



International Association
of Psychology and Counseling

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THE IAPC

Field Letter

Questions that travel. Searching for answers.

THE FIELD QUESTION

What can mental health professionals in one part of the world learn from colleagues in another?

PARAGUAY

When therapy learns the language of everyday life

NIGERIA

Five questions with Helen Kwanashie

AI + PRACTICE

The listener that never sleeps

IAPC AT FIVE

Our first five years

In this dispatch

TWELVE DEPARTMENTS · 30 MIN TOTAL READING

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Published by the International Association of Psychology & Counseling · Founded 2021 · intapc.org · **Join IAPC**

Co-Founding Editors Dr. Solmaz Kaynama · Dr. Joseph Horak

A new space for an evolving field

At pivotal moments, new answers matter, alongside new spaces for asking better questions.

DR. SOLMAZ KAYNAMA

Editor, The IAPC Field Letter · 2 min read



DISPATCH FROM

**Greater Vancouver ·
Canada**



Editor · Marketing Chair · Country Chair, Canada & UAE · IAPC

As an Iranian-Canadian based in Greater Vancouver, with experience working in more than 10 cities across four continents, Dr. Kaynama has long been drawn to what becomes possible when people and perspectives meet.

Her work spans relational leadership, organizational advisory, psychotherapy, and research, with a particular interest in how relationships shape psychological safety, well-being, and the capacity to navigate change.

She brings that same lens to The IAPC Field Letter, with a commitment to curiosity, thoughtful inquiry, meaningful dialogue, and keeping the human experience at the center of change.

FIELD Leadership Advisory, Psychotherapy & Counseling

BASE Greater Vancouver, Canada

Welcome to the inaugural issue of *The IAPC Field Letter*.

We chose the name deliberately. A field letter is a dispatch from where the work happens, written from within the questions, tensions, discoveries, and everyday realities that shape professional practice, and shared with colleagues beyond one's immediate borders.

That is what we hope *The IAPC Field Letter* will become: a space for thoughtful international exchange across countries, disciplines, and professional contexts. A place where a clinician in one part of the world might encounter the perspective of a researcher, educator, counselor, psychologist, psychiatrist, or practitioner in another, and return to their own work with a renewed perspective.

As Dr. Brian Canfield, a founding member and CEO of IAPC, explains, IAPC brings together helping professionals across disciplines, cultures, and areas of practice.

The timing of this first issue is significant. Our professions are navigating rapid social, technological, cultural, and professional change. Artificial intelligence (AI) is one part of this evolving landscape, raising important questions about how we learn, communicate, research, teach, and practice. These developments create new opportunities for international dialogue, thoughtful inquiry, and ethical reflection.

At the center of *The IAPC Field Letter* is a broader question: **What should travel across borders, and what needs to be translated along the way?**

Ideas travel across countries, cultures, languages, and disciplines, gaining new meaning as they encounter different histories, communities, and professional contexts. A concept developed in one setting may take on new dimensions in another. Perspectives that appear familiar can become richer when viewed through another discipline or another part of the world. These encounters create meaningful opportunities for learning, reflection, and exchange.

This issue also marks the formation of the IAPC Marketing Committee, created to strengthen the Association's global communications, member engagement, public visibility, and digital presence. The Committee will support a more connected approach to IAPC's global editorial publication for mental health professionals, along with its seminars, events, website, social media, and member communications.

As editors, we hope *The IAPC Field Letter* becomes a meeting place for ideas, questions, perspectives, and experiences from across the international community. A place to remain curious, explore assumptions, share knowledge, and approach our work with intellectual openness, ethical humility, and professional responsibility.

This is our first dispatch from the field. We are glad you are here. Read on, and write back.

Our first five years

The Chief Executive Officer on how IAPC began, how it is governed, and where it convenes next.

DR. BRIAN S. CANFIELD

Chief Executive Officer, IAPC · 2 min read



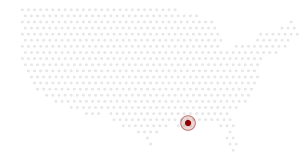
Chief Executive Officer, IAPC

Dr. Brian Canfield is a founding member and CEO of the International Association of Psychology and Counseling (IAPC). He is a past president of the American Counseling Association (ACA), and a founding member and past president of the International Association of Marriage and Family Counselors (IAMFC). Professor Canfield has held

FIELD Psychology & family therapy

BASE New Orleans, Louisiana, USA

academic and administrative appointments as Department Chair, Associate Dean, and Vice President of Academic Affairs at several prestigious universities. He is a licensed psychologist and family therapist with more than 40 years of clinical experience.



DISPATCH FROM

New Orleans · Louisiana

This past summer marked the 5th anniversary of the founding of the International Association of Psychology and Counseling. In a relatively short time, IAPC has grown into a truly international organization with members in more than 25 countries. IAPC was incorporated in 2021 as a not-for-profit 501(c)(3) professional association, governed by a nine-member Board of Directors. The current Board represents six different countries and is elected by the general membership of the Association. The Board appoints a President, who presides over Board meetings, and a Chief Executive Officer, who oversees day-to-day operations and manages the Association.

