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## PRESIDENT'S COLUMN

*Finding a Silver Lining During a Global Pandemic*

Elizabeth A. Yeater, Ph.D.



When I wrote my first Presidential Column for The Clinical Psychologist, I had no idea that my second entry would come during a global pandemic (this probably goes without saying!). These clearly are exceptionally difficult times for all of us – I have days when I think: “I got this!” and other days when I feel demoralized, sad, and scared for our future. Yet, even in my darkest moments, I realize that I have a plethora of resources at my disposal. I am a tenured professor, my husband is a VA psychologist, my children attend an excellent elementary school that is providing online schooling, my family has top-notch health insurance, and we do not come from a marginalized population that faces significant health disparities. We are uncomfortable and grieving for our pre-pandemic life, but we will survive. Importantly, and as you realize, this is not the case for many people, including, I am sure, many of the clients that we treat in our practices. I am reminded of an article by Dr. George Bonnano who found, among other noteworthy findings, that those individuals in New York City who experienced a decline in income as a result of the terrorist attack on 9-11 were significantly less likely to be resilient (i.e. more likely to have posttraumatic stress disorder symptoms, higher depression symptoms, and greater substance use). Given the devastating economic effects of COVID-19 on many families, I have no doubt that we will be dealing with the “psychological fall out” in our therapy rooms for years to come. If there is a silver lining here, it is that we know how to sit with and treat those who are suffering psychologically.

Brian Stelter, a journalist for CNN, reflected my feelings eloquently in a recent post on the network's website. He spoke of “hitting a wall” and being overwhelmed by feelings of grief for the people who have died from COVID-19, for senior citizens who are scared and missing their well-deserved golden moments, and for children (both young and older) who are missing school and other key developmental milestones (e.g., graduations). I too share those feelings and hit my own wall last week, when the gravity of this situation finally hit home for me on a deeper level. I am sure many of you have had similar experiences in the past weeks. Although our circumstances are vastly different, we are having a collective experience, and I suspect that the psychological aspects of this experience, including disruptions in feelings of safety, control, and power, are felt to greater or

less degree by everyone.

In my best moments, I believe that this time will make us better human beings; more connected to our communities, less connected to our devices, more empathic to others who are struggling and have less than we do, and more intent on using psychology, and the principles that we know are supported by science, to make the world a better place for all of us in general, and in particular, for those individuals who are historically and currently disenfranchised by our current sociopolitical system. COVID-19 has disproportionately affected these marginalized groups of people and, as a result, it has cast a blinding light on the health disparities and inequities that we know exist in our current system. We must do more to reduce these disparities – our future depends on it. In the “anti-science” environment that we find ourselves in, we need to remember what psychology can do to improve society. Lilienfeld (2012) noted that many academics and people in the community do not believe that psychology has made a valuable contribution to society and believe it to be less valuable than those contributions made by the hard sciences. Yet he reminds us in that paper that psychology has made significant contributions to society, such as identifying operant training procedures, constructing and validating tests that measure a variety of psychological constructs, and recognizing the ways in which memory is fallible, which has influenced decisions that are made within our legal system. These are no small feats. We have much to offer, during this time, and the time to come when this passes.

Perhaps as a result of COVID-19, we find our deeper humanity. On Easter, I delivered a ham, a frittata (my husband’s specialty), a chocolate bunny, and toilet paper (yes, toilet paper!) to a close friend’s house, because she was sad that we would not be spending the holiday together. I felt my mood lift considerably afterward, a clear sign that by giving during this difficult time, we also are helping ourselves. Recently, the Associate Dean for Faculty Development at my university reached out to me to see how I was doing given I have three young children at home and offering ways to support me, if I needed assistance. This was a small act, but I felt substantially better as a result, especially given the pressure I feel to be present for my children and continue to be productive in my academic roles. These experiences have led me to believe that we can find little ways to reach out to others that have a real psychological and emotional impact.

Reflecting on my personal life, I retrieve easily an example of how we might find our humanity in suffering, as well as how hope might ameliorate unnecessary suffering. When my eldest daughter was four years old, she was diagnosed with kidney cancer. My husband and I were devastated by the news – we were looking at a very long period of time in which we would not know whether our daughter would survive. That specter lived with us through seven months of chemotherapy and five years of follow-up visits to ensure that the cancer did not return. Then, one day, she walked out of our local children’s hospital as a cancer survivor. In the darkest moment of my life, I experienced great kindness and comfort from many people. While that did not take away my grief or fear, I did feel less alone in my suffering. My daughter’s tumor also had the worst genetic marker possible – children with the same tumor were more likely to relapse and die. As a scientist, I wanted data and exact probabilities, and as a mom, I wanted assurances that she was not going to die. I recall her oncologist telling me one day that I needed to have hope for my daughter. My knee jerk reaction was to exclaim, “What does hope have to do with anything?” Upon reflection, I realized he was right – I needed to be strong for her and behave “as if” everything was going to be okay. I found some peace in comporting myself this way, and I suspect such a stance will be helpful for all of us during these unprecedented times. We must have hope, and we must use our science to help those who are marginalized and disenfranchised – I believe this is part of our duty as clinical psychologists.

I realize that this is not a typical entry into The Clinical Psychologist, yet it felt odd to me, given our current circumstances, for it to be so. This has been therapeutic for me to write. Thank you for listening. Please take care, be kind to yourself and others, and stay safe and healthy!

Elizabeth

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## Scaling Up Psychological Treatments: Lessons the World Can Teach North America

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 Evidence-based psychological treatments are among the most effective interventions in medicine and recommended as the first-line of treatment (World Health Organization, 2015) to address the significant burden of depression, anxiety and stress-related disorders worldwide (Ferrari et al., 2013). Despite this evidence, these treatments remain inaccessible for the great majority of the world's population. For example, in low- and middle-income countries, less than 5% of people receive minimally adequate treatment for major depression (Thornicroft et al., 2017). Even in high-income countries, which devote exponentially greater resources on mental health care and with a thousand-fold or more density of specialised mental health providers, the effective coverage for depression management is as low as 20% (Thornicroft et al., 2017). This massive unmet need for evidence-based care is unprecedented for any other health condition and, as demonstrated in high-income countries, is not simply a challenge which can be addressed by training more specialist providers.

Global Mental Health (GMH) is the discipline of research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide (Patel & Prince, 2010). Equity is a driving principle, and this recognizes that inequalities exist within all nations and between nations. In this essay, we explore how GMH practitioners have sought to address a range of barriers to scale up the delivery of psychological treatments for common mental disorders. While the initial focus of the field has been to address access to quality care in low-and middle-income countries, this essay also draws attention to attention how similar strategies are being implemented at scale in some high-income countries, with appropriate modifications to suit the context. In doing so, we hope to engage the psychological community of North America to adapt these lessons for their own settings and contribute to reduce the burden of common mental disorders in their own contexts.

