. Psychotherapists can monitor the suicidal thoughts of their clients by
- a. Frequently asking them about their suicidal thoughts and behaviors
- b. Soliciting feedback from significant others
- c. Using brief survey instruments
- d. All the above

5. According to Hom et al. (2018) the belief of some suicidal patients that nothing can help them or that they have no reason for hope is called
- a. The orienting response
- b. Help negation
- c. Self-stigma
- d. Maintenance level of change

6. According to Shand et al. (2018), when former clients were asked how they felt about being involved in their treatment planning, about _____ said it was "helpful" or "very helpful".
- a. 6%
- b. 30%
- c. 75%
- d. 94%

7. **Which of the following accurately represents a principle of change? Psychotherapy is more likely to be successful if**
   a. Clients have intrinsic motivation for change
   b. Clients are matched to their preferences in terms of psychotherapist demographics
   c. Psychotherapists accommodate their client preferences for spirituality or religiously oriented psychotherapy
   d. All the above

8. **A client may have a diminished social network because of**
   a. Poor social skills
   b. Dysfunctional interpretations of social events
   c. The lack of opportunities for socializing
   d. All the above

9. **Which of the following are TRUE?**
   a. Matching clients and psychotherapists on gender and race always improves outcomes regardless of client preferences
   b. Clients who have their preferences for the demographics of their psychotherapist matched may benefit more from psychotherapy
   c. Client and psychotherapist demographics are never relevant to outcomes
   d. None of the above

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3.	a	b	c	d	6.	a	b	c	d	9.	a	b	c	d

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