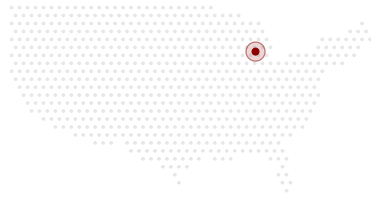
In early 2021, Dr. Brian Canfield, past president (2007–2008) of the American Counseling Association, sent a survey to selected past leaders of various mental health organizations, including colleagues in behavioral medicine, psychiatry, school counseling, mental health counseling, psychology, substance abuse counseling, marriage & family therapy, and social work. The response was overwhelmingly in support of establishing a new organization, devoid of partisan politics and grounded in clinical practice experience and research. IAPC was not founded in opposition to other organizations. Rather, it was envisaged that IAPC would play a unique role among professional bodies: interdisciplinary

nary in membership, global in scope, and exclusively focused on expanding excellence in education and clinical practice.

To fulfill this mission, IAPC establishes Chapters in various countries, provinces, and states, which serve as a contact point for members and prospective members. IAPC sponsors the annual Oxford Institute each July at St Hilda's College, University of Oxford, and has held World Conferences in New Orleans, Louisiana; Palm Beach, Florida; and Oxford, UK. The 2027 Oxford Institute will take place at St Hilda's College in July 2027, and the 2027 World Conference will convene in New Orleans in November 2027. Beyond these, professional events are in the planning stages for China, Cyprus, India, Paraguay, and Türkiye.

IAPC provides a professional home for students, educators, and clinicians who wish to share knowledge in order to advance education, training, and clinical practice. **Our overarching purpose is to provide a forum for professional helpers so they can better assist others in addressing the challenges of the human condition.**

To learn more about sponsored events, as well as professional service and leadership opportunities in IAPC, contact Dr. Brian Canfield, CEO, at Brian@intapc.org. We look forward, hopefully, to seeing you at future IAPC events.



DISPATCH FROM

Grand Rapids · Michigan · USA

Higher ground

Why an apolitical, global association matters, and an invitation to walk this path together.

DR. JOSEPH HORAK

President, IAPC · Co-Founding Editor · 2 min read



President, IAPC · Co-Founding Editor

Dr. Joseph Horak is a psychologist, leadership coach, and family business consultant based in Grand Rapids, Michigan. He previously directed the Family Owned Business Institute at Grand Valley State University and is an Entrepreneur in Residence and Honorary Teaching Fellow in Entrepreneurship and Strategy at Lancaster University Management School in the UK.

FIELD Psychologist, Leadership Coach, Family Business Consultant

BASE Grand Rapids, Michigan, USA

IAPC began with a simple conviction: mental health professionals do their best work when we remain free of political ideology. We watched other associations drift toward mixing advocacy with clinical standards, often without pausing to consider the long-term cost to science, to training, and, most importantly, to the people we serve. We chose a different path—one that stays deliberately apolitical so our focus can remain where it belongs: on evidence, clients, and open inquiry.

From the start, some colleagues hoped we would answer one political ideology with another. We said no. Tribalism helps no one. Because we are a global association, many of our colleagues face challenges that have nothing to do with Western political debates. We want the International Association of Psychology and Counseling to be a place where professionals from every background can gather without having to pick a side. We are finding ways to unify our profession so we can better meet the diverse needs of our clients, who are too often harmed by this extreme divisiveness.

What continues to excite me most is the atmosphere we create at our World Conferences and Oxford Institutes. There are very few places left where mental health professionals who hold genuinely different viewpoints, and who come from different cultures, can sit

together, listen carefully, and still enjoy warm, respectful, intellectually alive conversation. That commitment to free speech and civil discourse is rare. It is one of the main reasons people tell me they feel at home here.

We are now growing this community on purpose. We are launching new outreach and building better online platforms so colleagues across the globe can stay connected between our in-person gatherings. Membership is still small enough that every new voice genuinely shapes the conversation, yet large enough to offer real collegial support and innovative ideas. If you have been looking for a professional home that values data-informed practice over ideology, humility over certainty, and dialogue over cancellation, this is a good moment to join us.

"Belonging across borders does not require choosing a camp."

DR. JOSEPH HORAK

In November, an IAPC delegation will travel to Paraguay. At our recent Oxford Institute, we met Dr. Aramí Rojas, who shared a creative, multidisciplinary, systemic, and client-centered model of care developed in Asunción. Her article in this issue is well worth read-

ing—practical, entrepreneurial, and deeply community-minded. We look forward to visiting Asunción to learn more about this model and about the mental health needs in Paraguay.

This international work has a personal echo for me this year. In January I became a Czech citizen, and I now hold dual U.S. and Czech citizenship. My grandfather immigrated to the United States in 1921. War and communism later separated our family from relatives in Czechia; we found one another again after the Berlin Wall fell. This experience has reminded me why IAPC's posture matters. Belonging across borders does not require choosing a camp. Just as I have grown closer

to my family over the past several decades, I hope our members feel professional bonds growing stronger through the global collegial relationships we are building here.

We welcome every mental health professional who wants to help us build something unifying and lasting. Come to a conference. Submit an article to our new journal or a future edition of the IAPC Field Letter. Visit intapc.org, or just reach out and say hello.

If you have been looking for higher ground—where science still leads and colleagues still care enough to listen—come walk this path with us.

FROM THIS ARTICLE

"There are very few places left where mental health professionals who hold genuinely different viewpoints, and who come from different cultures, can sit together, listen carefully, and still enjoy warm, respectful, intellectually alive conversation."

