Psychotherapy

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

www.societyforpsychotherapy.org

BULLETIN

In This Issue

Society for the Advancement of Psychotherapy

2022 VOLUME 57, NUMBER 2

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PSYCHOTHERAPY BULLETIN
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PSYCHOTHERAPY BULLETIN

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

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PRESIDENT'S COLUMN

Clara E. Hill, Ph.D.
Professor, University of Maryland – College Park, MD

We have just finished our winter/spring board meeting and there's a lot of exciting things happening in the Society for the Advancement of Psychotherapy (SAP).

We have 231 students who have taken advantage of the free membership… welcome aboard!!!! Of course, we hope you'll stay and contribute to SAP. We need your energy, ideas, and enthusiasm. This is a new initiative on the part of SAP, to support our students.

Another exciting new initiative is starting a series of webinars and talks. Members will receive free Continuing Education credits (non-members will pay a fee…hoping you'll join the division and not have to pay the fee). One of the upcoming talks will be with Nancy McWilliams!!! The student group is offering presentations on student debt and getting internships.

Our journal (Psychotherapy) is a jewel and is now one of the top 10 in clinical psychology!!!!!

We have lots of awards and grants because we want to encourage practitioners, researchers, and educators who are doing such a wonderful job.

We have programs to foster diversity, equity, and inclusion. The Advocacy and Mentoring Program for Diversity (AMPD) scholars has sponsored two young scholars (Ingrid Hastedt and Michelle Joaquin) and will now be recruiting for two new scholars.

We have a vibrant website and social media presence.

We will be at the APA convention in August in person (hopefully). We'll get a full program, including panels, posters, a Presidential Address, Awards ceremony, and social hour. And join us for the Gab with the Greats….an exciting chance to meet some of the leading people in the field. Please join us!

The International group is actively involved in mentoring and encouraging representation at international congresses. They have expanded membership to other countries and are providing training opportunities particularly in China.

The Fellows Committee is actively looking for people who can be nominated for Fellows of APA. Please consider nominating yourself or others!

Finally, for my presidential Initiative, SAP approved a task force co-led by myself and John Norcross for a project following up on the highly successful three editions of *Psychotherapy Relationships that Work*…this time we are focused more specifically on *Psychotherapy Skills and Methods that Work*. The Task Force is co-sponsored by the Society for Counseling Psychology, Society for Psychotherapy Research, and the Society for the Exploration of Psychotherapy Integration. We have a contract with Oxford University Press for a book and an agreement to subsequently publish condensed article in *Psychotherapy*. We are very excited to have about 30 chapters commissioned with experts in the field reviewing the evidence for specific skills

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(e.g., challenges, advice) and methods (e.g., cognitive restructuring, mindfulness) used frequently across orientations in psychotherapy.

We welcome your participation in the Society. Most people start as members on committees, work their way up to being Committee Chairs, and then run for elected office. If you see a committee you'd like to be on, please contact the committee chair.

If there's something you think we could be doing, let us know!

We also have new and returning Board members and committee chairs… welcome aboard!!!! I was blown away with all the enthusiasm and ideas for the SAP. Here's are the newly elected Domain Reps:

- Rosemary Phelps, Public Interest and Social Justice
- Cheri Marmarosh, Education and Training
- Rebecca Ametrano, Membership
- Sheeva Mostoufi, Diversity

And thanks for those who are continuing as elected officers and Domain Reps:

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And perhaps the most important person:

- Tracey Martin, Central Office

Let's all work to enhance the science and practice of psychotherapy!

EDITOR'S COLUMN

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Greetings Division 29 and SAP Membership! Happy summer!

We start this issue with an intention for the remainder of 2022 that comes from a quote by Benjamin Franklin: "Either write something worth reading or do something worth writing." As the pandemic persists and we experience the continued fatigue and fear, we encourage you to remember the value of seeking purpose and meaning from your professional identities. Through writing, through action, and through service, you bring about change that enhances the lives and experiences of those around you. We hope that the *Bulletin* can be a space to showcase your work.

Since the start of 2022, we have sought to increase our number of submissions while seeking a range of author perspectives and identities. This issue represents one where the content is particularly engaging and thought provoking, and challenges us as practitioners, researchers, and instructors to think beyond our traditional ways of doing things. In addition to the presidential column by Dr. Clara Hill, we call your attention to an engaging submission led by doctoral students Wing Ng and Ava Anjom that is focused on the social justice issues associated with research compensation. This piece fits nicely with the special focus of the year, "Technology and Psychotherapy: Strategies for Increasing Access and Equity." We welcome content related to this theme or to any curiosity regarding how we understand people and their mental health needs as they engage with psychotherapy as a mechanism of change.

We extend our gratitude to the readers, authors, Division members, and our broader academic community who engage with the *Psychotherapy Bulletin*. Your dissemination of our articles makes for extremely interesting discourse, and more importantly, action. To write for the *Bulletin*, please visit our website (http://societyforpsychotherapy.org/bulletin-about/). Our schedule of deadlines for 2022 will be July 15th, and October 15th. Please reach out with questions to joanna.drinane@utah.edu. We seek to make the remaining two issues of 2022 as dynamic as possible. Wishing you well.

Best,
Joanna

Society for the Advancement of Psychotherapy

Helping Psychotherapists Adopt Productive Responses to Suicidal Patients

Samuel Knapp, Ed.D., ABPP
Sunnyvale, California

The death of a patient by suicide is the professional event most feared by psychologists (Pope & Tabachnick, 1993). Fortunately, evidence has accumulated for the effectiveness of the Collaborative Assessment and Management of Suicidality, Dialectical Behavior Therapy, and Cognitive Behavior Therapy for the treatment of suicidal patients, although other interventions are promising as well (Calati et al., 2018).

Unfortunately, some psychotherapists deliver less-than-optimal services to suicidal patients. Some may routinely overestimate the risk of suicide and thus endorse highly restrictive interventions, such as hospitalizations or unwanted disclosures to family members, even when the clinical picture would not require them. Others may routinely underappreciate the risk of a suicide and avoid even asking about suicide or, if they do, fail to appreciate the severe distress of their patients and the risk of a suicide. They may fail to develop or implement safety plans known to reduce the risk of suicide or withhold treatments out of a misguided belief that suicidal thoughts or behaviors are not a cause for concern.

Patients report feeling harmed when psychotherapists respond to them with alarm or denial/dismissiveness (Richards et al., 2019). This article describes these two unproductive responses to suicidal patients, gives examples, and describes how psychotherapists can cultivate a more productive attitude of concerned alertness toward their suicidal patients.

The Alarmist Response

An alarmist response occurs when psychotherapists overreact to any indication of suicide and greatly overestimate the likelihood that their patients will die from suicide. This response may prompt psychotherapists to adopt more restrictive and often clinically contraindicated interventions.

Psychotherapists responding with alarm may fail to do an adequate risk/benefit analysis of their interventions. For example, some patients may need to be hospitalized to ensure their safety. But psychotherapists should consider the potential risks of any intervention, including hospitalizations. Unfortunately, hospitalizations may have negative consequences. Patients may feel an increase in stigma, and the hospitalization itself costs patients time off work and money. Finally, many patients have reported negative experiences while in the hospital (Large et al., 2014).

In addition, psychotherapists responding with alarm may be too quick to disclose confidential information to others without the patient's consent. Ordinarily, psychotherapists will defer to the judgment of patients about disclosures of confidential information. However,

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psychotherapists who routinely overestimate the risk of suicide may not balance patient safety and patient autonomy adequately and may override patient autonomy without considering less intrusive options, incorporating patient preferences into their decisions, or considering how to minimize the harm caused by their unwanted interventions.

Involuntary hospitalizations are even more problematic because patients may lose the right to possess a weapon or their right to participate fully in medication decisions. It may discourage patients from seeking treatment voluntarily in the future or from being forthcoming about their suicidal thoughts, thus increasing the long-term risk of a suicide.

Psychotherapists responding with alarm may argue that they are "doing everything they can" to save the life of their patient or that they are only protecting themselves against a charge of negligence if their patient dies by suicide. But "doing everything you can" is not necessarily the same as being helpful. It would be hard to argue that interventions that harmed patients or increased their reluctance to receive mental health services in the future would be part of a strong defense in the event of a charge of negligence.

Evidence suggests that many psychotherapists overreact to disclosures of suicidality (Hom et al., 2020). Some patients fail to disclose their suicidal thoughts because they fear that their psychotherapists will overreact and put them in a hospital. One former patient stated,

> The message I received was that I couldn't ever be totally truthful with him if I wanted to avoid hospitalization. . . It really. . . sucks to have to deal with mental illness that already makes me feel alone and trapped and, on top of that, have to navigate how I go about asking for help (Love & Morgan, 2021, p. 537).

Another former patient stated,

> Everybody just freaks out and wants to get you hospitalize [sic], and acts like you're a danger, . . . 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 or anything (Richards et al., 2019, p. 43).

The Denial/Dismissive Response

Psychotherapists responding with denial or dismissiveness could fail to ask their patients about suicidal thoughts, or they may use negatively worded questions (e.g., "Not thinking of killing yourself, are you?"), which tend to elicit more denials than positively worded questions (e.g., "Have you ever thought of suicide?"; McCabe et al., 2017). Still, other psychotherapists who learn about their patients' suicidal thoughts may dismiss their patients' complaints as overreactions to minor life difficulties or manipulative (e.g., the patient staged a faux suicide attempt to influence the behaviors of others). They may not fully explore their patient's suicidal thoughts or fail to implement safety plans or effective interventions.

Evidence supports the presence of a dismissive attitude among some psychotherapists. In a survey of suicide attempt survivors, 15% stated that their health care professionals minimized their problems or denied the severity of their suicidal thoughts. One participant reported,

> They were like, "You just want attention. You don't need help." So I

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said, "No, I'm really suicidal, and here's my plan." They said, "Well, you're not going to do it" (Hom et al., 2020, p. 178).

In another study, a respondent stated that,

> They [the gatekeepers] didn't take me seriously enough. They had me fill out a safety plan and scheduled me for an appointment in a month ahead. If I had seen a psychologist right away or was able to talk to a skilled professional, I probably wouldn't have made the attempt (Love & Morgan, 2021, p. 539).