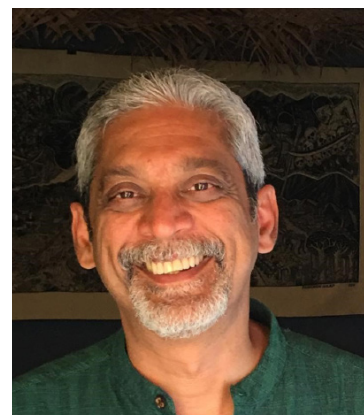
### Global Mental Health: A Brief History

The history of GMH has been documented elsewhere (Patel, 2012; Patel & Prince, 2010; Patel et al., 2018). The discipline of GMH represents a confluence of the extant fields of cultural, social and international psychiatry and psychology with the emerging discipline of global health, the latter owing its birth largely as a result of the dramatic global response to the HIV/AIDS epidemic in some of the poorest countries of the world (Koplan et al., 2009). Historic publications which set the field up were World Mental Health (Desjarlais, 1995) and the 2001 World Health Report (WHO, 2001) leading up to the landmark series of five articles in the Lancet in 2007 (Group, 2007; Jacob et al., 2007; Kakuma et al., 2011; Patel et al., 2007; Saxena, Thornicroft, Knapp, & Whiteford, 2007). These articles documented the large and ignored burden of mental disorders in the global context, the stark inequity of the distribution of mental health resources with over 90% of all specialist providers and beds located in countries which were home to 10% of the global population (concentrated in the USA), and that, despite the strong evidence for cost-effective treatments, the vast majority of the world's people went without care. The series closed with a call to action to scale mental health care in all countries guided by the principles of cost-effectiveness and respect for the human rights of people living with mental health problems. In 2010, the WHO's mhGAP initiative published guidelines for the treatment of a range of mental disorders in primary and secondary care recognizing the salient role of psychological treatments for mood, anxiety and trauma-related mental disorders (WHO, 2010).

This body of evidence catapulted the field of Global Mental Health and inspired the NIMH-sponsored Grand Challenges in Global Mental Health initiative. This initiative sought to identify priorities for research over the next 10 year which could substantially contribute



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to reducing the global burden of mental disorders, with a focus on low-resource countries where the unmet needs for care were the greatest. The initiative published a set of priority research themes dominated by implementation science questions, i.e. how could we expand the effective coverage of existing, evidence-based interventions, such as psychological treatments (Collins et al., 2011). A consortium of research donors, led by the NIMH and Grand Challenges Canada, with a gradually widening community of funders (now part of a coalition called the International Alliance of Mental Health Research Funders) has since contributed significant new funding towards addressing these implementation challenges. The resulting body of research has transformed our understanding of the strategies to scale up psychological interventions which, in turn, has contributed to incorporation of these strategies in global policy instruments such as the WHO's Mental Health Plan (WHO, 2015) and the inclusion of mental health targets in the United Nations' Sustainable Development Goals. We will now consider the major barriers to the scale up of psychological treatments, the strategies used to address these challenges, and end with case studies which demonstrate how these strategies may be applied across contexts.

### Common Barriers to Delivering Psychological Treatments

We have organized the barriers to scaling up psychological treatments into three broad domains.

The first involves **supply barriers** (i.e. the inadequate numbers of skilled providers). There is a massive shortage and an inequitable distribution of skilled providers to deliver psychological treatments in all countries but there are also massive global inequities in their distribution. For example, Saxena and colleagues (2007) showed that low-income countries have a median of 0.05 psychiatrists, 0.16 psychiatric nurses, and 0.04 psychologists and social workers per 100,000 population, as compared to 10.0 psychiatrists, 32.5 psychiatric nurses, 14.0 psychologists and 15.7 social workers per 100,000 populations in high-income countries. In absolute numbers, there are more mental health professionals in the state of California than the whole of Africa and more mental health professionals who trained in Africa and South Asia working in North America than in their home countries. These cross-national inequities are mirrored within countries, both rich and poor; mental health professionals are concentrated in urban and high-income populations.

The second reflects **demand barriers** (i.e. not seeking care when one is affected by a mental disorder). For example, across five countries in Europe—all of which enjoyed relatively good access to affordable, evidence based mental health care—36.5% and 26.1% of individuals with a mood or anxiety disorder,

respectively, consulted a formal health service over a 12-month period (Alonso et al., 2004). The rates appear to be higher in the US, but even then, about half of persons with major depression do seek care from any provider over a 12-month period (Croghan, Schoenbaum, Sherbourne, & Koegel, 2006). These demand barriers are even greater in low-and middle-income countries; for example, less than 20% of people with depression or anxiety in India's National Mental Health Survey reported seeking help in the previous 12 months (Gururaj et al., 2017). There are several reasons for low demand including: difficulty accessing mental health care due to geographic or cost barriers; stigma attached to mental health care; and the narrow focus of mental health care on clinical disorders, failing to address the wider concerns of people with mental health problems.

Finally, the third challenge involves **content barriers**. This refers to the complex nature of psychological treatments which requires extensive learning and supervision to deliver which, in turn, translate into high levels of investment of time and money to train providers and assure continuing quality of delivery. Multiple packages for each disorder mean that providers need to train in all of them to address the typically heterogeneous clinical populations seen in routine care. There is growing evidence that quality of mental health care is highly variable and only a minority of providers show reasonable levels of fidelity with the treatment protocols (Stirman et al., 2015).

### Global Mental Health Strategies to Address Barriers

A rapidly-growing body of evidence has flourished demonstrating the promise of a range of innovations seeking to address these three barriers.

#### Addressing Supply Barriers.

If we assume that a 'skilled' provider is a health care professional who has been trained in one of the allied specialist mental health disciplines (social work, psychology or psychiatry), then there is no chance of overcoming the dearth of mental health services worldwide. There are large gaps between the required and actual numbers of mental health professionals in all countries (Kakuma et al., 2011). Furthermore, the methods typically used to train these specialized persons are expensive, time-intensive and requiring of another, even more experienced specialist to conduct regular supervision for an extended period of time. An effective strategy to address this barrier is task-sharing. Task sharing is an approach which has been effectively used to enhance the coverage of a range of clinical and preventive interventions. It refers to the 'rational redistribution of tasks' amongst various members of a work force team (WHO, 2008). The aim is to train paraprofessionals (e.g., teachers, nursing assistants, community health workers) or lay persons to deliver

a specific intervention with appropriate levels of supervision. The strategy is integral to a stepped care approach where the most easily accessible, widely available, and least costly human resource is trained to deliver a first-level evidence-based intervention with adequate quality, allowing the scarce and expensive resource of the specialist to address more complex mental health needs. While the effectiveness of task-sharing in global health is well-established, GMH innovators have applied this strategy to the delivery of psychological treatments with great success. But, from a historical perspective, it is important to note that the concept of non-specialist providers precedes its current deployment in global health, dating back to the paraprofessional movements in the USA and other high-income countries where substantive evidence demonstrated comparative effectiveness of paraprofessional and specialist providers (Durlak, 1979; Hattie, Sharpley, & Rogers, 1984).