DR. JOSEPH HORAK

Bani Adam

Across centuries and borders, poetry has sometimes found language for what the helping professions are built around: the recognition that another person's suffering concerns us.

Selected and introduced by Dr. Solmaz Kaynama

For our first Field Letter, we turn to Saadi of Shiraz, the 13th-century Persian poet. In this passage from the *Gulistan*, Saadi imagines humanity not as separate lives, but as members of one living whole.

Human beings are members of a whole,
In creation of one essence and soul.
If one member is afflicted with pain,
Other members uneasy will remain.
If you have no sympathy for human pain,
The name of human you cannot retain.

SAADI OF SHIRAZ

From the *Gulistan*, 1258. English verse translation by M. Arianpour.

A QUESTION TO CARRY WITH YOU

What does another person's suffering ask of us, even when their history, identity, or worldview is not our own?



DISPATCH FROM
Asunción · Paraguay

Bridging Cultural Idioms and Evidence-Based Practice: The Architecture of Jopara Terapéutico

What happens when the intervention works, but the language it arrives in does not quite belong to the people receiving it? A psychiatrist in Asunción on building a framework that keeps the evidence intact and changes the voice.



DR. ARAMÍ ROJAS
Cross-Cultural Practice Feature · 11 min read

PARAGUAY · PSYCHIATRY + PSYCHOTHERAPY	
WHAT TRAVELS Preserve the therapeutic mechanisms. Start with formulation, integrate disciplines intentionally, build supervision and education, design access into the model, measure what matters.	WHAT TRANSLATES Language, cultural expression, examples, and delivery; local healthcare infrastructure; the barriers to access; and the model itself, as practice changes it.
Drawn from the author's own closing section, "What can travel beyond Paraguay?"	

There is a particular moment that happens when you teach a therapeutic skill to a patient and realize that the problem is not whether the skill makes sense. The problem is whether the way you are explaining it does.

The intervention may be evidence-based. The clinician may be well trained. The patient may understand every word being said. And yet something can still feel strangely distant: the language of the intervention belongs to a textbook, while the experience of distress belongs to everyday life.

This became a familiar tension in our clinical work in Paraguay. Our team had already been working toward an integrative approach, bringing psychiatric assessment, psychotherapy, neurodevelopmental considerations, family systems, psychoeducation, and functional assessment into the same clinical formulation, not out

of theoretical preference, but because our patients rarely presented with problems that respected the boundaries between disciplines.

The practical version of the problem was blunter still. Our patients were arriving with highly complex, overlapping presentations, and the protocols available to us were built for one diagnosis at a time. Delivering that level of specificity one patient at a time was not something our context could sustain or afford. Groups were the only realistic way to reach the number of people who needed help, but an off-the-shelf group protocol was too rigid to hold that complexity. We needed something that could be taught at group scale and still be tailored to what a specific group of people actually needed.

Eventually we began asking ourselves a different question: what would happen if we approached integration more intentionally? Not simply integrating different professionals, and not simply combining different therapeutic approaches, but integrating evidence-based practice with the language, culture, needs, and realities of the people receiving it.

That question eventually became Jopara Terapéutico.

A WORD THAT BECAME A FRAMEWORK

In Paraguay, Spanish and Guaraní coexist in a way that is difficult to describe through the idea of two separate languages. People move between them constantly, creating jopara, a dynamic linguistic form that belongs to everyday Paraguayan communication. We became interested in jopara as more than a linguistic phenomenon — it gave us a way of thinking about integration itself.

What if different clinical languages could coexist without one having to erase the other? What if the technical precision of evidence-based psychotherapy could remain fully intact while the way we communicated those concepts became more recognizable to the people we were trying to help? The idea developed slowly. For much of the first eight months, the real work was making sure we weren't building something azaroso — a haphazard combination of interventions risky enough to backfire on the very people it was meant to help. That meant a great deal of reading into how to combine evidence-based modalities responsibly rather than simply borrowing pieces that sounded compatible, and it meant leaning on input from international collaborators, whom I am not able to name here due to a non-disclosure agreement. Only after that groundwork did we move into four months of writing, testing, and rewriting the first edition. Jopara Terapéutico was developed by me as lead author together with Dr. Juan Jimenez, Dr. Sofía Alvarenga-Giosa, MSc. Giselle Román, and psychologists Celia Ortiz, Vivian Gunsett, and Nicolas Sepulveda.

What emerged was not a new psychotherapy. It was a transdiagnostic and integrative clinical skills framework designed to build a bridge between evidence-based therapeutic mechanisms and the linguistic and cultural environment in which they are practiced. The distinction matters: we did not want to dilute evidence-based interventions in the name of cultural adaptation.

We wanted to preserve what makes them therapeutically useful while making their language, examples, and delivery more accessible.

Our premise was that therapeutic fidelity does not require linguistic rigidity.

"Therapeutic fidelity does not require linguistic rigidity."

DR. ARAMÍ ROJAS

WHY A SINGLE DIAGNOSIS WAS NOT ENOUGH

The more we developed the framework, the more a second question emerged: if the language of treatment needed to become more flexible, perhaps our understanding of the person receiving treatment needed to become more flexible too. Our approach to Integrative-Functional Psychiatry & Psychotherapy grew from this concern. By "functional," we mean something close to precision — understanding what is actually interfering with a person's functioning, what processes contribute to the difficulty, what maintains it, and what needs to be addressed therapeutically.