The Concerned Alertness Response

Psychotherapists responding with concerned alertness may still have some anxiety or fear of a patient suicide. But they also have self-efficacy or the belief that they have the skills necessary to help their suicidal patients (Knapp & Schur, 2019). Psychotherapists may, for example, ask about suicidal thoughts directly and, when patients express those thoughts, respond with appropriate sensitivity, empathy, and nonjudgmental curiosity, which helps their patients to disclose more. Or when patients give indirect indicators of suicidal thoughts (sometimes wish-to-die thoughts may be indirect indicators of suicidal intent; Love & Morgan, 2021), they follow up with inquiries genuinely designed to help patients disclose more about their feelings even if it results in patients describing suicidal thoughts. Those with concerned alertness follow professional standards, listen carefully to their patients, and appropriately solicit their patient's input and involve them in treatment decisions as much as is clinically feasible. Psychotherapists who are more comfortable working with suicidal patients are more likely to conduct evidence-based suicide assessments and use adequate risk reduction strategies (Roush et al., 2018).

Here is an example of a patient's response to a psychotherapist who showed concerned alertness.

> There was no judgment or overly zealous attempts to get me to love life. It was gritty and real. I said, "yo I want to die," and she said, "damn, that sucks. Glad you're alive, though," and I thought that was amazing (Love & Morgan, 2021, p. 539).

How to Foster Concerned Alertness

Alarmist or denial/dismissiveness responses harm patients, and concerned alertness benefits them. Psychotherapists can begin to cultivate concerned alertness by reflecting on their own reactions to suicidal patients, including whether they have been influenced by the suicide of someone in their personal lives or whether they have internalized some of the myths about suicidal patients as being cowardly, weak, or selfish (Joiner, 2010). These unproductive attitudes, combined with a belief that one is entirely responsible whether the patient lives or dies, an exaggerated fear of the legal system or a failure to understand effective risk management strategies or a lack of adequate training in suicide, may contribute to alarmist or dismissive responses.

As much as they may wish, even the most talented psychotherapists cannot prevent all suicides. This fact can be hard to accept among those who are working assiduously to keep a patient alive. But psychotherapists practice more effectively when they understand their role. The patient, not the psychotherapist, decides whether to live or not. As stated by Jobes, "While I cannot guarantee a nonfatal outcome, I can nev-

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ertheless provide *the best possible clinical care* to the suicidal patient" (2016, p. 49, italics in original). Although we cannot stop all suicides, delivering high quality services is a considerable and substantial service to our patients.

Having a patient die from suicide is doubly burdensome when someone alleges that the behavior of the psychotherapist caused or contributed to the death. But psychotherapists need to put these risks into perspective. Suicide related lawsuits for outpatient services are rare (Knapp et al., 2013). Courts appreciate that outpatient psychotherapists do not control the lives of their patients outside of the psychotherapy session in the same way that hospitals control the lives of patients under their care.

The death of a patient by suicide does not necessarily mean that the psychotherapist failed to follow an acceptable standard of care. Courts do not expect professionals to have perfect judgment and will not simply judge them as to what they should have done in hindsight. Courts will use the standard of whether the psychotherapists acted like a reasonable professional in similar circumstances given the information that they had at the time (Knapp et al., 2013).

Also, the best risk management strategy is to deliver and document good quality care. Restrictive practices are only good risk management strategies when they are clinically indicated. When dealing with high-risk suicidal patients, prudent psychotherapists can implement some ethically based and patient-centered risk management (quality improvement) strategies, including (1) involving patients (and family members if indicated) in as many treatment decisions as is clinically feasible, (2) getting consultations, (3) monitoring patient risk and progress, and (4) documenting services adequately (Knapp et al., 2013). As the risk of a suicide or treatment failure increases, psychotherapists should give greater attention to these four quality enhancement strategies.

Finally, psychotherapists can seek out good training in the assessment and management of suicidal patients. Suicide-specific training is indicated. The research by Kraus et al. (2016) suggests that psychotherapists can achieve good clinical outcomes with many problem areas without necessarily getting good clinical outcomes when treating suicidal patients. Psychotherapists who felt that their training in suicide was sufficient knew more about suicide, expressed more comfort when working with suicidal patients, and had less fear of a patient suicide (Jahn et al., 2016).

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Society for the Advancement of Psychotherapy

ETHICS

Ethics and Values in Psychotherapy

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Devin Teehan, BASc
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Ethical practice is essential for all psychotherapists. As licensed professionals, we are obligated to ensure that we meet the minimal expectations set in our state's licensing law, the regulations that accompany it, other laws relevant to the practice of our profession, and our profession's code of ethics. Yet, our goal should be to go far beyond codified minimal expectations. Licensure creates a fiduciary responsibility that requires that our clients' best interests are our primary concern and motivation (Jorgenson et al., 1997). While this responsibility makes clear that psychotherapists should not engage in behaviors that are exploitative of or harmful to clients it does not provide clear guidance on how to best meet each client's treatment needs.

As an alternative to a focus on avoiding harm, Handelsman et al. (2002) recommend positive (or aspirational) ethics. This approach views meeting minimal expectations and avoiding unethical behaviors as necessary but not sufficient for meeting our ethical obligations. Rather, this approach encourages each of us to actively work to do the best we can for each client in our professional roles. This requires us to be cognizant of and motivated by the underlying values of our profession and to aspire to achieve their fullest possible intent in all decisions we make and in each action we take in our professional roles.

The Values of the Profession

Codes of ethics are based on a widely accepted set of underlying values. As described by Beauchamp and Childress (2012), these include:

Beneficence – the obligation to provide benefit to those we serve in our professional roles.

Nonmaleficence – the obligation to avoid exploitation of and harm to those we serve.

Fidelity – Fulfilling our obligations and acting with integrity.

Autonomy – Working to promote each client's independent functioning of us over time and not acting in ways that promote their dependence on us.

Justice – Treating clients fairly and equitably in the services we provide and in access to care.

To these, Barnett (2008) adds self-care as one of the values that guides ethical practice since a failure to adequately attend to one's self-care can result in a decreased ability to effectively implement the other five values.

Each of these values is foundational to the practice of psychology, as articulated in the Ethical Principles of Psychologists and Code of Conduct (Ethics Code, APA, 2017). This should be evident from even a cursory reading of the Ethics Code's General Principles:

Principle A: Beneficence and Nonmaleficence,

Principle B: Fidelity and Responsibility,

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Principle C: Integrity,

Principle D: Justice, and

Principle E: Respect for People's Rights and Dignity

Further, the final sentence of Principle A states, "Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work," highlighting the inclusion of self-care in the profession's underlying values.

These values-based General Principles of the APA Ethics Code are not enforceable and do not set minimum standards that must be met (Knapp et al., 2017). Instead, they are aspirational in nature; intended to guide us in our decision-making so we may do the best we can in our professional roles. It is also hoped that these General Principles will provide the foundation for each psychologist's professional identity.

Professional Identity and Personal Values

While it is hoped that psychotherapists will embrace the values of the profession, we each bring to our professional roles our own personal values as well. These personal values may be strongly held beliefs and convictions that are essential aspects of one's identity. Of course, personal values influence decisions and actions in our personal and professional lives. Although the Ethics Code makes clear that actions in one's personal life are "not within the purview of the Ethics Code" (Introduction and Applicability), the role of one's personal values in the context of professional work is less clear. The Ethics Code does state that when "making decisions regarding their professional behavior…", in addition to considering the Ethics Code, laws, and regulations, psychologists "may consider… the dictates of their own conscience."

Some psychotherapists may have strongly held personal values and convictions that are not in alignment with the values of the profession. Reconciling these differences may prove difficult for those attempting to be true to each of these. Knapp et al. (2017) propose an integration of personal and professional values (and ethics) as being optimal. This alignment is recommended over a focus on either alone. Being guided only by one's personal values may result in actions that violate the intent of the Ethics Code, while attempts to focus solely on the values of the profession will likely not be fruitful as our personal values are always present and influencing us to some extent.

The Psychotherapist's Personal Values in Psychotherapy

Psychotherapy cannot be free of the influence of the psychotherapist's (or client's) personal values. They are integrated into who we are as individuals, and they influence every decision we make and every action we take. Kelly and Strupp (1992) found that psychotherapists' personal values influence the treatment decisions they make as well as their perceptions of clients and treatment outcomes. They also found that over the course of treatment, some clients may adopt personal values similar to those of their psychotherapist, a phenomenon termed 'values conversion.' Interestingly, this occurs even when psychotherapists are not intentionally attempting to alter a client's values.

Alternatively, psychotherapists may have very strongly held personal values that may actively influence decision-making in their professional roles. The right to act on one's personal values in one's professional role is, for some, a highly controversial issue with significant emotional valence. This may include a

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desire to offer treatments that are consistent with one's personal values but that are not supported by the profession's values (or even state law), such as conversion therapy or refusing to treat certain individuals whose values conflict with one's own such as refusing to treat LBGTQ clients.

There is no requirement that psychotherapists have the same values as their clients and no requirement that psychotherapists exclude all influence of personal values from their professional work. A psychotherapist's personal values and aspects of their identity may inadvertently be disclosed to clients when they wear a wedding band, crucifix, Star of David, or religious attire, for example, but this hopefully is seen as quite different than imposing one's own values upon a client or refusing to treat certain clients due to differences in values. There is a need to exercise professional judgment to discern to what extent personal values should influence professional conduct while hopefully working on acting consistently with the values of our profession. If one's personal values are such strongly held convictions that they cannot be prevented from impacting one's professional decision-making, consultation with expert colleagues is recommended to help determine the most appropriate course of action moving forward.

Asserting Personal Values in One's Professional Role

In recent years there have been multiple court cases relevant to psychotherapists and psychotherapy trainees refusing to treat homosexual clients, stating that to do so would conflict with their religious beliefs (e.g., Bruff *v.* North Mississippi Health Services, Inc., 2001; Ward *v.* Willbanks, 2010). In each of these cases, the clinician in question attempted to refer the client to another clinician, citing a values conflict based on their strongly held beliefs and convictions. While these cases involve the counseling profession, considering the issues they raise may prove helpful to all psychotherapists.

These cases raise an important question: Should licensure as a mental health professional create an obligation to treat clients even if doing so might feel contrary to one's personal values or religious beliefs? The APA Ethics Code guides psychologists to be aware of and respect individual differences, including sexual orientation and gender identity (Principle E: Respect for People's Rights and Dignity) and promote "access to and benefit from" the services psychologists offer for all persons (Principle D: Justice). Further, relevant to treating clients of diverse backgrounds, Ethical Standard 2.01, Boundaries of Competence, requires that psychologists "obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals."

This raises the question of if a conflict between the psychotherapist's and client's personal values can be accepted as creating a lack of clinical competence and thus necessitating referring the client to another professional. It is possible that an inability to prevent one's personal values from intruding on one's clinical decision-making in treatment would be seen as meeting the requirements of this ethical standard. Using this reasoning, referring the client to another professional may be the most respectful action possible.