Non-specialist providers range from nurse practitioners, community health workers, teachers and peers and selected because of their availability, low-cost, access to and close ties with the population they serve (Singla et al., 2017). Recent systematic reviews (Cuijpers, Karyotaki, Reijnders, Purgato, & Barbui, 2017; Singla et al., 2017) have shown the effectiveness of NSP-delivered psychological interventions in LMICs are similar to those delivered by specialist providers in HICs. Specific examples of such interventions include the Thinking Healthy Program (THP)—a CBT-based intervention delivered by Lady Health Workers in Pakistan—which showed large effect sizes of 0.62 for the treatment of maternal depression (Rahman, Malik, Sikander, Roberts, & Creed, 2008). This 12 session treatment has been successfully implemented in over 20 countries by a range of providers including peers (Fuhr et al., 2019; Sikander et al., 2019) and is now recommended by the World Health Organization for the treatment of perinatal depression in low-resource settings ([https://www.who.int/mental\\_health/maternal-child/thinking\\_healthy/en/](https://www.who.int/mental_health/maternal-child/thinking_healthy/en/)).

Furthermore, researchers have developed scalable tools to enable non-specialist providers rate therapy quality through peer-led supervision (Kohrt et al., 2015; Singla, Ratjen, Krishna, Fuhr, & Patel, 2019; Singla et al., 2014). This, in turn, addresses the bottleneck of the need for supervision provided by mental health specialists.

#### *Addressing Demand Barriers.*

Three patient-centered solutions have helped to address relevant demand barriers.

*Cultural adaptations.* The first is the incorporation of culturally appropriate metaphors and techniques to enhance engagement with the treatment. A good example is the eschewing of the use of psychiatric

diagnostic labels such as ‘depression’ in the psychoeducation component of the treatment as a way to reduce stigma and fear associated with these labels (which are typically interpreted as being signals of ‘madness’), leading to better engagement and adherence (Patel, Chowdhary, Rahman, & Verdelli, 2011). Another example is the incorporation of culturally appropriate techniques within the treatment protocol, such as the design of a yoga routine for use alongside IPT in a program in India (Patel et al., 2010).

*Beyond psychological symptoms.* The second is to address the wider concerns of the patient, beyond a narrow focus on clinical symptoms. This approach is aligned with the ‘recovery’ movement for people with severe mental disorders and with the concept of person-centered care in the context of chronic conditions. Three examples illustrate how this is done in practice. In the Healthy Activity Program, a brief behavioral activation-based treatment for depression, providers explore the social determinants of the illness and provide practical guidance, such as information about social welfare agencies in the community (Chowdhary et al., 2016). In the Depression in Late Life intervention, based on problem-solving, the providers explore the physical health needs of elders with sub-threshold symptoms and offer practical guidance on navigation of the health care system and adherence support for medications for their co-morbid diseases (Azariah et al., 2019). Similarly, a community-based, peer-led parenting intervention in rural Uganda integrated a wide range of evidence-based psychological treatments along with psychosocial stimulation to prevent the worsening of maternal depressive symptoms and improve child cognitive and receptive language development (Singla, Kumbakumba, & Aboud, 2015). This 6-month intervention involved children, mothers and fathers—and targeted relevant and common issues related to relationships with self, child and spouse including interpersonal violence.

*Improving access.* The third is to address the time and cost barriers to accessing care consequent to the provider costs and place of delivery of the treatment. Thus, access tends to be provider-focused rather than patient-focused—they are typically delivered face-to-face, in urban specialist facilities, and at a time that is most suitable for the provider. These delivery formats pose particular challenges to people from lower social classes and ethnic minorities (Hasnain-Wynia et al., 2007)—and treatment retention of most psychological treatments is less than 50% in most patient populations. Task-sharing itself contributes to greater affordability as the providers are relatively low-cost and, in most instances, employed within public health care systems. Treatments are offered in settings and at times that are convenient to the patient (for example, at home and during the weekend). In addition, the use of telemedicine and other digital platforms can facilitate



this flexibility as well as guided self-care. Delivery of the same treatment through a digital platform is as effective as in-person treatments, but preferred by the recipient and with better sustained outcomes (Andersson, 2016; Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; Choi et al., 2014; Lee, Denison, Hor, & Reynolds, 2016). In all contexts, these feasible and cost-effective solutions may be particularly beneficial for individuals with limited financial, social or physical capacity to travel to health facilities, such as mothers with infants, individuals with physical disabilities, or people who are homebound for various reasons, including due to the impact of mental disorders. These strategies are therefore critical to enhance equitable provision of psychological interventions, and essential coverage of mental disorders.

#### *Addressing Content Barriers.*

Interest in the identification of ‘active’ components of complex psychological treatment packages has identified a number of common treatment ‘elements’ (such as behavioural activation, exposure, problem solving and communication skills) which account for a significant fraction of the effectiveness of the package (Chorpita, Daleiden, & Weisz, 2005). Focusing on these elements can reduce the complexity of needing to learn complex treatment packages for specific clinical phenotypes (such as depressive, anxiety and stress-related disorders). The Healthy Activity Program is a good example of such a common element based psychological treatment. Lay counsellors trained over 2 weeks to deliver this treatment attained impressive remission rates and sustained outcomes in primary care attenders with moderately severe to severe depression (Patel et al., 2017; Weobong et al., 2017). Delivery of a parsimonious, common element-based psychological intervention is not only efficient and scalable, but is also consistent with emerging scientific consensus on the neural mechanisms of these disorders and also as effective as the full package. For example, the COBRA trial in the UK demonstrated that non-specialist undergraduate students delivering a treatment package that focused on the core element of behavioural activation was of equivalent effectiveness in reducing depressive symptom severity as specialists delivering longer courses of cognitive behavioural therapy (Richards et al., 2016).

Most recently, innovators have begun to package a set of evidence-based common elements which can address a range of common mental disorders, adding a decision-making algorithm to support providers in ‘matching’ the patient’s psychopathology with specific elements. The best example of this strategy, which has been successfully deployed through task-sharing in humanitarian contexts, is the Common Elements Treatment Approach (Murray et al., 2014) with impressive effect sizes across a wide range

of disorders (Bass et al., 2013; Bolton et al., 2014). Recent results (Murray et al., 2019) from two of these trials highlight the dose-response effect of CETA in two contexts (Thailand and Iraq), with 50% of patients showing some improvement after 4-6 sessions and after 7-10 sessions.

#### **Global Mental Health in High-Income Countries**

Despite the growing evidence base supporting these exciting innovations, access to psychological treatments is an exception, rather than the norm. One unique exemplar of successful scaling up psychological treatments is England’s Improving Access to Psychological Treatments (IAPT). In a country of 56 million people, IAPT services treats more than 500 000 patients with depression and anxiety annually, with psychological treatments delivered both by NSPs and specialists trained in brief, accredited courses. The program is unique in that it assesses the progress of almost all (98%) patients using a digitally enabled monitoring outcome system (Clark, 2018). Their results show that stepped care models of delivery are clinically effective, facilitate short wait times to improve patient attendance, and ultimately increase collaboration between therapists—including non-specialist providers—and their patients (Clark, 2018; Clark et al., 2017). While IAPT is not explicitly influenced by GMH research, its strategies (for example, contextually appropriate task-sharing) are entirely aligned with the GMH strategies.

#### *Two Examples of Ongoing Programs that Explicitly Embrace GMH Strategies.*

New York city’s Thrive program which is seeking to reduce the treatment gaps for mental disorders has embarked on a city-wide initiative to build mental health intervention capacity across diverse sectors (Belkin & McCray, 2019). One of the approaches has been to adapt the Friendship Bench approach, a strategy to deliver problem-solving treatment through NSPs on ‘benches’ in community settings to NYC.