Diagnosis remains important; it gives clinicians a shared vocabulary and real value for communication, research, and treatment planning. But a diagnostic label does not always tell us what we need to know about the person sitting in front of us. Two people can receive the same diagnosis and arrive with entirely different problems to solve. This is one reason we find dimensional approaches such as the Hierarchical Taxonomy of Psychopathology (HiTOP) conceptually useful: rather than assuming psychopathology always fits neatly into discrete categories, HiTOP describes symptoms and psychopathological processes along dimensions and hierarchies, addressing some of the limitations created by extensive comorbidity and heterogeneity within diagnoses. Our own approach is not an implementation of HiTOP, but the underlying question resonates with our clinical experience:

What is actually happening here, and what does this particular person need?

Our formulations consider biological, developmental, psychological, relational, functional, and contextual dimensions together before determining therapeutic priorities, and this also changes how we use therapeutic skills.

We use the core structure of Dialectical Behavior Therapy because its organization of skills provides an exceptionally coherent framework for teaching and practicing complex therapeutic concepts. Within that structure, we draw from Radically Open DBT, Acceptance and Commitment Therapy, Rational Emotive Behavior Therapy, Cognitive Behavioral Therapy, Compassion Focused Therapy, neurodivergent adaptations, and additional clinical considerations involving areas such as violence, empathy, enmeshment, ecpathy, and interpersonal functioning. The result is not meant to be a collection of therapies placed side by side; the formulation determines which elements become most important. A group struggling primarily with emotional dysregulation may spend more time developing regulation skills; another may need greater emphasis on interpersonal boundaries; a group with substantial neurodevelopmental diversity and sensory sensitivities may require significant adaptation in how skills are presented and practiced.

The core framework provides coherence. The formulation determines where we place the emphasis.

"The core framework provides coherence. The formulation determines where we place the emphasis."

DR. ARAMÍ ROJAS

FINDING THE PARAGUAYAN VOICE OF A THERAPEUTIC SKILL

People do not experience distress in the language of a manual. They experience it in their bodies, relationships, memories, thoughts, environments, and every-

day conversations — and the words they use to describe those experiences can be very different from the terminology used in psychotherapy textbooks. When a clinical concept remains too far removed from a person's everyday language, the clinician ends up doing the work of translating everything in real time.

Jopara Terapéutico tries to build that bridge into the material itself. The workbook uses Spanish to provide conceptual structure while incorporating Guaraní expressions and jopara constructions to connect therapeutic concepts with familiar ways of describing experience. This is especially useful when teaching skills that initially seem abstract: instead of asking a participant to adopt an entirely new clinical vocabulary before they can begin practicing a skill, we start from the language they already use and connect it to the therapeutic concept.

The goal is not to make therapy "more Paraguayan" for the sake of cultural symbolism. The goal is to make the skill more usable.

"The goal is not to make therapy 'more Paraguayan' for the sake of cultural symbolism. The goal is to make the skill more usable."

DR. ARAMÍ ROJAS

AND THEN THE PATIENTS STARTED CHANGING THE MANUAL

"It is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried."

CARL ROGERS

On Becoming a Person (1961)



DR. ARAMÍ ROJAS, MD, MSC

Psychiatrist & Educator · Paraguay

Dr. Aramí Rojas, MD, MSc is a psychiatrist and educator from Paraguay. Her work spans trauma, integrative psychiatry, neurodivergence, and neuroscience, with a particular interest in how culture, language, and context shape the way people experience mental health and engage in therapy. Her clinical and postgraduate training has included experiences in Paraguay, the United States, Canada, Mexico, Spain, Chile, and Argentina. She currently coordinates postgraduate training at the National Psychiatric Hospital of Paraguay. She is Co-Founder and Director of Sabiamente, a multidisciplinary mental health center in Asunción, and Founder of the Paraguayan Institute of Integrative Psychiatry and Psychotherapy (IPPIC). She is also a Global Ambassador for the National Neuroscience Curriculum Initiative (NNCI), a U.S. initiative dedicated to integrating neuroscience into mental health education and clinical practice.

FIELD Integrative psychiatry

BASE Asunción, Paraguay

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One of the things we have learned during this process is that cultural adaptation cannot happen entirely at a desk — it has to happen in contact with the people who are actually using the material. That is why Jopara Terapéutico is deliberately unfinished. We are currently working on a second edition that expands the emotional-regulation material and introduces a new, expanded section on self-compassion informed by Compassion Focused Therapy, along with concepts that emerged directly from our clinical experience.

One example is Keikó?, a new approach within the mindfulness section of the DBT skills material. The name combines qué (“what”) with piko, a Guaraní colloquial expression that can intensify a question and also give it a lighter, more playful quality. The idea was to create a different way of approaching the question of what is happening in the present moment.

The first time we introduced it in group, people laughed. Then something shifted — they grasped it almost immediately, in a way the formal “what skill / how skill” language had never quite landed. Participants started using it on themselves between sessions, describing moments where they would catch an impulse or an emotional wave building and think, in their own words, “keikó estoy haciendo” — a colloquial way of asking “what on earth am I doing?” That small, half-joking phrase put the entire what-and-how skill directly at hand, early enough to use before the wave gained ground. It became something the group started saying to each other, not just something we had taught them.