One may also ask if entering a profession necessitates acceptance of that profession's values and keeping one's personal values from superseding them. In the case of Keaton v. Anderson-Wiley (2010), a student was dismissed from

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her graduate program after she insisted on her right to counsel LGB clients that being gay is immoral. She did not acknowledge that her personal values could have a negative impact on the client and did not seek to refer the client. Rather, she believed she had the right to assert her personal beliefs in her professional role.

Relevant Issues to Consider

It is understood that psychotherapy is not a values-free endeavor (Kelly & Strupp, 1992). We each bring with us who we are as individuals to our professional roles. Yet, the role of the psychotherapist's personal values in psychotherapy is a highly complex and potentially controversial one. Should psychotherapists be required to keep their personal values to the side and use their clinical training and skills to meet all clients' treatment needs for which they are appropriately trained? Or should psychotherapists be allowed to refer clients to others when they believe that to treat a particular client would violate their personal values (even when they may possess the necessary clinical competence to treat that client)? Is it appropriate to assert that such a values conflict reduces one's competence and, thus, making a referral is the ethical action to take? The APA Ethics Code is open to interpretation on these questions. In response to the Ward *v.* Wilbanks case, which involved a counselor, the American Counseling Association strongly asserted (see Kaplan, 2014) that to make a referral "based solely on the counselor's personally held values, attitudes, beliefs, and behaviors" violates the ACA Code of Ethics (ACA, 2014, p. 6). No such standard presently exists in the APA Ethics Code.

For psychologists and other psychotherapists, each of these questions can be difficult to answer, and consensus may be elusive. Case law continues to evolve in response to lawsuits being filed. An additional challenge is the recent and ongoing passage of state laws and licensing board regulations in some states that allow licensed health professionals in those states to refuse to treat LGBTQ and disabled individuals due to religious or moral objections (c.f., PBS NewsHour, 2021). This raises the challenge of laws and regulations conflicting with the profession's ethics code and with the underlying values of our profession.

While it is desirable that all psychotherapists comply with the dictates of the code of ethics of their profession as well as their state's licensing law for their profession, these may at times come into conflict. If such conflicts arise, psychologists are required to "make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code" (Ethical Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority).

Recommendations

As with all ethical dilemmas, to the extent that it is possible, a focus on prevention is recommended. Thus, the following specific recommendations are provided:

Psychotherapists

- Know your profession's ethics code, your state's relevant laws, and your institution's or organization's policies.
- Keep in mind that just because a law or policy *may* allow a certain action, that does not mean that one *must* act in this way.

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- Clarify your values and disclose any potential value conflicts as early as is feasible. When unsure about the appropriateness of this or how to best do so, consultation with expert colleagues is recommended.
- Engage in transparent communication with the public and with clients about the nature of the professional services you provide so that they may make informed decisions when considering your services (e.g., faith-based psychotherapy that follows a specific set of religious beliefs or values) to include on one's website and during the informed consent process.

Graduate Programs and Training Sites

- Explicitly state the values of the program and its expectations of trainees on the program's website, in application materials, during interviews, and in policy documents.
- Ensure that all educators and trainers review expectations with trainees at the beginning of each training experience.
- Clinical supervisors should openly discuss these issues with each supervisee to encourage self-reflection and awareness about the potential impact of their values on their clients and on the psychotherapy process.
- How these issues are to be addressed in supervision and with clients should be clearly articulated in the informed consent to supervision.

Graduate Students and Trainees

- Thoughtfully consider one's personal values and their potential impact on clinical decision-making.
- Research the values and mission of education and training programs prior to applying to them.
- Education and training programs whose values are sufficiently contrary to one's own should not be applied to.
- When conflicts do arise, discuss them openly with your supervisor to help determine the most appropriate course of action.

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FEATURE

Beyond Amazon: Social Justice and Ethical Considerations for Research Compensation

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"Despite the quest for knowledge, social scientists can get stuck in a paradoxical mind set of 'this is how things have always been done.'" (Paquin et al., 2019).

What initially drew the authors to the University of Utah was a shared interest in and passion for bringing social justice values to the many subdisciplines of research within Counseling Psychology. In keeping with those values, we hope to design research that directly impacts and improves the lives of marginalized individuals and communities, and we imagine the same is true for many other students, professionals, and members of Division 29. As we conceptualize our roles, we are influenced by the arguments and proposed framework developed by Paquin, Tao, and Budge (2019). The authors detail how researchers can evaluate and implement social justice work in psychotherapy research. As we have approached new and exciting lines of inquiry, and have sought to implement them, we have noticed problematic trends with regard to how we have been advised to conceptualize incentives and compensation for participation. In this article, we invite you may be an agent for change not only in the questions you ask, but in how you structure the studies you conduct.

From our observation, it seems that compensation is almost synonymous with the distribution of Amazon gift cards. While our observations are anecdotal, we feel confident that, in many people's inboxes, there will be emails with a similar line, "X out of Y participants will be eligible to win a $Z Amazon gift card," or, "Participants who complete the survey will receive a $Z Amazon gift card." Where did this increasingly common trend begin? Why is our field beholden to providing such a singular form of compensation to our participants? In discussions of ethics, there appears to be a significant concern for the *amount* we compensate participants (e.g., APA Code of Ethics, 2017; Festinger et al., 2009) but little to no attention to *how* we compensate our participants. Compensation is how we incentivize participation. Researchers need a form of compensation that is reliable, easy to distribute, and, most of all, persuasive and beneficial to participant populations. Amazon and other large multinational corporations offer many of these benefits for researchers that are strapped for time and labor. At the same time, researchers may want to consider how their research funds, from grants, fellowships, scholarships, or other sources, are contributing to injustice for workers and the environment.

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"Do no harm," or nonmaleficence, is a guiding ethical principle defined by American Psychological Association (2017). As noted by Paquin et al. (2019), nonmaleficence can be interpreted to mean, "we do not continue to develop, design, implement, or ask participants to engage in research that contributes to systemic oppression," (p. 493). Over the past few decades, there have been collective concerns regarding the growth of large multinational corporations and their contributions to human and environmental exploitation. Despite the increased productivity of workers and colossal revenues, median blue-collar wages have stagnated at these corporations (Alimahomed-Wilson & Reese, 2021; Mishel et al., 2013). Furthermore, an in-depth interview with current and former Amazon warehouse workers in Inland Southern California indicated recurrent instances of racial and gender-based discrimination (Reese, 2020). A detailed report of workers demographic released by Amazon in 2021 revealed that while workers of color (predominantly Black and Latinx) made up 68% of the blue-collar workforce, Black (1.5%), Latinx (2.7%), and female (20.8%) employees were underrepresented in senior-level and executive positions (Kantor et al., 2021; Long, 2021). Alimahomed-Wilson & Reese (2021) argue that Amazon's growing power and dominance in the workforce is partly due to the large-scale exploitation of vast blue-collar labor that is often racialized and/or marginalized.

With the exponential growth of e-commerce and the expansion of warehouses during the COVID-19 pandemic in response to surging consumer demands, issues of health and safety in Amazon and its contemporaries have been further brought to the surface. Amazon warehouse workers are electronically surveilled and monitored through an algorithmic management system, which pressures workers to work quickly, resulting in high rates of burnout, injury, and turnover (Alimahomed-Wilson & Reese, 2021). According to a Washington Post Analysis of the Occupational Safety and Health Administration (OSHA) reports, Amazon warehouse workers experience some of the highest rates of injury, reporting 5.9 serious injuries per 100 workers in comparison to their competitor Walmart, which reported 2.5 cases per 100 workers (Greene & Alcantara, 2021).

In addition to low wages and challenging working environments, researchers might consider the inextricable link between social and environmental injustice. Rising activism and unionization attempts by Amazon workers to address the disproportionate environmental harm within the Black, Indigenous, Latinx, and immigrant communities have been emblematic of long-standing issues regarding workforce and environmental racism (Glaser & Miranda, 2021). Nearly 70% of Amazon warehouses are located in lower-income and racially diverse communities (Calma, 2021). Air pollution as a result of warehouse activities leads to severe health problems and dislocation, exacerbating the adversities experienced by marginalized communities. Because we aspire to help vulnerable and marginalized communities with our research, we must also recognize the potential harm we enact with our research design. While individual research funding may not represent a significant amount, it is concerning that many, if not the majority of online psychological research, utilize this compensation system that contributes to ongoing exploitation and injustice. Psychological researchers are obligated to consider the ethical consequences of any research design.

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A potential critique of this perspective may be that we, as researchers, are acting in paternalistic ways over our participants. After all, participants have the right to access forms of compensation that they ultimately want or find useful (Gordon et al., 2011). Therefore, we encourage and recommend that researchers consider offering participants a menu of compensation options. While not exhaustive, compensation such as cash, honorariums, gift cards to local businesses, digital reward services (e.g., Tango Card), donations to community organizations, course credit, food, and service exchange (e.g., providing psychoeducational workshop) are possible approaches to allow participants to choose a method of compensation that aligns with their personal needs, desires, and values. Compensating in a singular form, such as with Amazon gift cards, may disincentivize groups of participants who find little use in these services or wish not give business to these ethically compromised organizations.

We do acknowledge that, at times, we cave to the convenience and affordability associated with making purchases through big businesses. Again, there is no doubt that the services provided by Amazon and other multinational corporations add ease to our personal and researcher lives. Nonetheless, we ask researchers to at least consider how their method of compensation, as with any part of their research design, aligns with the values they espouse. If we really endeavor to advocate and create change through our research, we also must be more intentional in how we direct our funds and in which companies we support. While we do not imagine that researchers will discontinue utilizing accessible means of compensation, we hope this article encourages intentional conversations about our research practices. How do we integrate social justice at each step of our research design? How can we be sure that our work supports and centers the voices of marginalized populations? We're eager to engage with you and to learn what you suggest. Let us know what you think!

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FEATURE

Measurement Based Care for Depression: PHQ-9's Suicidality & Functional Items

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Depressive disorders are highly prevalent mental health conditions (NIH, 2022). Although effective treatments exist, barriers to care frequently interfere with access to care (Mojtabai et al., 2011). In the absence of prompt interventions, depressive symptoms can last over six months (Whiteford et al., 2013). Thus, there is an imperative to for the mental health field to facilitate access to care, while promoting the delivery of high quality, evidence-based care. There are several evidence-based psychotherapies (EBPs) for depressive conditions that are currently available (see Cuijpers et al., 2021; Munder et al., 2019). Moreover, EBPs, demonstrated in RCTs, display similar efficacy and effectiveness in naturalistic clinical settings (Minami et al., 2008; Reese et al., 2014).