A second example, is the as the Scaling Up Maternal Mental healthcare by Increasing access to Treatment (SUMMIT) Trial ([www.thesummittrial.com](http://www.thesummittrial.com)). This large-scale, non-inferiority, pragmatic randomized controlled trial (RCT) for the treatment of perinatal depression compares two delivery modes of a brief, evidence-based, behavioral activation intervention for depressive symptoms (telemedicine vs. in-person) provided by two different delivery agents (mental health specialists vs. trained NSPs). This multi-site, trial is being implemented across real-world, primary care settings in Toronto, Canada; Chapel Hill, North Carolina; and Chicago, Illinois. This study will utilize the Healthy Activity Program (Chowdhary et al., 2016; Patel et al., 2017) as one of its resource manuals—highlighting

a unique opportunity for reverse engineering (i.e., use of a 'developing world' intervention manual in a 'developed world' setting).

## Summary

Empirically-supported psychological treatments can be scaled up through a range of innovative strategies comprising the delivery of a pared down set of common elements by non-specialist providers, either face-to-face in community settings or through telemedicine platforms. This delivery format should form the first step of a comprehensive, coordinated architecture of a population based mental health care system. As demonstrated by IAPT, this model of care would consist of two levels: an entry, low-intensity step for the majority of patients with mild to moderate symptoms; and a high-intensity step for the minority of patients suffering from severe symptoms and those who do not respond to the first step. The first step encompasses the strategies discussed in this paper, but could also additionally include promoting guided self-care. In addition to providing low-intensity psychological treatments, NSPs could also perform a range of tasks including screening and as a case manager to link the patient, family physician, mental health specialists and social welfare providers. In the higher-intensity step, mental health specialists treat the more severe spectrum of these disorders, monitor use and adherence to medication when appropriate, and supervise and support NSPs. Thus, GMH strategies are intended to expand mental health care in all contexts rather than replace specialist providers. This stepped care model emphasizes patient-centered approaches and collaboration with local communities. This includes receiving input on how treatment could be best delivered in order to reduce administrative barriers to the provision of care, and engaging patient advocates in planning and improving the navigation of existing systems. In doing so, we may also have the opportunity to reach marginalized groups who may not typically seek mental health care.

There are a number of major bottlenecks which remain to be addressed, including how such comprehensive population mental health care systems can be resourced, in particular in the highly fragmented delivery contexts of North America. One major bottleneck which we are attempting to address is that of training and supervision which, even in the shortened format adopted by GMH practitioners, remains hard to scale up due to its reliance on face to face formats. Perhaps one of the most important lessons arising from the ongoing COVID-19 crisis is how much of our daily roles and activities can be moved to digital platforms. The real-life evidence is aligned with the evidence which demonstrates the acceptability and effectiveness of digitally delivered learning and supervision of psychological treatments. This evidence informs the foundation of the EMPOWER

initiative of GlobalMentalHealth@Harvard which seeks to apply tested methods for digitizing the curriculum of evidence based manualized treatments, assessment of competencies, and peer supervision of therapy quality to enable a front-line provider to learn how to assess mental health, match patient assessments with specific treatment decisions (e.g. whether to refer to a more specialised provider), learn how to deliver evidence based psychological treatments, complete a validated competency assessment, deliver the treatment with fidelity, receive supervision and support to master a treatment and participate in peer supervision to assure quality of care.

We hope that psychological communities in North America will welcome a global mental health perspective as a cost-effective approach to massively expand the effective coverage of psychological treatments and, in doing so, to reduce the large and growing global burden of mental disorders.

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## BECOME A DIVISION 12 MENTOR

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## Ethics Column: Requests to Provide Emotional Support Animal Certifications

**Adam Fried, Ph.D.**  
*Midwestern University*

 It has become somewhat commonplace for practicing psychologists to receive requests for emotional support animal (ESA) certification evaluations from clients/patients. These types of assessments require a licensed mental health professional to certify that having access to a pet is critical to maintaining the client/patient's mental health. Common reasons for ESA certification requests include being able to have a pet travel with an individual during an airline flight and as an exception to housing units that traditionally do not allow pets. In a small survey of mental health practitioners, Boness, Younggren, and Frumkin (2017) found that almost one-third of their sample had completed such an evaluation.

Clinicians are often unsure of how to respond to these requests and may face a specific type of moral dilemma. For example, some may feel that performing these types of evaluations creates a professional role conflict but, at the same time, they also do not want to disappoint their client/patient. Another dilemma may be that while they do not believe that their client/patient requires an emotional support animal, denying this request would create hard feelings or otherwise harm the therapeutic relationship. The ethical dilemma for many psychologists often has to do with perceived benefit and harm. Some clinicians may reason that providing a letter is something that may take relatively little time or effort and may be enormously helpful to their patient. These types of moral dilemmas can be quite stressful as the best course of action may not be clear. These types of situations are similar to other ones in which a clinician can act in a way that they believe fulfills a client/patient's wishes but, in doing so, are potentially putting themselves at ethical risk. While it's commendable that a clinician be concerned about not disappointing a client/patient, it's important to remember that one's professional role and responsibilities may prevent them from always fulfilling a client/patient's request.

This column will review important ethical issues to consider when receiving ESA evaluation requests from current clients/patients, including understanding the implications of these assessments, potential role conflicts, and recommendations about communicating with clients/patients to minimize misunderstanding and harm to the therapeutic relationship. Ethics expert Gerald Koocher, Ph.D., of Harvard Medical School and former American Psychological Association president, has recently co-authored an article on emotional

support animal assessments (Younggren, Boness, Bryant, & Koocher, 2019) and will provide some helpful considerations and recommendations.

### What are the Ethical Issues Involved?

Research suggests that a substantial number of mental health professionals believe it is appropriate for treating clinicians to provide a professional determination about the need for emotional support animals (Boness, Younggren, & Frumkni, 2017) but many may not be aware of the ethical conflicts associated with such requests. Younggren et al. (2019) point out three significant ethical issues involved with these types of evaluations: 1) clinician competence in terms of being able to conduct an ESA assessment (including adequate understanding of related laws and regulations); 2) the validity of assessment methods as well as the scope of assessment necessary to make an adequate determination; and 3) boundary and multiple relationship considerations in terms of a treating therapist also taking on an additional role in conducting an assessment.

### Understanding What Is Being Asked

First, it's important to understand the ramifications of an ESA evaluation. By providing such a certification, the clinician is not simply saying that a patient/client is happier or less anxious when in the presence of their pet. The laws that apply to airlines and housing, for example, often require that the person applying for an ESA be diagnosed with a psychological condition by a licensed mental health professional and that this person is disabled by this condition. Koocher explains that this may have far-reaching consequences: "A person diagnosed with a psychological disability may be denied certain licenses or jobs. In some states they cannot get a firearms or concealed carry license. They may be denied security clearance, or other jobs involving public safety (e.g., military, police, fire fighter, nuclear plant employee). Applications for these positions will ask about disability under penalties of perjury. In addition, if you have a psychological disability you may not qualify for work-related disability insurance or pay higher rates for life insurance. If you do not admit to the disability finding or lie and later are discovered to have done so, you may be charged with insurance fraud."