This is how we want the framework to develop: not by assuming the first edition is the final answer, but by allowing clinical experience to continuously challenge what we have written. We try something. We observe. We listen. We modify. We try again.

Jopara Terapéutico is therefore not presented as a finished protocol, but as a continuously evolving clinical framework.

A WORKBOOK EVENTUALLY BECAME A QUESTION ABOUT SYSTEMS

At some point, another realization became unavoidable: a therapeutic framework can be well designed and culturally appropriate and still fail if the system around it cannot deliver it. Who teaches it? Who supervises the clinicians? How do professionals coordinate? How do we know whether it is helping? How do we

make it available to people who cannot afford it? And how does the model continue to improve once the original developers are no longer in the room?

Those questions pushed the project beyond the workbook. Our broader clinical model includes interdisciplinary formulation and structured supervision, patient-facing training materials, and pedagogical infrastructure. We are currently developing a more extensive therapist manual and formal clinical competencies that could eventually allow the framework to be taught and evaluated more systematically. This is an important transition; an idea remains fragile when it depends entirely on the person who created it. For an approach to become transferable, it needs a structure through which other professionals can learn it, practice it, question it, and eventually improve it.

THE QUESTION OF WHO GETS TO PARTICIPATE

The same question eventually led us to access. If we were serious about building an integrated mental healthcare ecosystem, we could not treat access as someone else’s problem.

In response, we developed SabiaMente ComUnidad, a community initiative that provides scholarships within our therapeutic groups for people who would otherwise be unable to participate. The initiative operates through what we refer to locally as *mecenazgo*, a community-supported funding mechanism: former patients and other donors contribute to a solidarity fund, while larger organizations and businesses participate as impact partners. Donated professional hours and space, together with symbolic compensation at this stage, allow the initiative to operate while we work toward greater sustainability. In English, I would describe this as a community-philanthropy or community-supported funding model rather than simply “patronage” — the underlying idea is that someone who has benefited from care can help make care possible for someone else.

Access was never only a financial question, though. In our context, mental health still carries real stigma, and group formats brought their own resistance on top of that: people worried about being seen walking into a group, and many arrived expecting something closer to the version of group therapy they had seen in films — a circle of chairs, open-ended sharing about whatever was troubling everyone that day. Jopara Terapéutico groups are not that. They run more like structured teaching sessions, with rules closer to stan-

dard DBT skills groups and firm limits on what gets disclosed and when. Part of building trust meant making that structure visible and predictable from the first session — down to small rituals, like a Tibetan singing bowl we sound whenever the group drifts into judgment or needs to re-ground its attention.

Since early 2025, that combination — subsidized access plus a format people could trust — has translated into roughly 800 individual consultations and 200 completed group sessions under ComUnidad: 24 scholarship holders moving through groups that each run 27 to 32 weeks.

"The community does not only receive care. It can participate in sustaining it."

DR. ARAMÍ ROJAS

Access therefore becomes part of the architecture rather than an external consideration. The community does not only receive care. It can participate in sustaining it.

FROM CARE TO A LEARNING SYSTEM

This brings us to the part of the model that remains perhaps the most challenging: measurement. We already collect baseline information and have planned follow-up assessments, and we maintain communication with participants' individual therapists to understand whether participation in the groups appears to support, complicate, or otherwise interact with individual treatment. But we have not yet found a single Spanish-language instrument that captures the entire picture we want to understand — which has forced us to think more carefully about what we actually want to measure.

FROM THIS ARTICLE

"Integration is not the accumulation of therapies. It is the intentional connection of people, disciplines, institutions, communities, and knowledge around the person receiving care."

DR. ARAMÍ ROJAS

We are interested in the participant's experience, but also in functioning, the therapist's perspective, the interaction with individual treatment, caregiver burden, community implementation, and the performance of the system itself. The question becomes larger than "did the patient's symptoms improve?" We also need to ask: did the person's life become more workable? Did the therapeutic system become more coordinated?

Could another professional implement the intervention? Did the community become more capable of supporting mental health?

Our long-term vision is a feedback loop in which clinical experience generates data, data informs research, research modifies practice, practice informs training, and training improves care. In that sense, Jopara Terapéutico became the starting point for something much larger: a model of mental healthcare designed to learn from itself.

THE ARCHITECTURE

Clinical experience generates data, data informs research, research modifies practice, practice informs training, and training improves care.

01 Formulation

Biological, developmental, psychological, relational, functional, and contextual dimensions considered together, before therapeutic priorities are set.

02 Skills, in the patient's language

A DBT core structure drawing on RO-DBT, ACT, REBT, CBT, CFT, and neurodivergent adaptations, taught through Spanish, Guarani, and jopara.

03 Supervision & education

Interdisciplinary formulation, structured supervision, a therapist manual and formal competencies, so others can learn, question, and improve it.

04 Access, designed in

SabiaMente ComUnidad scholarships funded through mecenazgo: since early 2025, roughly 800 individual consultations and 200 completed group sessions.

05 Measurement

Participant experience, functioning, the therapist's perspective, caregiver burden, community implementation, and the performance of the system itself.

← and what is learned changes the model again

Editors' diagram, drawn from the article.