To accompany theoretically and empirically driven approaches for treating depression, researchers have found that clinician engagement in measurement-based care (MBC) can further enhance outcomes (Bugatti et al., 2022; Lambert et al., 2018; Miller et al., 2015). MBC consists of the routine treatment outcomes monitoring, which is indicative of client progress (or lack thereof) and undergirds clinical responsiveness. As further evidence supporting the importance of MBC, the American Psychological Association (APA) has recently established an Advisory Committee for the Measurement-Based Care and the Mental Behavioral Health Registry to delineate practice guidelines informing the implementation of MBC (Boswell et al., in press). Although clinicians' embracement of MBC is an ongoing process, clients commonly express a desire to be part of the assessment process, have a clear rationale for how the MBC will assist their treatment, and for it to be discussed each session (Solstad et al., 2019).

MBC has been found to improve treatment outcomes and reducing client dropouts (see Lambert et al., 2018). Yet, very few therapists (about 1 in 5) utilize MBC in their practice (Lewis et al., 2019). Some of the reservations reported by therapists for not engaging in MBC include insufficient training on the effective use of MBC and the time/effort burden associated with this practice

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(Cuperfain et al., 2021). To overcome these barriers, several technology companies have developed platforms streamlining the administration and interpretation of MBC data. This supportive use of technology has improved the accessibility and relevance of MBC to both clients and therapists. For example, a currently available behavioral health technology platform offers clinical support services which include automated MBC. These services comprise the automated administration and interpretation of routinely administered outcomes measures, including the Patient Health Questionnaire-9 (PHQ-9), the Generalized Anxiety Disorder-7 (GAD-7), and a life functioning scale. Additionally, some platforms lead clinical engagement efforts, such as facilitating access to guidelines, workshops, and materials supporting the implementation of MBC. While some of these additional support tools (e.g., visualization and psychoeducational services) are unique to this platform, many of the described services supporting the implementation of MBC are consistent with the best practices outlined by Boswell et al. (in press). These advances could benefit from further investigation of the predictive nature of the MBC measures.

The current study aims to examine the PHQ-9 in the treatment of depression for clients who were receiving treatment through private practice licensed therapists. While the PHQ-9 is commonly examined based on the overall score, there is an opportunity to gain more understanding about the predictive nature of the suicide ideation item and over impact to life functioning item on therapy outcomes. We will examine the association between these two items and therapy outcomes, as well as test whether these associations vary based on initial severity of depressive symptomology.

Method

Participants

We utilized a sample of clients (N = 1,464) who were diagnosed with depressive conditions (mainly Major Depression Disorder) who completed the PHQ-9 over the course of their treatment. We restricted the sample to those who scored a 10 or higher on the PHQ-9, which is a common indicator of moderate to severe depressive symptoms and who had complete data. Clients were on average 32 years old (SD = 12.64), and were mainly women (70.4%), 25.6% were men, 2.9% were non-binary, and 1.1% preferred not to answer. Due to some technical issues, race/ethnicity were not able to be reported.

Measure

Patient Health Questionnaire-9. The Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) is a 9-item, self-report scale. It was designed to be administered to adult individuals to measure depressive symptomatology. The suicide ideation item is: "Thoughts that you would be better off dead or hurting yourself in some way" and the function item is: "If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?" For this item, the rating scale ranges from "Not difficult at all" (0) to "Extremely difficult" (4). In a validation study (Kroenke et al., 2001), the PHQ-9 demonstrated excellent internal reliability (Cronbach's a = 0.89), and test-retest reliability. In the present study, the PHQ-9 was administered electronically. The SonderMind platform is designed to automatically send, via email, a link to an electronic version of the PHQ-9 to clients 48 hours prior to their first scheduled psychotherapy session. Clients who are diagnosed with a depressive disorder by their therapist

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are then automatically sent a link to complete an electronic version of the PHQ-9 before every session. Clients are given 48 hours from the receipt of each email to complete the assessment.

Research-Practice Network

SonderMind is a technology-based platform that supports therapist-client matching for psychotherapy and medication management, though the present study focused exclusively on psychotherapy services. Therapists registered on SonderMind report their demographic and professional characteristics. Additionally, they are asked to report three clinical specialty areas. Prospective clients who register on SonderMind are asked to report several preferences, including preferred demographic and professional therapist characteristics, as well as preferences for certain aspects of treatment (e.g., psychotherapy approach). The SonderMind platform enters these preferences and characteristics into a proprietary algorithm that produces a set of therapist-client matches. Therapists who are matched with a new prospective client are informed of the match and are allowed to confirm or decline. Besides supporting this matching process, the SonderMind platform offers additional services, such as MBC (i.e., routine clinical administration of measures), access to clinical training and resources (e.g., webinars, evidence-based practice guidelines), and administrative support (e.g., credentialing, billing). While SonderMind therapists are free to select clinical interventions based on their clinical judgment, they are also supported toward the achievement of required clinical group standards, which include the implementation of evidence-based practices such as MBC. Therapists registered on SonderMind deliver psychotherapy as part of their private practice and rely on the SonderMind platform as a means of finding new clients, while also taking advantage of its clinical and administrative support features.

Results

The pre-PHQ-9 mean score was 16.04 (SD = 4.23) and the post-PHQ-9 score was 11.21 (SD = 5.74). As such, the overall pre-post effect size was Cohen's d = 1.14. We conducted a regression model predicting PHQ-9 post score by PHQ-pre score, suicide ideation item, and the PHQ-functioning item. Both items significantly predicted therapy outcomes: suicide ideation item (b = 0.54, p <.001) and functional item (b = 0.53, p <.001). That is, clients who reported more suicide ideation and more difficulty functioning in life had worse therapy outcomes. Next, we tested whether pre-PHQ-9 scores would moderate the association of these two items and therapy outcomes. The results demonstrated that pre-PHQ-9 scores significantly moderated the relationship between the functional item and therapy outcomes (b = 0.53, p <.001). For clients who reported more depressive symptoms at pre and reported more difficulty functioning in life had worse therapy outcomes than those with less difficulty functioning in life. Pre-PHQ-9 scores were not a significant moderator for the association between suicide ideation item and therapy outcomes.

Discussion

Two main findings were illuminated through the current study. First, as to be expected, clients struggling with suicidal ideation tend to have worse therapy outcomes. Clearly, suicidal ideation is a strong indicator that clients are suffering and potentially might require more intense treatments. Based on the PHQ-9, the suicidal ideation item was rated at 2 (More than the days) or 3 (Nearly every day) by 14.7% of the sample. Accordingly, therapists could benefit from uti-

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lizing the PHQ-9, suicidal ideation as a screener and then conduct a more in-depth suicide assessment. Second, clients who report that their depressive symptoms were impacting their life functioning also had worse therapy outcomes. In addition, those with more depressive symptoms prior to therapy this effect was compounded. Previous research has shown that life functioning takes longer to change in therapy (e.g., Owen et al., 2016). This study adds to this literature, highlighting the potential interaction between life functioning and symptoms. Accordingly, therapists may benefit from attending to this rating in concert with the overall level of depressive symptomology to guide treatment. Targeting inventions that promote healthy engagement with others while attending to emotion regulation of the depressive symptoms may be well suited for these clients to promote change on both dimensions.

This study also highlights the benefits of a technology assisted platform to help facilitate MBC. By removing the burden of sending out MBC measures as well as having interactive visual displays can be a step to enable MBC. There were also some limitations of this study. For instance, we do not know how therapists were utilizing the PHQ-9 in their sessions. But, as seen in Bugatti et al., (2022), therapists who viewed the measures more had better outcomes, and that higher severity at baseline was associated with more views of the PHQ-9. We also do not know what types of treatment/techniques were being utilized. Although we have some information provided by the therapist, there were no adherence checks. In conclusion, there appears to be some nuances in understanding how the additional item on the PHQ-9 may benefit therapists.

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Society for the Advancement of Psychotherapy

FEATURE

Improving Access to Mental Health Supports of Undocumented Immigrants

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The voices of hope, courage, and perseverance ring strong for the approximately 590,000 deferred-action for childhood arrivals (DACA) recipients, often called 'Dreamers' (American Immigration Council, 2021; Guter et al., 2017):

> "Having an actual identity in this country gave me life."
>
> "I just can't imagine going under the shadows again."
>
> "¡No me callo, no me siento, no me voy!"
>
> "I could actually… drive, go to college. It was a new beginning."

This last statement is especially significant for me. That is the voice of my husband, a dreamer who also envisioned his American dream much more tangible after receiving DACA benefits at age 26. Still, these voices represent only a fraction of the nearly 11 million immigrants who currently reside in the United States (US) under an undocumented status (Migration Policy Institute, 2021). The situation is dire, but small steps may be taken to support those whose livelihood is at stake while ensuring the appropriate mental health supports are being provided.

Many situations within the immigration system in the US are reaching levels of humanitarian crisis. Specifically, in 2020, families were separated at the border, including approximately 545 migrant children still missing their caregivers who were deported and had not been located (Dickerson 2020a). There was also the erratic dismissing of these migrant children into Mexico by US border authorities, which was incomprehensible as they were from different countries and had no ties to Mexico (Dickerson 2020b). Despite these cases being minimal, a more overarching form of family separation is deportation, with nearly 200,000 removals by US Immigration and Customs Enforcement (ICE) in 2020. These tensions, along with other forms of adversity (e.g., discrimination, personal conflict, acculturation stressors, limited resources; Garcini et al., 2021), greatly impact health and mental wellbeing. Moreover, a study by Woofter and Sudhinaraset (2022) found that non-DACA recipients face more barriers to healthcare compared to DACA recipients. Although we have been looking at macro-level, broad-band resolutions, taking small steps like focusing on the reinstatement and expansion of DACA can ultimately lead to smaller successes and better access to mental health supports.

After federal judge Andrew Hanen ruled DACA unlawful in Texas v. United States, more than 81,000 DACA applications are pending, as the ruling prohibits the Department of Homeland Security from processing first-time applications (Ibe, 2021). This adds more uncertainty to those who would find

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solace and a path toward *normalcy* via DACA. DACA has provided an opportunity for socioeconomic mobility and stability for those who could not work legally and who faced the possibility of deportation. Taking the small step of reinstating DACA so that new applications may be considered is an important way of acknowledging the crisis we face while providing access to better income and employer-based insurance, making mental health supports more accessible (Giuntella & Lonsky, 2020).