### Boundary Issues and Multiple Relationships: Evaluator and Treating Clinician.

Many argue that conducting ESA assessments by treating psychologists constitutes an additional relationship that can create a "risky role conflict" (Younggren, Biosvert, & Boness, 2016). As an advocate for the patient/client, it may be difficult for the treating therapist to simultaneously serve as impartial evaluator. Standard 3.05 Multiple Relationships of the

APA Ethics Code (APA, 2017) prohibits psychologists from taking on multiple roles with a client/patient when doing so might cause impairment, risk exploitation, reduce professional objectivity, or otherwise be harmful. While it's important to remember that not all multiple relationships are unethical, the psychologist who takes on multiple roles bears the responsibility to demonstrate that taking on an additional role did not violate the standard. As Koocher points out, there may be some disagreement about the ethics of performing two professional roles simultaneously: "Some contend that this can be done ethically. I am not one of them. Hence, I cannot support doing it."

There may, however, be times when providing an evaluation may be appropriate, especially if you are acting in an evaluator role only<sup>1</sup>. Questions about how to conduct such an evaluation (including what measures to use and how to assess the veracity of responses) continue to be debated. Younggren et al. (2019) offer a model and guidelines for performing these types of evaluations. These include gaining a thorough understanding of the laws involved, adequately evaluating the client (including attempting to determine the genuineness of client/patient reports), and assessing the animal and the interaction between client/patient and animal. These last components may be more difficult. Koocher recommends trying to determine (as best one can) "...whether the animal poses a danger to the public or would be endangered by the proposed use."

### Communicating with Your Clients/Patients

These types of requests may lead to some difficult conversations with clients/patients; in an effort to avoid them, we may acquiesce to appeals that make us feel uneasy or about which we have reservations. Recognizing that these situations create these feelings in us is a critical first step in ethical decision-making and can help us to think more clearly about the right course of action, even if it may disappoint a client/patient. Below are some recommendations about ways to discuss ESA assessments to minimize confusion and potential harm to the therapeutic relationship.


**Informed Consent.** If you have a professional position on providing these types of evaluations, it's best to make it clear to the client/patient in the beginning of treatment. Having a clear statement may provide clarity from the outset and prevent uncomfortable situations or patient/client beliefs that you are choosing not to help them because of some other reason (e.g., that you do not like the client/patient or that you believe they are not being truthful in their request). For example, many clinicians are including language in their informed

consent documentation about whether or not they provide these types of assessments. Boness, Younggren, and Frumkin (2017) and Younggren, Boisvert, and Boness (2016) provide helpful sample language that may be adopted for consent documents.

**Helping Clients Understand What This Means for Them.** When clients/patients make these requests, they may not realize that many of these assessments require some sort of disability determination and, as noted above, may have far reaching consequences. Koocher recommends alerting clients/patients about the possible unrealized consequences of writing these letters. He explains, "You can try explaining that writing such a letter includes a finding that they (the client) has a mental disability under the ADA... The client might want to consider that having a letter that they are mentally disabled (and in need of an ESA) could cause adverse consequences for them in the future (e.g., getting disability insurance or certain jobs)."


**Making Clear the Ethical Conflict.** If the request creates an ethical conflict, it may be helpful to clarify the ethical considerations of these requests, as clients/patients may not be aware of the nuances of the profession's ethical code of conduct. For example, the clinician could explain that they while want to be helpful, fulfilling this type of request requires them to take on a dual role that could create professional ethical risk. As Koocher explains, "The ethical code makes evaluating disability a separate act from therapy, and one cannot ethically evaluate one's own therapy clients."

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<sup>1</sup> Some certifications require that a treating licensed mental health professional complete the forms, which can cause difficulty if the individual isn't currently in treatment.

## SCP Member Spotlight on Dr. Amanda Raines

 Dr. Amanda Raines is a Core Research Investigator with the South Central MIRECC and the Southeast Louisiana Veterans Health Care System in New Orleans. We had the opportunity to learn more about Dr. Raines through our Q&A correspondence. Read on to learn more!

### Please provide an overview of your work

My research interests focus on the prevention and treatment of emotional disorders, namely anxiety, mood (including suicide), and trauma – and stressor-related disorders. I am particularly interested in the development and dissemination of psychotherapies that can be applied to individuals with multiple disorders or to mixed diagnostic groups, as such protocols could overcome access and resource obstacles both within and outside the VA. I am also interested in technology based treatments, particularly those targeting transdiagnostic risk factors like Anxiety Sensitivity (AS), as such modalities could reduce cost while also increasing portability. To this end, I recently completed a pilot project examining the effects of a brief, one session computerized AS intervention delivered to veterans seeking treatment for an opioid use disorder; these findings were published in *Addictive Behaviors* earlier this year. Further, I am in the process of writing up results from another pilot project wherein I tested the acceptability, feasibility, and utility of a group-based transdiagnostic treatment delivered to veterans living in rural and underserved areas throughout Louisiana. Findings from these investigations will be used as proof of efficacy for larger federally funded submissions.

### Where did you complete your training?

I completed my Doctor of Philosophy in Clinical Psychology at Florida State University (FSU) in 2016 under the supervision of Dr. Brad Schmidt and my doctoral internship and postdoctoral residency at the Southeast Louisiana Veterans Health Care System (SLVHCS) in 2016 and 2017, respectively, under the supervision of Drs. Laurel Franklin and Joseph Constans.

### What is your current position/occupation?

Currently, I serve as a Clinical Investigator with SLVHCS and the South Central Mental Illness Research, Education and Clinical Center and hold an academic appointment as an Assistant Professor in the School of Medicine at Louisiana State University. In these roles, I conduct research in areas of importance to the VA and veterans, particularly those living in rural and underserved areas throughout Louisiana. In addition, I serve as a member of our Training Committee providing

interns and residents exposure to clinically relevant research.

**Can you describe the ways that your career has taken shape over time? How did you get to where you are today?**

After earning my bachelor's degree, I received a full-time research assistant position working with Drs. Brad Schmidt and Michael Zvolensky on a

large-scale multi-site NIMH treatment trial examining the effects of an AS intervention on the development of panic disorder and smoking abstinence. As a graduate student in Dr. Schmidt's laboratory, I continued to explore the associations between AS and various anxiety and related conditions, namely obsessive-compulsive disorder, posttraumatic stress disorder, and suicidality. During my doctoral internship and post-doctoral residency at SLVHCS, I sought to extend this risk factor research to veterans. In a series of papers I published while on internship, I demonstrated that AS, in particular the cognitive concerns dimension, is associated with PTSD using a small treatment-seeking sample of veterans. Using a similar yet distinct sample, I also demonstrated the mediating role of AS in the relationship between PTSD and suicidal ideation, plans, preparations, and impulses. More recently, I applied this risk factor research to the clinical arena by examining the effects of a brief, one session computerized AS intervention delivered to veterans seeking treatment for an opioid use disorder.