WHAT CAN TRAVEL BEYOND PARAGUAY?

The obvious temptation when presenting a culturally specific model internationally is to ask whether other countries can reproduce it. I think that is the wrong question. Another country does not need Jopara. It needs its own equivalent of the question that led us here:

What happens when the evidence-based intervention we are offering does not fully belong to the people receiving it?

The answer will look different in every context. The relevant language may be different. The cultural assumptions may be different. The healthcare infrastructure and the barriers to access may be different. What may be transferable is the architecture: preserve the therapeutic mechanisms, adapt the expression, start with formulation, integrate disciplines intentionally, allow the needs of the population to determine emphasis, build systems for supervision and education, design access into the model, measure what matters — and then allow what you learn to change the model again.

That is ultimately what Jopara Terapéutico has taught us. Integration is not the accumulation of therapies. It is the intentional connection of people, disciplines, institutions, communities, and knowledge around the person receiving care.

We began with a very local question: how could evidence-based therapeutic skills speak more naturally to the people we were trying to help? The answer led us far beyond language — it changed how we thought about formulation, interdisciplinary practice, cultural adaptation, professional education, community access, and measurement. And perhaps that is the most useful lesson we can offer from Paraguay: a clinical model should not be something we finish and then protect from change. It should remain close enough to practice that the people using it can continue to change it.

The goal is not simply to bring evidence-based care to a community. It is to build a system in which evidence-based care can genuinely belong to that community.

No easy answers. Better questions.

The listener that never sleeps

An ethical dilemma, held open: when a client turns to AI

By Dr. Solmaz Kaynama

A client tells you that on their hardest nights, when no one else is awake, they turn to an AI chatbot. It is free, always available, and, they say, easier to talk to because they can say things they are not yet ready to say to someone else.

What do you hear in that disclosure?

Where professional care is scarce, unaffordable, or difficult to access, AI is beginning to occupy a space that can feel like support, reflection, or companionship.

The appeal is understandable: immediate access, little or no cost, and, for some, a first place to put difficult thoughts into words.

The limitations matter too. A chatbot is not a clinician. It does not bring clinical case conceptualization, professional accountability, or a therapeutic relationship. It can generate language that sounds empathic without participating in the embodied attunement that can unfold between two people.

Something important in therapy happens through relationship itself. A practitioner notices tone, pace, silence, expression, posture, and emotional presence. There can be a nervous-system-to-nervous-system quality to the encounter, where attunement and co-regulation help safety, trust, and meaning develop.

A chatbot can respond to language, but it cannot participate in this embodied relational process in the way another human being can. It can also be confidently wrong, and its privacy protections, safeguards, and ability to recognize serious risk may be difficult to assess.

Still, dismissing the tool may mean missing something important: the need the client is trying to meet.

That leaves the practitioner in a difficult position. If we condemn its use, will the client stop telling us about it? If we endorse it too readily, do we lend professional credibility to a system whose limits we cannot fully know?

Perhaps the more relational position is curiosity held alongside clear boundaries.

What are you turning to it for?

What feels useful about those conversations?

What are you able to say there that feels harder to say here?

What becomes possible in a human relationship that cannot happen in the same way with a chatbot?

These questions keep the client at the center.

AI capabilities can cross borders instantly, while meaningful care takes shape within relationship. Trust grows through presence. Cultural understanding deepens through listening. Professional discernment develops through context, responsibility, and the person in front of us.

The wisdom to use it well grows through relationships, communities, and professional cultures of care.

THE DIFFICULT TABLE · AI + PRACTICE

WHAT CROSSES BORDERS

The capability.

WHAT TAKES SHAPE IN RELATIONSHIP

Trust, safeguards, humility, curiosity, and accountability. These are strengthened through relationships, shaped within communities, and grounded in professional cultures of care.

Some of the most meaningful dimensions of care emerge in the encounter itself: presence, attunement, and co-regulation.

Where do you draw the line?

MARKETING@INTAPC.ORG

AI Literacy Belongs in Professional Practice

Why helping professionals need a basic understanding of AI, even if they do not plan to use it in practice. Whether that remains a realistic choice a few years from now is an open question.

By Dr. Solmaz Kaynama

You do not have to use AI to be affected by it.

Clients, students, colleagues, and organizations are already bringing AI-generated information, expectations, and decisions into professional spaces. That makes a basic level of AI literacy increasingly relevant to helping practice.

AI literacy is more than knowing how to use a chatbot or an AI agent. It includes understanding bias, privacy, data use, misinformation, human oversight, documentation risks, academic integrity, and the limits of auto-

mated systems. It also means knowing when to question an output, when to verify it, and when human discernment needs to remain at the center.

The practical message is simple: helping professionals need enough understanding to ask better ethical, clinical, educational, and organizational questions.

AI literacy is becoming less about mastering technology and more about remaining thoughtful, informed, and accountable in a world increasingly shaped by it.

IN BRIEF

The goal is practical AI literacy: enough understanding to ask better questions, and enough judgment to know which questions matter.