Expansions to this program would also benefit those currently enrolled as well as those who would qualify as they age into eligibility criteria. For years, a proposed expansion has been a possible pathway to citizenship for *Dreamers*. I strongly view this as a critical step in the right direction. However, I fear a pathway to citizenship will continue getting rejected while thousands of young immigrants experience great trauma and unprecedented psychological impact stemming from living undocumented (Garcini et al., 2017). For this reason, and while a path to citizenship is forged, we need to reexamine health and immigration policies and consider evidence-based solutions to prevent the negative impact of psychological distress in at least a subset of the larger immigrant population: DACA recipients. A better understanding of immigration-related stressors can better inform interventions that are culturally and contextually sensitive to this population (Garcini et al., 2021).

If we value reuniting families, helping those escaping from danger in their home country, and fostering diversity, as a country, we must do better. Considering the colossal responsibility for addressing the mental health of undocumented immigrants in the US would be scratching the surface of a greater social concern. Nonetheless, taking steps such as reinstating DACA and expanding the program to include mental health supports to prevent psychological distress would help support the health and wellbeing of thousands of young immigrants hoping for a better future, my husband included.

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FEATURE

Conceptualizing Epistemic Trust in Psychotherapy: A Triadic Model

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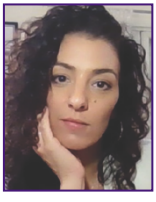

Introduction

In today's rapidly changing social environment, people face the challenge of determining whom they can safely trust and who will lead them astray. Dealing with this challenge is crucial not only for individuals' survival but also for their adaptation to social norms, habits, and the unstated rules of culture. However, people do not navigate the ever-changing social world blindly; rather, Nature has endowed humans with the ability to be influenced by new information under certain circumstances and wary of it in others. This evolutionary ability to correctly identify others as trustworthy and hence rely on the information they convey as personally relevant and generalizable is known as Epistemic Trust (ET; Fonagy & Campbell, 2017) and enables individuals to benefit from positive social communications and avoid deception. Theoretical conceptualizations suggest that ET develops at a young age within attachment relationships (Fonagy and Allison., 2014). Infants are instinctively look for cues from their primary caregivers that will allow them to better understand and act in ambiguous situations (Corriveau et al., 2009; Fonagy et al., 2017; Ronfard & Lane, 2019). Positive cues such as eye contact, turn-taking contingent discourse, and being called by name indicate to the infant that new and relevant information is being conveyed, which is thus worthy of being retained (Fonagy et al., 2017). Growing up in a sensitive caregiving environment equips children with the ability to better identify potentially misleading information, thus allowing them to be justifiably vigilant (Fonagy et al., 2019). In contrast, under predominantly hostile caregiving or insecure attachment relationships within the infant's early environment, the ability to discriminate reliable from untrustworthy communication may be severely hampered (Campbell et al., 2021). These individuals may become excessively cautious about learning from others and discriminate poorly between genuinely trustworthy and potentially false social information. As a result, their ability to update their understanding of social situations is curtailed and they appear inflexible in the face of rapid social change (Fonagy et al., 2019).

Depending on their distinct developmental trajectories, individuals will

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develop relatively stable trait-like characteristics of ET that may dictate different types of functioning in social and interpersonal contexts as adults. Some individuals may adjust their inner position safely in light of new information or experiences (Fonagy et al., 2018), may rely on their agentive sense of self and remain open to learning about themselves and others. Other individuals rely on the same fixed models of relating to the self and others, which prevents them from accepting new valuable information (Luyten et al., 2019). This perspective assumes that by definition, part of the construct of ET is considered to be a stable, quasi trait-like capacity which is formed during childhood and serves as a template in adult relationships. Nevertheless, ET is also subject to formative social influences throughout the lifespan. A range of interpersonal contexts can offer differential exposure to reliable sources of information in which social learning can occur. Teachers, peers, social media, and psychotherapy may change people's general expectations of trustworthiness (Luyten et al., 2020).

ET in psychotherapy: the triadic model

Psychotherapy can draw on patients' epistemic trust as leverage to safely challenge inner working models and enable them to acquire the skills needed to navigate the social environment (Fonagy et al., 2019). However, psychotherapy can also serve as an essential context for creating state-like changes in ET itself. When the ET trait-like component is well-established, genuine curiosity can develop about the self and others, which fosters the ability to learn and deduce from one interpersonal context to another. However, in cases where ET is not sufficiently established, its restoration can become the core driver of effective therapeutic change (Fonagy et al., 2015; Luyten et al., 2019). Identifying a person's ET levels and, if necessary, using ET as a mechanism of change requires understanding how it is expressed and its components in interpersonal relationships in general and in treatment in particular. Here, three components are suggested to capture the construct of ET in psychotherapy: sharing, the we-mode, and learning (Fisher et al., 2020).

Sharing refers to a person's willingness to discuss meaningful experiences and the thoughts and feelings that ensue. Communicating meaningful experiences can create a sense of companionship or allyship, which can mitigate a person's feelings of isolation. However, it also contributes to fulfilling various other possible psychological functions such as clarifying vague emotions, creating a logical order in one's experiences, broadening one's perspectives of the social world, etc. In psychotherapy, patients are invited to share; that is, to present thoughts or experiences so that another person (the therapist) can envision the same event and consider its effects (Fonagy & Campbell, 2017). The willingness to share experiences in therapy is assumed to reflect patients' trait-like approach toward relationships and their long-term views on others (including the therapist) in their social network (Fonagy et al., 2019). When engaging in therapy, some patients are better able to 'tune into' their social environment and perceive the therapist's intentions as beneficial or at least benign, which prompts them to believe that sharing their conflicts is worthwhile. These patients may show curiosity regarding the therapist's input and can enjoy a fruitful dialogue within the therapeutic session. Other patients, however, may be ambivalent about the value of sharing. Because they view the social world as generally malevolent, these patients covertly expect to be misunderstood, be subject to criticism, and made to feel guilt

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or shame, which may lead them, at least partially, to abandon the possibility of sharing altogether. A shift towards greater willingness to share in these patients is thus crucially important since sharing heightens the possibility that their discourse will be accurately understood and appreciated. The willingness to share within therapy constitutes the foundation of all therapeutic processes regardless of specific therapeutic modalities. It also mediates another essential component of this process: the willingness to share with others outside the therapy room. Sharing outside therapy is a key part of the change process since interpersonal relationships can be reconfigured and scaffold important adjustments in self-perception. Improving the capacity and motivation to share self-experiences with others is likely to contribute to the individual's well-being and adaptation to life's challenges by reinforcing intra- and inter-personal changes.

"We-mode" When an individual is open to sharing experiences, thoughts, and feelings with another, a co-creation of mutual communication is enabled. The delicate moments in which two conversation partners acknowledge each other's perspectives and reflect on the same piece of subjective reality are often termed the "we-mode" (Choi-Kain et al., 2022). In we-mode moments, partners establish joint attention to explore and better understand one another's emotional perspectives (Bo et al., 2017). Therefore, we-mode moments can help assuage a sense of loneliness and alienation (Fonagy et al., 2019). Engaging in we-mode interactions enhances the ability to understand oneself and others and helps provide the individual with new ways of acting and reacting to others (Gallotti & Frith, 2013).

At its most fundamental, psychotherapy works by exchanging and processing information about oneself and others. Irrespective of the therapeutic approach, it constitutes a setting where minds can meet; i.e., establish we-mode moments (Bo et al., 2017). Despite the central role of the we-mode in all types of therapy, the patient-therapist dyadic ability to achieve and maintain these moments can vary widely. Some patients engage in frequent we-mode moments more easily so that therapeutic interventions can be grounded on this personality facet to achieve change. Other patients may find it almost impossible to feel that their "personal truth" can be recognized and conveyed (Fonagy et al., 2019). When working with these patients, the therapeutic goal needs to focus on achieving, establishing, and preserving such moments. Either way, the patient and therapist must mutually explore and acknowledge what happens in the patient's mind when interacting with social partners, including with the therapist (Fonagy et al., 2019). This sense-making process gives conscious meaning to inner narratives and may allow for an internal dialogue to take place in the patient's mind (Benjamin, 2004) and with others (Fonagy et al., 2019; Luyten et al., 2020).

Learning is the process of acquiring new knowledge about how the social environment operates, which can then be applied to other life situations (Csibra & Gergely, 2006; Reed et al., 2010). When navigating the social world, individuals need to recognize when and with whom it is safe to open their minds to acquiring new knowledge, and under what circumstances it is not advisable (Sperber, 2001). Being open and sensitive to new knowledge and experiences can be an advantage as long as individuals can adapt flexibly to their ever-changing environment. This is because the social environment is constantly changing, thus

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providing individuals with countless opportunities for absorbing and integrating social knowledge. Therefore, an individual must be able to learn about opaque cultural artifacts or interpersonal skills which do not reveal their meaning or function upon simple observation. The mechanism that allows this information to be transmitted is activated through human communication (Csibra & Gergely, 2006; 2009; 2011). For the safe activation of this mechanism, nature endowed humans (learners) with the capacity to attend to others to receive key information essential to survival (Csibra & Gergely, 2011). Human beings have preserved this unique sensitivity to signs indicating that information is intentionally directed at them and, therefore, is to be tracked. (Fonagy et al., 2017). We have argued that achieving a meeting of the minds in situations such as the we-mode may be a sign or signal, regardless of age, which generates the willingness to learn from a social situation.

Psychotherapy can be considered a learning opportunity since it is built upon humans' innate evolutionary capacity for social learning. It provides patients with a safe and reassuring context to be exposed to new knowledge they can then apply to other interpersonal contexts. However, learning in therapy depends on the patient's degree of openness to new information and events that unfold during therapy (Fonagy et al., 2015). Patients capable of social information exchange ("good" learners) can easily update their knowledge about themselves and others during therapy. Other patients may fail to benefit from benign social interactions, including in therapy ("poor" learners). In order to revive the ability to learn, they must first be able to calm their a-priori apprehensiveness towards new information and informants. Whether learning from social situations is the purpose or the product, by enabling patients to revisit their perceptions of themselves and the world, psychotherapy can pave the way towards further learning outside therapy (Fonagy et al., 2017).