### How long have you been a member of SCP?

I first became acquainted with Division 12 and their mission while taking a Techniques of Behavior Change course as a graduate student at FSU. Taught by Drs. Christopher Lonigan and Thomas Joiner, this course provided exposure to a number of intervention procedures, their theoretical underpinnings, and most importantly the literature in support of their efficacy. We spent a great deal of time understanding the issues involved in evaluating the efficacy and effectiveness of various psychological treatments. Such experiences provided me with framework for selecting interventions for my own clients as well as a foundation from which to evaluate the utility of my own work. Over the years, I have utilized the "Browse Treatment List" and "Browse



**Amanda Raines, Ph.D.**



Treatments By Diagnostic” tabs on the website countless times when treatment planning with clients or even conducting my own research. Because of this and my belief in the Division 12 mission, I decided it was finally time to join in 2019. I now pass on my love of Division 12 to my own mentees!

**Please describe any roles you have with APA or other national, state, or local organizations.**

I am committed to giving back to the field of psychology. In addition to serving as a research supervisor to trainees in our APA accredited internship and residency programs, I currently serve as a Director on the Executive Council of the Louisiana Psychological Association and as a Co-Chair of our convention committee. This experience has taught me how to advance the interests of our members through the design, organization, and delivery of high-quality continuing education events. Additionally, I am a member of the Advisory Board for the Louisiana Violent Death Reporting System which seeks to understand when and why violent deaths including suicides occur. Lastly, I am a new member of the Associate Editorial Board for Behaviour Research and Therapy which allows me to further contribute to the betterment of psychological science, while also more critically evaluating my own work.

**What do you see as an important direction for the field of Psychology?**

In a time where pseudo-science seems to reign, we have to continue branding ourselves as a science. Consistent with the mission of Division 12, this means we have to continue integrating psychological science into our education, research, and clinical missions. I believe this starts with ensuring that all graduate programs are providing students with an underlying knowledge of science in psychology, as well as the requisite skills to contribute to the field. In turn, this allows for a greater understanding of psychopathology and the importance of incorporating evidence based skills into practice.

**What’s something nobody would know about you?**

Like many girls growing up in the south, I was passionate about pageantry. I have competed in over 20 pageants and held several small town titles. Other than the opportunity to wear a beautiful gown, my favorite aspect of the competition was the on-stage question. I believe that my ability to field questions regarding my own research in a respectful and poised manner stems somewhat from my time on stage.

**What are your hobbies?**

New Orleans is world famous for its cuisine. Since moving here in 2015, I have thoroughly enjoyed tasting all this city has to offer. My two favorite local dishes are charbroiled oysters and barbecued scallop fettuccine.

And the drive-thru Daquiri shops aren’t too bad either! 🍹

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## Diversity Spotlight: Honoring Dr. Karen Suyemoto

**Fanny Ng**

This Diversity Spotlight is dedicated to honoring Dr. Karen L. Suyemoto for her passionate and enduring commitment to furthering social justice through her distinguished career as an educator, researcher, and scholar in the areas of race, culture, and diversity. Dr. Suyemoto is a licensed psychologist who provides diversity consultation, training, and mentoring both locally and nationally. In 2012, she was recognized for her commitment to mentorship as the inaugural recipient of the Joan H. Liem Award for Outstanding Doctoral Mentoring and in 2013 she was recognized as a White House Champion of Change: Asian American Pacific Islander Women. She has also received the Asian American Psychological Association's Distinguished Contributions Award. Dr. Suyemoto is a Professor of Psychology and Asian American Studies, and the Director of the Critical Ethnic and Communication Studies graduate program at the University of Massachusetts, Boston. She is currently overseas serving as a visiting scholar to teach a course focused on the Ethnocultural Socialization and Racialization in Comparative Contexts at Malmo University in Sweden as a Fulbright Scholar.

Dr. Suyemoto has devoted her career to research, teaching, and mentorship focused on raising awareness and fostering social justice for marginalized groups and communities that have included racial and ethnic minorities, women, refugees, transnational adoptees, religious minorities, and immigrants. As a researcher, she strives to give voice to the unique struggles and experiences of oppressed peoples whom are frequently overlooked and ignored in mainstream literature and discourse. An ongoing research project examines how people of color resist racism and promote equity and justice in a variety of ways. This project elucidates how different cultural and racial groups resist the impact of racist experiences differently - with some groups preferring to engage in individual acts of personal resistance, such as not colluding in racist jokes or distancing themselves from insensitive others. Other group members may prefer to engage or join in communal action to advocate against racism, such as participating in rallies, protests, or organizing. Dr. Suyemoto examines how these actions to resist or challenge racism personally or systemically may moderate the negative psychological effects of experiencing racism for people of color.

Simultaneously, Dr. Suyemoto is also working on the development of an innovative series of intervention workshops to address racism related stress and its negative health impacts for people of color. These

workshops empower people of color to better resist and cope with racism through fostering a greater understanding of societal systems of power and privilege and breaking down the cumulative impact of both infrequent and day-to-day experiences of racism. It provides practical psychoeducation grounded in clinical interventions for anxiety disorders and draws from multicultural and feminist psychology perspectives that makes space for participants' unique experiences of racism.



**Karen Suyemoto, Ph.D.**

Dr. Suyemoto's passion for education that increases understanding, awareness, and strategies to support social justice has culminated in two books, more than 40 articles and chapters, and over 100 conference presentations or posters, frequently in collaboration with students. Her writings have focused on such topics as inter-minority race relations, ally and advocacy development, training psychologists for cultural sensitivity, teaching for transformation and social justice, and feminist applications and connections with multicultural understandings in psychotherapy. Dr. Suyemoto continues to share her extensive expertise through an ongoing collaborative two-book project focused on teaching and learning about racism relationally that engages both the emotional process and interpersonal dynamics.

In the classroom, Dr. Suyemoto is an experienced professor whose courses focuses on issues within psychology and ethnic studies related to racialization, culture, and diversity, with secondary foci on applications of psychology and qualitative methods. She invites students to take ownership of their learning through exercises in self-exploration, self-reflection, and perspective-taking to examine their experiences of the world and deeply embedded social hierarchies and systems. UMass Boston undergrads and graduate students have described the educational journey in Dr. Suyemoto's classroom as being uniquely transformative and eye-opening. Their newfound awareness and understanding of systems of power and privilege have led many of them to explore their own roles and responsibilities with these systems. Dr. Suyemoto has served as a critical catalyst for a generation of students who are seeking ways to combat the inequalities that can no longer go unseen or be ignored in the broader society and in local communities. Many of Dr. Suyemoto's former students have gone on to

become local and national leaders, mentors, teachers, researchers, clinicians, and other professionals who continue to spread a passion for social justice and fight against systemic inequalities through their broad and varied work across the country.

Finally, Dr. Suyemoto has also expanded her positive impact through notable contributions to leadership and service to national and regional associations such as the New England Center for Inclusive Teaching, the Association for Asian American Studies, and the American Psychological Association's Minority Fellowship Program. She previously served as President of the national Asian American Psychological Association (AAPA) and was one of the first co-chairs of the AAPA Division on Women. She has also served as AAPA's delegate to the American Psychological Association Council of Representatives (2014 - 2017) and currently serves as the Chair of the APA Task Force for developing the new Guidelines for Race and Ethnicity in Psychology.