RESEARCH → PRACTICE

FROM THE FIELD

EVENTS & GATHERINGS

Where the IAPC community is convening next

OXFORD · JULY 2–9, 2027
UNITED KINGDOM

2027 IAPC Oxford Institute

St Hilda's College, University of Oxford. Registration and full program details: intapc.org/2027-oxford-institute

NEW ORLEANS · NOVEMBER 2027
LOUISIANA, USA · EXACT DATES TO BE CONFIRMED

2027 IAPC World Conference

New Orleans, Louisiana. Exact dates and program details will be announced soon at intapc.org.

IN PLANNING

CHINA · CYPRUS · INDIA · PARAGUAY · TÜRKİYE

Future Professional Events

Events are in development for China, Cyprus, India, Paraguay, and Türkiye. Details will be updated soon at intapc.org.



DISPATCH FROM
Abuja · Nigeria



Helen Kwanashie

A brief conversation across borders about the person, the practice, and the story behind the work.

Professor of Pharmacology & Guidance-Counselor · Nigeria, West Africa · 5 min read

IAPC Country Chair, Nigeria

FIELD Guidance & counseling; pharmacology

BASE Abuja, Nigeria

01 / 05

WHAT FIRST DREW YOU TO THIS WORK?

My journey into Guidance and Counseling did not start in one day. Rather, it was a natural evolution born out of over four decades as a university Lecturer / Professor of Pharmacology living and working in Nigeria. Throughout my career, my core passion has always revolved around education, human development, and supporting students beyond the conventional classroom. Starting in the early 1980s at Ahmadu Bello University, Zaria, Nigeria, I served as an Academic Adviser to first undergraduate students, and later on, postgraduate students. The Lecturer Adviser-Student Advisee which is a specialized form of counseling, was part of our official work and every year, I was assigned 5-6 students to be my academic advisees. In 2000, while serving as President of the ABU Chapter of National Association of Women Academics, I led a university-wide effort to reactivate the struggling Lecturer Adviser-Student Advisee scheme. These practical experiences, alongside volunteer roles with organizations such as 'Hope for the Blind' in Nigeria and 'Home-Start UK', deepened my realization that academic success and human development in general, is inextricably linked to psychosocial well-being.

During this period, I saw firsthand how students struggled under immense pressure without structured mental health support or strategic guidance in the courses they studied and in their future careers. Driven by a desire to formalize what I started to realize was a lifelong calling, I pursued formal qualifications, beginning with a summer program at Middlesex University London in 2016, followed by Postgraduate Diploma in Education and Higher Diploma in Guidance and Counseling Education, both at ABU. Eventually, I also undertook a Master degree program in Guidance and Counseling at the National Open University of Nigeria (NOUN). Thus, what drew me to this work was the profound understanding that providing empathetic, structured psychosocial scaffolding can completely alter a person's educational and personal trajectory.

02 / 05

WHAT DOES YOUR WORK TEACH YOU THAT YOU WOULD WANT COLLEAGUES IN OTHER COUNTRIES TO UNDERSTAND?

My work in Nigeria has taught me that effective counseling must meet people where they are, and adapt flexibly to unique systemic, cultural, and technological landscapes. Operating within an Open and Distance Learning (ODL) environment at NOUN has shown me the incredible potential of digital pedagogy coupled with online-enabled counseling. During the COVID-19

lockdown, I conducted a project entirely virtually on the Adviser-Advisee scheme from which I wrote a paper, titled "My Academic Life is Screaming for Help!", highlighting how higher education students desperately need accessible academic advising and mental health intervention. Colleagues worldwide should appreciate that resource constraints such as experienced by Nigeria and many other countries, do not limit human resilience; rather, they drive creative, technology-enabled solutions.

Furthermore, my experience reinforces that counseling must be radically inclusive. Whether supporting individuals with special needs such as visually impaired students navigating environments lacking structural support or addressing critical needs like suicide prevention and family dynamics, counselors must act as systemic advocates. We need to bridge global perspectives with local realities, combining rigorous research with compassionate, culturally sensitive interventions. International colleagues should recognize that mental health challenges are universal, but the pathways to delivering scalable, impactful support require leveraging every available tool (from digital networks and local media) to community-based mentorship models.

03 / 05

HOW WOULD YOU DESCRIBE YOUR FIELD, WHERE YOU WORK, IN YOUR OWN WORDS?

In Nigeria where I do most of my counseling work (in addition to a much smaller on-line counseling), I would describe the counseling field as a vibrant, rapidly evolving bridge between academic empowerment and holistic psychosocial care. Counseling as a discipline is uniquely positioned at the intersection of educational guidance, relationship dynamics, mental health advocacy, and strategic life planning. While modern-day counseling in my country historically started with, and is still largely centered on formal educational system, today's Nigerian landscape demands a far broader, integrative approach and hence counselors like myself are expanding into critical areas such as suicide prevention, intervention, and postvention, as well as marriage and family therapy, academic advising, and self-care for counseling practitioners.

In our local context, the field is also defined by the need to democratize access. Through initiatives like my private counseling practice, named All-Round Counseling Solutions (ARCS) which is based in Abuja, and through reasonable engagement with digital out-

reach platforms, we are working to strip away the stigma surrounding mental health support. We operate in an environment where counselors must be multi-dimensional, serving not only as therapists and advisers, but as institutional strategists and community educators. Ultimately, I view our field as the art and science of nurturing human potential, helping individuals navigate life transitions, overcome systemic barriers, and build sustainable frameworks for personal/professional fulfillment and societal development.