Communicating Vessels

All three components are theoretically essential parts of ET (Fisher et al., 2020). When individuals put their overall experience into perspective and calibrate their mind to those of others (sharing) while establishing a mutual discourse for the processing of ideas (we-mode), new information pertinent to social adaptation (learning) can be acquired. However, these three postulated components can manifest differently within psychotherapy, depending on the patient's trait-like ET characteristics. Nevertheless, the process of psychotherapy is one of the critical factors that can bring about state-like changes in ET by making the patient open to social learning and personal change (Luyten et al., 2021). Since psychotherapy is a form of social communication that provides the opportunity to learn, achieving state-like changes in ET during therapy can be a valid treatment goal insofar as a change in ET makes the broader change process through social learning possible. One potential mechanism to bring about state-like changes in ET is associated with therapists' recognition and articulation of their patients' more fine-grained self-experiences (Fonagy et al., 2019). Feeling accurately reflected in the therapist's mind may pave the way to social learning and the restoration of ET in the patient (Fonagy & Target, 2006; Sharp et al., 2020). Figure 1 illustrates how feeling reflected accurately and validated appropriately (we-mode) can allow patients to be more permeable to new information (learning) that can modify internal working models (sharing). The therapist's explicit effort to see

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the world from the patient's standpoint (i.e., person-centered intervention) may be instrumental in facilitating this process of change by making the patient feel safe enough to share openly and learn (Fisher et al., 2020).

Figure 1: Theoretical Model of trait-like characteristics and state-like changes in ET in psychotherapy. Establishing the 'we-mode' in therapy enables learning about the self, others, and the viability of sharing.

Present and Future Directions

ET theory considers acquiring new information through social interactions as essential to people's sense of security, confidence, and survival (Bo et al., 2017; Csibra & Gergely, 2009; Fonagy et al., 2015). In recent years, a number of theoretical works have explored the potential implications of ET for psychotherapy (Fonagy et al., 2017; 2019). Clinicians and researchers have shown a growing interest in understanding the contribution of ET to successful treatment outcomes (e.g., Bo et al., 2017). However, little is known empirically, particularly in terms of studying the contribution of each component (sharing, we-mode, and learning) separately. To date, there is no method or measure to quantify patients' level of ET within a therapeutic relationship (Folmo et al., 2019). Empirical assessments could provide an effective framework to characterize individual patients and their outcomes and the ways in which the development of ET unfolds in therapy. Focusing on individual differences can help identify how psychotherapy works for certain subpopulations (Zilcha-Mano, 2021) since certain subpopulations with various difficulties are likely to benefit differently from therapeutic interventions, depending on their trait-like ET. Future studies should thus focus on whether specific interventions by the therapist can bring about state-like changes in ET and whether this, in turn, can translate into beneficial treatment outcomes. Overall, focusing on patients' ET can enable clinicians to tailor the therapeutic approaches used in treatment for each patient's particular needs.

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FEATURE

Anti-oppressive work is trauma-work: A call for a new perspective when teaching multiculturalism in classrooms

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Look at me
But please
Don't look at me

In this op-ed, I propose a novel perspective for engaging in anti-oppressive work within classrooms. But first, I provide a framework to better explain why this approach may be necessary for disentangling and de-threading the oppressive fabric that exists in every single one of us.

In order to do anti-oppressive work, we need to recognize the oppressive systems that we are in. Scholars have highlighted the traumatic impacts of oppression on historically marginalized communities (e.g., Bryant-Davis, 2005; Carter, 2007; Crenshaw, 1991; Paradies, 2006; Smith et al., 2007; Utsey, 1998) as well as those from privileged groups (e.g., Goodman, 2001). Societal trauma, or the ways in which people are oppressed (Bryant-Davis et al., 2009), can occur on interpersonal, institutional, and systemic levels (e.g., Gomez, 2015). Examples of societal trauma include historical trauma, discrimination, and societal status (Bryant-Davis et al., 2010; Lindquist et al., 2013; Littleton & Ullman, 2013; Klest et al., 2013). Societal trauma occurs within the very systems that we depend on to survive. Due to this high level of dependency, harm that is perpetrated systemically, including by those who represent those systems, may be considered a betrayal.

Building off Betrayal Trauma Theory (Freyd, 1996) that asserts betrayal as the disregard of trust and safety between a person and another entity they are dependent on (i.e., person, family, institution; Delker et al., 2018; Freyd, 1997; Smith & Freyd, 2014), I argue that there is a level of trust that members of a society have in the systems in place for access to resources, opportunities, and other means of living. This phenomenon is different from institutional betrayal (Smith & Freyd, 2014) that speaks to specific institutions and the ways that they did not protect and instead reinforced and perpetuated betrayal among survivors of trauma (e.g., military sexual trauma), regardless of their social identity (e.g., race, gender, ability, nationality). This is also different from Cultural Betrayal Trauma Theory (Gomez, 2012, 2015a, 2015b) that speaks to the violation of (intra)cultural trust, a uniquely harmful form of betrayal, which occurs within marginalized communities. Instead, I speak of a betrayal that refers to the society at large, systems to access human needs, systems of oppression, and the ways that members of society perpetuate betrayal. Thus, societal trauma can be conceptualized as a form of high betrayal (i.e., violation within a high-dependency dynamic; Freyd, 1996) to those with bodies, minds, tongues, energies, birthplace, and connections of difference.

When we situate education on multiculturalism in a frame of betrayal, we can liken the process of anti-oppressive

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work to healing members of an abusive home. The ways in which abuse is enacted may look different across household members, with some receiving more frequent and direct forms of abuse. If we look at the example of a child being beaten in the home, there may be another child who gets beaten with a different weapon, another child who may be frozen in terror and not beaten, another person who is hiding while listening, another person who is screamed at, another person who is neglected, another person who ignores what is happening, another person who unsuccessfully tries to stop the abuse, another person forced to co-perpetrate, and another person who sides with the perpetrator. Alas, we have the perpetrator themselves. Any methods that are used to survive the abuse within that household are just that: methods of survival and protection.

How might this relate to anti-oppressive work? I argue that to do anti-oppressive work within each of us is to embark on a path of healing trauma. We must take an honest look at how we, personally, have enacted methods to protect ourselves within an abusive oppressive system. If we are the ones being targeted, then we might have experienced helplessness, shame, dissociated from the abuse, ignored the abuse (betrayal blindness; Freyd, 1996), or even pleased and appeased the perpetrator to continue surviving (i.e., fawn response, Walker, 2013). We may also experience a sense of betrayal from those who didn't protect us (Freyd, 1996). If we are the ones to hide while listening in terror, or to distant and disengage from anti-oppressive conversations while sitting in heightened distress, then we might be afraid of what the system will do to us if we get too close to the abuse that is happening (e.g., *will I get hurt?*). If we are neglected, we may feel that our voice and experiences don't matter and may become reactive or angry. If we side with the perpetrator, we may be attempting to position ourselves with higher power so that we can reap the benefits of safety, consistency, and ability to have the environment catered to our needs. And if we perpetrate, we may be searching for ways to gain power over another body while in a system that heavily rewards, celebrates, and protects those with more power.

We see in the literature that trauma, indeed, exists within our bodies (van der Kolk, 2015; Menakem, 2017). Thus, discussions around multiculturalism in classrooms are likely activating the very bodies that exist in that room. Therefore, **it is vital to take an approach to education that is trauma informed.** What might this look like? ***First, tend to stabilization.*** In Judith Herman's seminal work, *Trauma and Recovery* (1992), she proposes that all trauma work must start with and continue to focus on building a sense of safety and stability. Tending to the foundational elements of consent, emotion-regulation skills, psychoeducation, etc. may help one to start moving towards a sense of safety within their body. A similar approach can be taken in the classroom by, first, naming that the topics going to be discussed in class are linked to societal trauma. Introduce psychoeducation on the impact of trauma on our bodies. Introduce concepts like window of tolerance, hyper- vs hypo-arousal symptoms, and invite students to reflect on and identify what that looks like for them. This prepares students to come into their bodies, be present, and engage with the material. This also empowers students to engage in methods inside and outside of the classroom (we continue to exist within oppressive systems even after leaving the classroom, after all) to help widen

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their window of tolerance (what I conceptualize as a frame for *building tolerance*) so that they can truly integrate the material. Most of all, students are explicitly informed and are consenting to engage in the process.

Second, pace curriculum. Instead of addressing each system of oppression per class by, for example, moving through all of the historical elements of racial trauma for 1 hour, then current literature on racial trauma for 1 hour, then class discussion for 1 hour (while positioning students of color to educate); highlight key forms and examples of systemic trauma specific to the system of oppression being referred to (while underscoring intersectionality as a multiplicity; Hames-Garcia, 2011), some literature (or other forms of), then prompt students to go within to find their own examples. Facilitate the recursive process of going within and going out with the personal and the material. Instead of asking students with bodies of difference to share societal trauma that lives in their bodies (which can be retraumatizing), provide opportunities for students to pose meaningful inquiry of people in their own lives whom they care for (or watch interviews with people they admire) who may also hold that form of trauma in them. Show forms of literature, film, dance, and other expressive arts that can convey the emotive elements of the topics being discussed to not only bring life to the topic, but to also help students access empathy.

Lastly, don't forget to acknowledge the very real experiences of societal trauma within the classroom. We are the very bodies that we are learning about. So, care for our bodies. Don't highlight or tokenize those with difference in the classroom. Don't use our bodies as educational tools for others. Don't demonize our very real and effective methods of surviving an abusive system. But don't ignore us. Don't perpetuate betrayal in the classroom. Do your own work as we do ours. Be mindful of the gaze you take and encourage others to take when discussing bodies of difference. *Look at me, but please, don't look at me.*

I'll leave you with the famous lick, *the personal is political*. The feminist and multicultural literature tells us that what we experience on a personal level is greatly informed by the sociopolitical nature of the power-over culture we navigate (Brown, 1990). Thus, to do anti-oppressive work, especially in the classroom, we must engage that personal work in a way that is respectful to the trauma that cohabits our bodies.

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FEATURE

A Synopsis of Treatments for Black Women Following Intimate Partner Violence

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The purpose of this paper is to assist non-Black therapists address critical issues when treating Black women who have experienced intimate partner violence (IPV). This paper was written from a place of cultural humility in an effort to educate on how to provide culturally relevant treatment, rather than an attempt to speak for Black women. Further, this paper attempts to reduce the burden on members of the Black community that are simultaneously advocating for themselves while experiencing shared trauma.

IPV encompasses rape, physical violence, and/or stalking by an intimate partner and affects 42.4 million women in the U.S. (Stockman et al., 2015). Almost 44% of Black women (BW), compared to 35% of White women (WW) self-report as survivors of IPV (Stockman et al., 2015). In general, survivors of IPV experience increased rates of depression, posttraumatic stress disorder (PTSD), and suicidality as compared to those who have not experienced IPV. Marital rape and other forms of sexual assault against BW are also associated with depression (Campbell & Soeken, 1999), as well as posttraumatic stress and stress in general (Temple et al, 2007). Unfortunately, the research is limited in regards to comparisons among different racial groups as most studies use predominantly White samples, making generalizations to marginalized racial groups difficult (Kelly et al., 2020). Furthermore, research that does include BW participants tends to engage in "ethnic lumping," making differences among African, Black American, Caribbean, etc. Survivors difficult to discern (West, 2021). However, some findings note that BW as compared to WW report higher rates of nonfatal strangulation (Messing et al., 2018), reproductive coercion (Basile et al., 2021), and domestic homicide (Kivisto et al., 2021).