Dr. Suyemoto has been and continues to be a role model in the community as a longtime educator, scholar, advocate, and mentor who has maintained a steadfast commitment to her values and passions for social justice throughout her career. She is sure to continue making significant contributions to the field of psychology and to society as a whole through the many ways that she shares her knowledge and compassion with others. 🙏



## Division 12: Section 8 Announcement

The Association of Psychologists in Academic Health Centers (APAHC) is maintaining a page which serves as a repository of resources related to the ongoing challenges surrounding Coronavirus Disease 2019 (COVID-19). The page contains information for psychologists as well as for the general public with specific resources for parents, children, and the elderly. This page is updated regularly, and we appreciate any contributions. Ideas for resources can be submitted directly to Philip Fizur at pfizur@gmail.com.

The link is <https://ahcpspsychologists.org/covid19/> 🙏

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## Section 2: Geropsychology

### Supervision

**Sheri Gibson, Ph.D.**

*University of Colorado, Colorado Springs*

 Clinical supervision is a complex activity and is influenced by clinical practice, ethics, the law, health care reform, and research. The practice of Geropsychology presents unique challenges given the multiplicity of issues facing older adults and families, as well as the diversity of care settings in which older adults are served. Geropsychologists receive specialized training in providing a wide range of services including assessment, intervention, and consultation (Karel, Knight, Duffy, Hinrichsen, & Zeiss, 2010) with a focus on older adults. The often-interacting psychosocial, medical, cognitive, and psychiatric issues affecting older adults place geropsychologists in positions to detect, report, and intervene in situations of potential elder abuse, exploitation, and neglect. Even for the seasoned clinician, such situations can elicit feelings of anxiety and uncertainty, particularly around reporting protocols and the process of engaging the older adult or intervening in a conflicted family system. For clinicians who provide supervision to students or interns, the supervisory relationship provides a unique opportunity to address ethical and legal issues related to risk assessment and intervention through education and modeling.

The aim of this article is to introduce the global phenomenon of elder abuse, exploitation, and neglect, and to expose the reader to a competency model of supervision used for training geropsychologists to increase their knowledge base and skills, particularly pertaining to assessment, reporting, and intervention strategies in cases of elder abuse. Additionally, the author reminds the reader that through the process of teaching and experiential modeling, the supervisor continues to grow in his/her/their own clinical and ethical practice, and learns in tandem with the student.

#### **Aging and Risk Factors for Abuse and Neglect**

It's no secret that the global population of older adults is growing exponentially. In the U.S. alone, the number of Americans age 65 and older is projected to rise from 40.3 million in 2010 to 72.1 million in 2030 (U.S. Census Bureau, 2012), with far reaching implications for psychologists and for every sector of health care delivery. For many older adults, living longer means enjoying good health and independence. But, for others, advanced age is accompanied with an accumulation of loss and illness that include diminished social support, physical limitations, medical comorbidities, and cognitive impairment. Current statistics indicate

that 5.8 million Americans are living with Alzheimer's disease, a number that is projected to increase to 14 million by the year 2050. Additionally, a staggering 16 million Americans are providing unpaid care for people with dementia due to Alzheimer's disease or other causes (Alzheimer's Association, 2019). Cumulatively, many of the challenges faced by older adults increases an individual's risk for abuse and neglect.

Although estimates regarding the prevalence and incidence rates of elder abuse vary considerably, the consensus is that elder abuse is a fast-growing social problem (Deem, 2000) that impacts federal spending and ultimately creates strain on social service programs such as Adult Protective Services (APS) agencies (Jackson, 2017). Recent prevalence rates suggest that elder abuse and neglect affects an estimated 1 in 10 Americans over the age of 65 (Acierno et al., 2010) and varies by type of abuse: financial exploitation (5.2%), caregiver neglect (5.1%), emotional/psychological abuse (4.6%), physical abuse (1.6%), and sexual abuse (<1.0%; Acierno et al., 2010). The same prevalence study conducted by Acierno and colleagues (2010) also revealed two important findings correlating with older adults' self-reports of some form of elder mistreatment: low social support and exposure to prior trauma. Additional data collected by APS indicated that between 30% and 40% of abuse reported by older adults included more than one type of abuse simultaneously, also referred to as polyvictimization (Clancy, McDaid, O'Neill, & O'Brien, 2011; Hamby, Smith, Mitchell, & Turner, 2016; Teaster et al., 2006).

While practitioners, lawmakers, and academics generally accept the concept of "elder abuse", there exists extreme variability among individual states in how they define, respond to, investigate, prosecute, and prevent incidents of elder abuse (Nerenberg, 2008). In the United States, mandatory reporting laws (in all states except New York) require certain professional groups to tell designated authorities about suspicions of elder abuse (<https://www.justice.gov/elderjustice/elder-justice-statutes-0#SL3>), which has increased the reporting behaviors by professionals. However, there remains a broad consensus and deep concern that elder abuse is underreported. Reasons for underreporting have been speculated and studied by researchers and practitioners alike and include the older adult's perception of the strength of the relationship with the offender (Gibson, 2013), fear of reprisal from the offender, embarrassment and shame, fear of losing one's independence (Beaulaurier, Seff, Newman, & Dunlop, 2007; Wright, 2010), or in cases of financial exploitation, having no awareness that one is being exploited (Jackson & Hafemeister, 2014). For members of the community, persons do not report for failure of recognizing that abuse is occurring (Lindland et al., 2015), believing that there is nothing they can

do to stop it, not knowing whom to contact for help, fear associated with involvement in a “family matter,” or a belief that the older adult would certainly self-report if he/she/they felt they were being abused or exploited (Plaisance, 2008). Perhaps equally or even more concerning is the lack of reporting by health care professionals, for reasons including patient autonomy and confidentiality (Helmes & Cuevas, 2007; Kennedy, 2005) and unfamiliarity with reporting protocols (Marson et al., 2009; Mills et al., 2012). This review of the literature on elder abuse highlights the complexities faced by clinicians: specifically, those situations where reporting may need to occur, where assessment and intervention are possible pathways to detection, and where difficult discussions with older adults and families are essential.

### **A Competency Model for Training and Supervision.**

In recent years, the field of geropsychology has adopted a competency-based theoretical model for supervision. In competency-based supervision, the supervisor and supervisee mutually agree to competency objectives achieved through systematic review of audio-video work samples and case notes. In addition, the supervisor provides ongoing feedback on competency development, and encourages supervisee’s practice of self-assessment, self-reflection, and providing feedback to the supervisor (Falender & Shafranske, 2007). As in other models of supervision (e.g., developmental and interpersonal), the supervisory relationship plays a critical role in increasing supervisee’s confidence and feelings of safety, and assists in the development of ethical decision making (Barnett, Erickson, Cornish, Goodyear, & Lichtenberg, 2007). The Pikes Peak Knowledge and Skill Assessment Tool (Karel, Emery, Molinari, & CoPGTP Task Force on the Assessment of Geropsychology Competencies, 2010; Karel et al., 2012) is a competency-based measure which employs a two-pronged approach to the development of professional geropsychology competencies: 1) didactic (knowledge-based) and, 2) supervised experiential (skills-based) learning. As part of the tool, supervisors evaluate supervisees on a range of competencies with the goal of building foundational skills and defining ongoing goals and training needs that cover a wide range of age-related issues including assessment of neurodegenerative disorders, knowledge of medical and physical comorbidities, psychopathology and psychopharmacology, family systems, end of life issues, and interprofessional care teams. One specific area of competency involves the application of ethical and legal standards in identifying the tensions “between sometimes competing goals of promoting autonomy and protecting safety of at-risk adults” (Council of Professional Geropsychology Training Programs, 2008, p. 6). A second area is in risk assessment, which includes assessing “risk of elder abuse in emotional, physical, sexual, financial, and neglect domains”

(Council of Professional Geropsychology Training Programs, 2008, p. 10).