04 / 05

WHAT HAS BEING PART OF A GLOBAL COMMUNITY LIKE IAPC MEANT TO YOU?

Being part of the International Association of Psychology and Counseling (IAPC) has been a profoundly enriching experience, offering a collaborative global platform that bridges geographical, cultural, and disciplinary boundaries. As the IAPC Country Chair for Nigeria and a member of its International Leadership Council, serving this organization allows me to connect Nigerian practitioners and scholars with international best practices while bringing our unique perspectives to the global conversation.

IAPC's commitment to advancing knowledge, research, and clinical excellence in psychology and counseling deeply aligns with my vision of lifelong learning and interdisciplinary scholarship. Engaging with international peers at events like the 2024 IAPC World Conference in the United States of America, and both 2025 and 2026 Oxford Institute in the United Kingdom, provides valuable exposure to diverse therapeutic methodologies, scholarly insights, and the highest professional standards. Belonging to IAPC reminds us that while our local challenges may vary, our shared mission to foster psychological well-being, human dignity, and educational excellence is truly universal.

05 / 05

WHAT ARE YOU MOST HOPEFUL ABOUT, OR WORKING TOWARD NEXT?

As I transition from a 44-year career in Pharmacology which included some Guidance and Counseling services, toward full-time counseling practice following my institutional retirement, I am filled with immense hope for the future of mental health and educational guidance in Nigeria. I am actively working toward expanding All-Round Counseling Solutions (ARCS), into a premium multi-specialty practice in Abuja. Through ARCS, my goal is to deliver accessible, high-impact

services across academic advising, marriage and family therapy, crisis intervention, and strategic planning.

I am particularly hopeful about advancing online-enabled counseling and virtual academic advising frameworks, ensuring that learners in distance education and underserved communities receive high-quality psychosocial support regardless of location. Furthermore, as IAPC Country Chair, I am dedicated to mentoring early-career counselors, empowering women in science and academia, and championing inclusive education for individuals with special needs.

Seeing emerging generations and resilient individuals thrive strengthens my conviction that professional guidance and counseling can transform lives. I look forward to dedicating my next chapter to expanding mental health access, building sustainable institutional support systems, and advancing the counseling profession nationally and internationally.

"Resource constraints ... do not limit human resilience; rather, they drive creative, technology-enabled solutions."

HELEN KWANASHIE

NIGERIA · GUIDANCE & COUNSELING	
WHAT TRAVELS Technology-enabled academic advising and online counseling for distance learners; counseling as inclusive, systemic advocacy.	WHAT TRANSLATES Delivery through the channels a context actually has: local media, community mentorship, the resources on hand.
Editors' framing of Professor Kwanashie's answers to questions 02 and 03.	

FROM THIS ARTICLE

"Seeing emerging generations and resilient individuals thrive strengthens my conviction that professional guidance and counseling can transform lives."

HELEN KWANASHIE

The page begins with you.

Some of the most meaningful exchanges begin with something small: a question, an observation, a response, or a thought that stays with us after the reading ends.

Notes Between Us is a space for brief reflections and correspondence from members across countries.

- Something you are noticing in your work.
- A response to something you read here.
- A question you would like to place before colleagues elsewhere.
- An idea you are still thinking about.
- A brief story or reflection worth sharing.

FOR THIS FIRST ISSUE, WE ARE LEAVING SOME ROOM.

What would you like to put between us?

SHARE A NOTE Even a few sentences. marketing@intapc.org

Selected notes may appear in a future issue of *The IAPC Field Letter*.

THE COMMONS

BRIEF UPDATES & WAYS TO TAKE PART

Ways to take part

IAPC's journal

Global Journal of Psychology and Counseling, IAPC's professional journal, will open for contributions soon. Editors: Dr. Fotini Economides Kranou · Dr. Ed Gunberg. Contact: fotinie@gmail.com · gunberge@lindsey.edu

Support IAPC

IAPC is a not-for-profit association. Contributions help sustain its work across borders. [Support IAPC →](#)

Bring a colleague

Membership is still small enough that a single introduction genuinely shapes the community. Point a colleague to intapc.org.

Join IAPC

Professional and student membership: intapc.org/join-iapc

NEXT DISPATCH

ISSUE 02

What should we ask next?

Have a field note, a question, or a member story to share? The IAPC Field Letter is written by its community as much as for it. We invite you to contribute to the next issue. We would also love to hear your ideas for future editions: tell us what you would most like to see.

VOTE

Culture & diagnosis

VOTE

AI & clinical practice

VOTE

Training the next generation

TELL US

Something else →

LEAD WITH PURPOSE. SERVE WITH EXCELLENCE.



The IAPC Field Letter

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Views expressed by contributors are their own. Contribute, respond, or suggest
a topic: marketing@intapc.org

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ADVANCING EXCELLENCE IN EDUCATION AND CLINICAL PRACTICE.

DESIGN & AI USE STATEMENT

Dr. Solmaz Kaynama developed the editorial concept, creative direction, design, and all visual and creative ideas for this edition. Claude, an AI model developed by Anthropic, was used solely as a design-production tool to help translate Dr. Kaynama's direction, ideas, and specifications into the final layout and visual presentation. All articles are attributed to their named authors. The editors retained editorial judgment, content selection, review, and final publication decisions. Dr. Kaynama retained creative direction and design decisions.