Despite these disparate risks, BW are less likely than their White counterparts to seek mental health treatment for IPV (Flicker et al., 2011; Johnson & Zlotnick, 2007; Satyen et al., 2019), with only 7.7% of BW compared to 13.5% of WW seeking treatment (Cheng & Lo, 2015). Although seeking treatment for IPV is low across races, due to the intersectionality of social inequality in the U.S., BW are also more likely to be homeless, of lower socioeconomic status, substance using, or incarcerated, which further compounds their likelihood of developing PTSD and related symptoms (Rice et al., 2020). Indeed, systems of oppression around race, ethnicity, and gender disproportionately place women and women of color at higher risk of being physically assaulted (Ford, 2012).

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Mental Health & Coping

Benítez et al. (2014) found that Black Americans have high rates of chronicity of PTSD, with only 6 out of 67 individuals diagnosed with PTSD recovering during their study. Black Americans with PTSD showed significantly lower psychosocial functioning than those with anxiety diagnoses. For example, adaptive strategies including exercise, deep breathing, and acceptance were rarely endorsed, while comparatively maladaptive strategies such as substance use were endorsed (Sullivan et al., 2018). Substance use may be a maladaptive coping strategy as indicated by Sullivan et al. (2018), or it may be that substance use is a risk factor for IPV (Nowotny & Graves, 2013).

PTSD is correlated with suicidality (Cox et al., 2016). Up to 80% of women who attempt suicide attribute this to an abusive partner and are more likely than women who have not experienced IPV to make numerous attempts (Davis et al., 2009). Indeed, experiencing IPV more than doubles BW's risk of attempting suicide (Davis et al., 2009).

Women who experience extreme danger in their intimate relationships often become depressed (Lucea et al., 2012). Houry et al. (2005) found that BW who were impoverished, experienced IPV, or had attempted suicide had higher levels of depressive symptoms than non-attempters. In addition, suicide attempters tended to use coping strategies that accommodated the destructive environment (i.e., the abusive environment) by means of substance use which may numb the reality of their painful situation (Reviere et al., 2007). Interestingly, they also showed slightly higher use of positive coping via therapy and a focus on their children (Reviere et al., 2007). Both suicidal survivors and non-suicidal survivors of IPV reported coping with the use of religion and community resources (Reviere et al., 2007).

According to Fleming and Resick (2016), women of color may be predisposed to dissociative symptoms before IPV due to the cumulative impacts of racism, sexism, and trauma exposure. Additionally, compared with depression, anxiety, and intrusive experiences, dissociation was the most predicted mental health outcome following IPV (Mills et al., 2018). Disordered eating is another common posttraumatic symptom for BW and may be viewed by BW women as a way to regain autonomy over their own bodies, despite violation by their partner (Harrington et al., 2010). BW who reported IPV experienced significantly higher risk for disordered eating than non-abused women, especially those with physical or sexual abuse (Lucea et al., 2012). Further, women with depressive symptoms and PTSD were at an even higher risk for developing disordered eating (Lucea et al., 2012). Binge eating in particular may be used as a coping tool that is deemed culturally acceptable in responding to and coping with trauma (Harrington et al., 2010).

Barriers to Treatment

Black Americans are "one of the most vulnerable, underserved populations in the mental health system," (Briggs et al., 2011, p. 4). In general, there is a lack of utilization of mental health services by Black adults: 57% compared to 70% for White Americans (Rostain et al., 2015). BW are less likely to seek help following IPV than WW (Sabri et al., 2013). Psychology in the U.S. has been complicit in the mistreatment and neglect of Black Americans throughout the years. Cultural mistrust (i.e., distrust of White Americans resulting from historical racism and oppression of people of color;

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Terrell & Terrell, 1981) of psychology has resulted (Ward et al., 2009). In addition, BW are of a double minority status—race and gender—that impacts their access to services (Ward et al., 2009). Further, BW may be less likely to seek out psychological treatment due to affordability. In the U.S., 27% of Black Americans live below the poverty line compared to only 10% of White Americans (Rostain et al., 2015). A similar disparity is found in the rates of insurance, where almost twice as many Black Americans (19%) are uninsured compared to White Americans (11%; Rostain et al., 2015). Despite rising insurance coverage rates, as of a 2019 report, the uninsured rates among Black and Latinx/Hispanic adults were still significantly higher than that of White adults (Baumgartner et al., 2021). Regarding IPV specifically, economic dependence on the abusive partner is frequently cited as one of the most significant barriers to leaving or seeking help (Hien & Ruglass, 2009). Interestingly, there is no general consensus on whether there are racial disparities in disclosing IPV. For example, Temple et al. (2007) did not find a difference between WW and BW in regards to number of reported sexual assaults by a partner. However, Ramisetty-Mikler et al. (2007) found that Black couples report two times as much sexual aggression compared to White couples, suggesting that there is an underreporting issue at play.

Community mental health facilities often become the only option for Black Americans (Briggs et al., 2011). While this is better than no access to treatment at all, resulting treatment differences between Black and White Americans cannot be ignored. Community mental health facilities sometimes lack the financial resources, political support, and knowledge in providing culturally competent care for racial minorities (Briggs et al., 2011; Rostain et al., 2015). Especially for Black Americans living in rural communities, transportation issues may affect treatment-seeking (Kawaii-Bogue et al., 2017). BW who experience IPV may also have the added barrier of finding childcare during their sessions, as they often cannot ask their partner(s) to watch their children and may not feel comfortable asking family or friends due to privacy concerns (Kawaii-Bogue et al., 2017). Further, the authors report that childcare adds to the cost of treatment, again making the barriers BW face cumulative.

When Black Americans engage in treatment, they also have higher rates of attrition (Sprang et al., 2013) than other races (Lester et al., 2010), perhaps due to clinician bias. Black clients who receive treatment from clinicians with higher levels of implicit bias (i.e., unconscious stereotyping) reported more negative treatment experiences than White clients (Kawaii-Bogue et al., 2017), even when the implicit bias was positive (Davis et al., 2009). Further, White clinicians tend to over-pathologize or misdiagnosis Black clients due to cultural differences in symptom presentation (Kawaii-Bogue et al., 2017).

Only 5% of mental health clinicians are Black, despite 12% of the population identifying as Black (Rostain et al., 2015). Some ethnic minority mental health scholars have argued that this impedes the therapeutic relationship because the clinician may be unable, or perceived as unable, to understand cultural differences (Kawaii-Bogue et al., 2017). Feeling unrepresented may add to Black Americans' cultural mistrust of mental health.

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Integrative Care for BW Survivors of IPV

BW may feel more comfortable disclosing their experiences of IPV and other issues with family and friends rather than healthcare providers. Implementing family psychoeducation and family therapy may improve treatment effectiveness and adherence (Kawaii-Bogue et al., 2017). Further, community resources, especially churches, are often first stops for Black Americans seeking help and clinicians should bridge such alliances and might make themselves more visible to the Black community (Briggs et al., 2011; Kawaii-Bogue et al., 2017).

It is recommended that clinicians operate from a holistic framework, in which clients can have physical and mental health needs met in the same location (Kawaii-Bogue et al., 2017; Weist et al., 2014). This reduces stigma by creating ambiguity around reasons for consulting, allowing for greater levels of privacy which are especially critical to a survivor of IPV.

Treatment Approaches

Motivational Interviewing

Motivational interviewing (MI; Miller & Rollnick, 2013) is an evidenced-based collaborative, person-centered practice of eliciting and strengthening motivation for change. While less than a handful of studies have explored the use of MI with survivors of IPV, theoretical, anecdotal, and practical arguments have been made for its use (Wahab et al., 2014). Consistent with trauma-informed treatment, MI focuses on strengths and self-efficacy, while emphasizing collaboration, empowerment, and respect for choices. MI with survivors of IPV focuses on changes that survivors can control (e.g., self-care, safety planning, social support). Wahab et al. (2014) found that MI significantly reduced rates of depression by building self-efficacy and a sense of accomplishment in BW who experience IPV. Of note, researchers are beginning to examine the efficacy of peer-provided MI (Tsai et al., 2017) which may be especially effective with BW given higher rated comfort with family and friends.

The Grady Nia Project

The Grady Nia Project (Nia; a Kwanzaa term meaning "purpose") is a culturally-informed treatment for BW who have experienced IPV. Nia incorporates Africentric Theory which empowers BW through cultural history and knowledge (Corneille et al., 2005). Clinicians must consider that IPV survivors likely already feel disempowered because of their abuse, and that this may be especially true if they are also Black. Wright et al. (2010) found that empowerment mediated the relationship between race and PTSD in BW who experienced IPV. Womanism, the culturally relevant feminist theory that addresses the intersection between race and gender, is also incorporated (Davis et al., 2009).

Nia is housed within Grady Health System, which is a large, public, urban hospital in Atlanta, Georgia. Nia consists of 10 manualized group sessions for 90-minutes each co-led by one Black and one non-Black therapist in an outpatient setting (Davis et al., 2009). Women are assigned homework reinforcing session content, and are also supplied with tip cards which summarize key take-home points (Davis et al., 2009). Participants are not required to leave their partners, but rather, are taught strategies for removing themselves from abusive relationships, in the hope that this will lead to more violence-free lives (Kaslow et al., 2010). A number of adjunctive services are also incorporated. Nia has been effective in reducing suicidality and de-

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pressive symptoms, but not PTSD symptoms (Davis et al., 2009; Kaslow et al., 2010).

The Interconnections Project

The Interconnections Project (TIP) intervention is an academic-community partnership between two universities and a domestic violence center for BW (Nicolaidis et al., 2013). TIP utilizes the Chronic Care Model (CCM) which aims to place the Black community and its resources at the core of the program to address depression. Unlike Nia, TIP was not intended to invent new depression care therapies; rather, it aimed to create an environment that empowered and supported Black IPV survivors to take best utilize existing depression treatment strategies. Services frequently included the use of MI. Participants were welcome to utilize other services (e.g., support groups), but due to unforeseen events, services at the center were variably available (Nicolaidis et al., 2013). Initially, TIP facilitated a series of nine interactive workshops based on Cognitive Behavioral Therapy (CBT) approaches to managing depression. However, due to low attendance at group sessions, group sessions were discontinued. For the remaining participants, CBT-based materials were integrated into the individual MI sessions. Significant improvements in depression severity, self-efficacy, self-management behaviors, and self-esteem were found.