Gero-trained psychologists who assume the role of supervisors are responsible for knowing the ethical codes and standards as outlined by the American Psychological Association (APA, 2010) and implementing portions of the codes to inform ethical decision-making. Additionally, supervisors integrate the legal standards and state-specific statutes into supervision to help guide specific behaviors, specifically, assessing and reporting situations of elder mistreatment. Several models of ethical decision-making have been introduced in the literature and can be especially useful in dealing with more complex issues (Bush, Allen, & Molinari, 2017). One model that compliments the APA codes and standards is presented next and speaks to the processes involved in ethical decision-making in clinical situations of elder mistreatment.

### **Ethical Principles: A Model for Action**

Karen Kitchener (1992) first proposed a model identifying five critical ethical principles for comparing and choosing options for clinical decision making, and for evaluating ethical dilemmas in professional practice. The five principles are:

1. Autonomy – responsibility for one’s behavior; freedom to choose that does not interfere with the freedom of others.
2. Nonmaleficence – to prevent or minimize the infliction of harm.
3. Beneficence – to attempt to contribute to the welfare of those with whom we work.
4. Justice – to approach care with fairness and equity.
5. Fidelity – to provide honest, genuine, and consistent interaction.

Each of the principles can be applied in the context of any clinical issue and can be related to both the APA ethical codes and the context of an immediate situation. Consider the following example: A supervisee is providing psychotherapy to a 77-year old Hispanic widowed gentleman for treatment of depressive symptoms, and describes in supervision that the client reported feeling fearful of his 54-year old daughter who lives with him and who stopped taking her medication for schizophrenia, and was experiencing heightened paranoia. According to the client, his daughter had recently kicked holes into the walls and had verbally threatened the client. He worries that if the authorities are contacted, his daughter will go to jail or be hospitalized, or worse, become homeless. The client also stated during the session, “She’s all I have and since her mother died, I can’t put her out on the

streets.” The supervisee expressed to the supervisor her concern for the client and the ethical dilemma of breaking confidentiality to report potential abuse. The supervisor reviewed with the student the state laws including the definition of an at-risk older adult, and the protocol for reporting. The student acknowledged the ethical demands of autonomy and fidelity – that is, respecting the client’s ability to make decisions around his relationship with his daughter and, being honest and transparent about the therapist’s role as a mandated reporter for elder abuse. With the ethical issues clear, the supervisor and supervisee were able to discuss possible approaches to partner with the client in contacting Adult Protective Services (APS) to obtain help for his daughter and ultimately, ensure the safety and well-being of the client.

In another case, a supervisee is providing home-based cognitive-behavioral therapy with an 84-year old non-Hispanic White widowed woman with chronic obstructive pulmonary disease (COPD), anxiety, and diabetes mellitus type II. The client also has moderate cognitive impairment and physical limitations due to obesity. The client’s daughter lives in the client’s home and works full time at a children’s day care center. Although the daughter ensures that her mother eats breakfast and takes her medications each day before leaving for work, she admits that she leaves her mother alone during the weekends and works late hours at a second job during the week. The student has been providing psychoeducation to the daughter about cognitive impairment and introducing the idea of employing caregiving services or securing respite care, and she has been working with the client (the mother) on reducing symptoms of anxiety. The student reports in supervision that her client called to state that her daughter had been gone for a week, spending time at her boyfriend’s home, and that she had run out of groceries and had a bout of incontinence that resulted in her clothing and bedding being soiled. The client stated that she had left a tearful voice message for her daughter who eventually responded with frustration, but stated she would be home that evening. The supervisee and supervisor discussed the ethical obligation to promote the safety of her client (i.e., beneficence) by addressing alternative care strategies with the daughter in the context of the client’s cognitive impairment, medical comorbidities, and physical immobility, while emphasizing that if other care services could not be employed, APS would need to be contacted (i.e., nonmaleficence). At the center of the supervisory discussion is the ethical principle of Autonomy. What are the client’s wishes? What ability does the client have to advocate for herself? To what extent does her cognitive impairment and physical immobility make her susceptible to neglect or abuse, and do her vulnerabilities override her autonomy?

Competency-based supervision also involves

promoting supervisees’ self-reflection practices. Exploratory questions can be posed to highlight a supervisee’s perceptions of and potential biases around autonomy and protection of older adults. Normalizing the anxiety and uncertainty around detecting and intervening in situations of elder mistreatment can be helpful, while modeling appropriate use of outside resources such as reviewing the APA Ethics Code (2010), jurisdictional laws, and consulting with ethics committees or experienced colleagues, can provide additional learning toward professional development.

## Summary

This article has addressed a number of issues relevant to clinical supervision and increasing supervisee’s competence around assessment, detection, and reporting of elder abuse. The author’s goal for this article was to expose the social problem of elder abuse to those who may be less familiar, and to possibly deepen the practice of those who routinely work with older adults and help train students, interns, and post-doctoral fellows in clinical practice. Additionally, a competency-based training tool was introduced to assist professionals in their role as supervisors, and to provide a mechanism that can only enhance the supervisory alliance and relationship through dialogue and accountability. A quotation that best captures this author’s philosophy and approach to learning and teaching was offered by the Zen monk and teacher, Shunryu Suzuki (1904-1971):


*In the beginner’s mind there are many possibilities. In the expert’s mind, there are few.*

Keeping one’s mind open to learning and with the awareness that the student becomes the teacher, and the teacher is also a student, is perhaps the most important lesson for all of us to embody, particularly in a profession that is never stagnant and always evolving.

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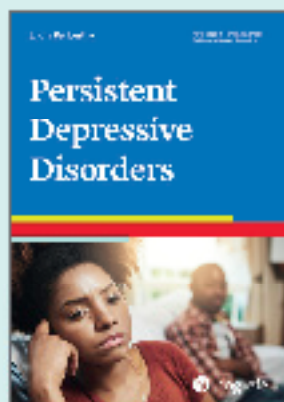
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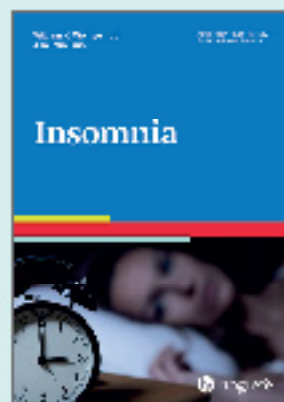
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Internet use is an integral part of our daily lives, but at what point does it become problematic? What are the different kinds of internet addiction? And how can professionals best help clients? This accessible, evidence-based book by leading experts answers these questions by outlining the current assessment and treatment methods for internet addiction. Includes a 12–15 session treatment plan using the method and setting with the best evidence: group CBT, and printable tools for assessment and treatment.



Gregory S. Chasson/  
Jedidiah Siev  
**Hoarding  
Disorder**

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ISBN 978-0-89937-407-2  
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