Discussion

The disproportionate number of barriers that face BW in receiving adequate mental health care is undeniable. With such a large percentage of BW experiencing IPV (43.7%), and the severity of resulting symptoms, these barriers must be broken down. Research currently suggests that methods to achieving this include, but are certainly not limited to: reducing clinician bias (Kawaii-Bogue et al., 2017), training more Black clinicians (Rostain et al., 2015), offering culturally-informed integrative frameworks (Kawaii-Bogue et al., 2017; Weist et al., 2014), and pro-bono or sliding scale services (Briggs et al., 2011; Rostain et al., 2015).

While there is research to suggest that there are treatments for women survivors of IPV, few are specific to BW (Iverson et al., 2011) or are not specific to intimate partner violence (Williams et al., 2014). Researchers have begun investigating treatments for BW who have experienced IPV, informed by research on the barriers to treatment, in an attempt to increase utilization rates and decrease treatment attrition. Preliminary evidence from these pilot studies indicates that addressing these barriers improves treatment outcomes and reduces attrition (Davis et al., 2009; Kaslow et al., 2010; Nicolaidis et al., 2013; Wahab et al., 2014). While this is certainly a step in the right direction, there is still much more work to be done. For instance, while the aforementioned studies have shown promise in decreasing depression and suicidality among BW survivors of IPV, only one study targeted PTSD symptoms (Dutton et al., 2013)—despite PTSD being potentially chronic among Black Americans (Benítez et al., 2014). Therefore, future research should focus on culturally informed approaches to treating PTSD symptoms specifically, in addition to the other symptom sequelae that results from IPV. The impetus remains on clinicians and researchers to pursue further data collection to continue improving treatment effectiveness, as would be the expectation with any other population. Additionally, research that has been conducted at specific sites (e.g., Nia) should be implemented in other areas throughout the U.S., to not only demonstrate generalizability, but

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also to provide more BW with treatments that are specifically designed to be effective for Black survivors of IPV.

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"The Voice of the Sandpiper is Soft and Sweet": The Administration's Historic Fiscal Year 2023 Budget

Pat DeLeon, PhD
Former APA President

Department of Health and Human Services Secretary Xavier Becerra proffered: "Budgets are about more than dollars. They're about values. And the President's budget is a reflection of our values as a nation. From addressing health disparities to strengthening behavioral health to investing in our children, this budget will help turn hardship into hope for millions of families. And it will ensure we can fulfill our department's crucial mission of improving the health and well-being of the American people."

Highlights of the Secretary's proposal include: Effectively addressing the national tragedy that the maternal mortality rate in our nation is significantly higher than most other developed countries and is especially high among Black and Native American/Alaska Native women, regardless of their income or education levels. The budget supports the President's call for *full parity* between physical health and behavioral health care, comprising mental health and substance use disorder care. It addresses the significant connection between mental health and substance use by investing in a broad spectrum of behavioral health services. $7.5 billion has been proposed for a new Mental Health Transformation Fund, to be allocated, over 10 years, to expand access to mental health services through mental health workforce development and service expansion, including the development of non-traditional health delivery sites, the integration of quality mental health and substance use into primary care settings, and the dissemination of evidence-based practices.

Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use Administrator, who received her doctorate in clinical psychology from Purdue University, further noted: "Millions of people in America today are experiencing mental illness, coping with substance use disorder, or both – they deserve a healthcare system where everyone who needs help can access care when and where they need it. This funding brings us closer to providing necessary wraparound services in all communities across the country."

The Administration has also proposed an historic investment in youth mental health and suicide prevention programs and in training, educational loan repayment, and scholarships that help address the shortage of behavioral health providers, especially in underserved communities. APA Chief Advocacy Officer Katherine McGuire consistently emphasizes that these are a very high priority for APA and she further heralded Miriam as a proud product of the APA Minority Fellowship Program.

Back in 2017, while exploring the most promising opportunities to improve health and health care in the United States, the National Academy of Medicine (NAM) noted that the nation's be-

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havioral health workforce was undersized and inadequately resourced, and that the available providers often lacked the specific skills and experience to offer effective, evidence-based and integrated care. Racial, ethnic, and geographical diversity of the workforce was lacking, and there was extreme maldistribution of behavioral health professionals. Further, it was observed that health systems will need to integrate physical health, behavioral health, and social-service delivery further to promote well-being optimally. Effective practice models of integration of primary care with behavioral health did exist but had not yet been scaled. Providers in different parts of the health care system were not sufficiently incentivized to work efficiently as a coordinated team to identify, engage, and manage care effectively for people who have both medical and behavioral health conditions. And, NAM specifically noted: "Our health system has not made full use of new communication technologies, such as telehealth and mobile health, to leverage the capacity of the existing behavioral health workforce… It is crucial to integrate new technologies with other treatment approaches so that they do not constitute an extra burden but rather become a seamless part of practice that enhances outcomes." As long-time Hill colleague Peter Reinecke reflected: "This President's budget proposes the biggest investment in mental health that I can recall!" The next step, we would suggest, is for psychology and psychiatric nursing to fulfill their societal responsibility to provide proactive and truly visionary leadership.

The 30th Anniversary Celebration

During his service on the Senate Appropriations Committee, Senator Inouye was instrumental in establishing the Department of Defense (DoD) TriService Nursing Research Program (TSNRP). We recently had the pleasure of participating in a Zoom video discussion, hosted by TSNRP Executive Director Heather King (CAPT, NC, USN), with Ada Sue Hinshaw (the first Director of the NIH National Institute for Nursing Research), and former DoD Nurse Congressional Fellows Diana Kupchella and Nancy Lescavage reflecting upon the establishment of the program after a Senate coffee break, scribbled out on a coffee napkin.

Heather: "TSNRP is a DoD program dedicated to ensuring that all service members, and their beneficiaries, receive EBP of health care in all care settings—from military treatment facilities in the U.S. to austere deployed operational environments worldwide. This unique DoD program not only provides support for operationally relevant research and EBP, but also offers research and EBP courses to enhance the knowledge and capabilities of military nurses to serve as Principal Investigators to answer critical research questions that affect the care that military nurses provide."

"This year, TSNRP celebrates its 30th Anniversary. The humble beginnings of this program are inspiring. At the AMSUS Annual Meeting in the late 1980s, military nurse scientists discussed the need for tangible support to conduct rigorous research specific to the environments in which they practiced. The idea for what would become TSNRP was conceived. However, it wasn't until a few years later, and with the help of many key leaders, that the idea of TSNRP became a reality. TSNRP has honored the late U.S. Senator Daniel K. Inouye, who championed TSNRP and military nursing during his distinguished career. He would be proud of the expanded cadre of military nurses now able to conduct rigorous research, publish scientific findings in peer re-

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viewed healthcare journals, advances in care that service members receive as a result of this support, that over 500 research investigations have been funded, and that research findings are reaching the hands of deployed military healthcare providers with publications like the *Battlefield* and *Disaster Nursing Pocket Guide*. TSNRP is grateful for this incredible history and legacy, and looking forward to leading future innovative research, support partnerships, inform leaders, and support operationally relevant research and EBP to meet the needs of our nation's warfighters."

The 11th Biannual Chicago RxP Networking Dinner

Beth Rom-Rymer: "As President and CEO of the Illinois Association of Prescribing Psychologists (IAPP), I was delighted to Chair the Eleventh Biannual and second hybrid Prescriptive Authority networking dinner event in snowy Chicago this past month. We had 100 participants, with about 35 attending in person. Psychologists joined us from all over the U.S. and the world, including Brazil and Canada, Oregon, Idaho, Texas, Iowa, Maryland, Alabama, and Florida. Keynote speakers included Morgan Sammons, one of the first Department of Defense prescribing psychologists, our chief lobbyist, Mark Taylor, and Corey Dabney, CEO and Chairman, Dabney Behavioral Health Hospital. Corey focused his remarks on the need for Illinois Medicaid to authorize treatment by prescribing psychologists. This authority is critical so that prescribing psychologists can more effectively meet the demand for comprehensive mental health care in the most vulnerable communities in Illinois. The IAPP, in conjunction with several partners, is currently pursuing legislation to achieve this goal."

"Illinois now has 13 licensed prescribing psychologists with over 50 licensed clinical psychologists and doctoral psychology students pursuing education and training to become licensed as 'prescribing psychologists' in Illinois. The prescribing psychologists' excitement about the expansion of their skills and scope of practice was palpable at our event."

"To further the education and training of psychologists and psychology graduate students in clinical psychopharmacology, I recently established nine annual funding grants with the American Psychological Foundation (APF). To provide additional opportunities for psychology doctoral education and training for Indigenous students, I have been working with the Society of Indian Psychologists (SIP) and APF to create targeted funding grants."

Social Justice for All—Through the Lens of Those Who Served

One of Senator Inouye's personal priorities was to secure Congressional recognition for the heroism of the more than 260,000 Filipino soldiers who served alongside our nation's military during World War II. In October, 2017, after waiting more than seventy years, the Congress authorized the Congressional Gold Medal for their service which was signed into Public Law 114-265 by President Barack Obama. This year, the Filipino Veterans Recognition and Education Project (FilVetREP) developed its fully online interactive educational program bringing to life the story of U.S. colonization and war from the perspective of Filipinos who fought under the American flag. "Duty to Country" (www.dutytocountry.org) is an initiative that explores the untold story of the United States and the Philippines designed for teachers in the classroom. Its story includes five lesson plans on key historical moments: the colonial period, World

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War II, the establishment of an independent Philippines and the passage of the Rescission Act, and the civil rights movement to restore Veterans' benefits and path to U.S. citizenship.

"Students and teachers need to hear the voices and see the faces of American and Filipino soldiers who fought under the American flag and make their stories come to life," noted FilVetREP National Chairman Maj. Gen. Antonio Taguba (Ret). "By creating an educational venue, we will enshrine their story in American history, and continue telling their story for generations to come." The presentations are most timely and tackle some of the biggest questions in world and U.S. history—war, empire, colonization, military service, racism, immigration, civil rights, and the fight for racial justice. "Because their story was largely written by American military historians, they conveniently left out the contributions of these brave men and women. This is tantamount to being non-existent, because when the story of Filipino World War II Veterans is not told in their own voices, their service will never be known."

"Where the sea is peaceful and calm." (Israel Kamakawiwo'ole, Ulili E)

Aloha,

Pat DeLeon, former APA President – Division 29 – April, 2022

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We'd love to hear from you!