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CONTENTS

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PRESIDENT'S COLUMN

Every Cloud has a Silver Lining: Disasters and Prevention

Annette La Greca, Ph.D., ABPP

Every cloud has a silver lining. That adage certainly applies to disasters. Growing up in the Northeast, I don't recall being exposed to any major disasters as a child. Sure, there were school closings due to winter storms and occasional hurricanes that traveled up the coast. It wasn't until I was an adult living in Miami that I first experienced a disaster – and it was a doozy – Hurricane Andrew.

Before Andrew, my hurricane preparation included stocking up on nonperishable food – such as cans of baked beans and Spam – which I was certain I would never eat. I also "protected" the windows of my home by covering them with duct tape, which was impossible to remove days later when the heat and humidity melted the adhesive onto the window. Oy!

Andrew was a game-changer. It was terrifying to think that a Category 5 hurricane, packing winds exceeding 165 mph, was about to strike Miami. Fortunately, my preparation for that storm far exceeded prior attempts. Amazingly, I slept through most of the storm, awaking at times to hear a very loud whistle – like the sound of a railroad train running through the safe place I was staying.

By morning, the storm had passed, and my world changed overnight. It was as if a bomb had dropped! Outside, all the leaves had been stripped from the usual lush Florida landscape. No traffic lights or road signs were anywhere in sight. There was debris everywhere. And, of course, no electricity (for weeks). Needless to say, life did not return to "normal" for a long while, at least for anyone residing in Miami-Dade County. Although it took two years to have the damage to my home repaired, I considered myself lucky.

So, what is the silver lining here? Despite the distress, there were many. For one, I learned to appreciate that one's life can "turn on a dime," and not to take things for granted. And, consequently, to treasure and be grateful for the positive things we have on a regular basis.

As a psychologist, I also learned ***the importance of prevention.***

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Mental Health Needs Increase During and After Disasters

At that time, we did not fully appreciate the mental health fallout of disasters. We now know that hurricanes such as Andrew, but also other natural disasters (e.g., fires, tornadoes, floods), acts of violence, and major accidents, often result in increased symptoms of anxiety, depression, and traumatic stress, as well as increased alcohol consumption and suicide ideation (among other effects) for many youth and adults directly affected. We also know that up to 20-30% of affected youth and adults do not fully recovered even one to two years after the disaster event.

How can mental health providers deal with such burgeoning mental health needs, especially when disasters strike a large population? Under "normal" circumstances, there is already a dearth of mental health professionals. There simply are not enough providers to address the increased mental health needs of those affected by disasters. And individuals most at risk for adverse outcomes often have limited access to evidence-based mental health care. As practitioners and scientists, we need to think about what we can do to minimize the collateral damage of disasters on youth and adult mental health.

Prevention Context for the COVID-19 Pandemic and Other Disasters

This brings me to the summer of 2021, as we are all in a disaster mode! The COVID-19 pandemic is still a huge concern (especially with the rise of the Delta variant), and the annual Atlantic Hurricane and North American Wildfire Seasons are in full swing (and expected to be active!). With respect to COVID-19, for example, all evidence points to increased mental health needs for youth and adults. In fact, mental health providers report that they are overwhelmed and cannot keep up with demand for services.

As psychologists, we need to do what we can to "flatten the cure" in terms of the mental health fallout of disasters. This may mean adopting a prevention perspective to support youth and adults at risk, so that fewer reach the level of needing intensive clinical care. We all should be thinking of ways we can work in a prevention mode, while trying to meet the needs of those already experiencing problems.

Psychologists already know about evidence-based strategies for managing stress and for preventing symptoms of anxiety and depression in youth and adults. Psychoeducation can also be an effective tool for reducing psychological distress. Wide-scale use of preventive interventions in schools and community settings, or via telehealth, could go a long way to promote resilience and reduce the psychological fallout of disasters. Special attention to vulnerable populations, such as children, parents, and caregivers, as well as the elderly and those from disadvantaged backgrounds, will also be important.

Prevention requires a new mindset and some challenges. As psychologists, we must address prevention in multiple contexts – practice, research, education, and advocacy – if we wish to make significant inroads in improving youth and adult mental health and well-being. *Embracing a prevention perspective could be one of your silver linings from disasters.*

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SOCIETY OF CLINICAL PSYCHOLOGY

LEAD ARTICLE

Misophonia: New disorder, or needs more research?

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Since the 20th century inception and recursive iterations of Kraepelian classification models for problems with mental health, there have been significant changes to psychiatric nosology. Indeed, over 70 years the Diagnostic and Statistical Manual (DSM) transformed from, among other things, being descriptive and theory-driven to criterion-based, atheoretical, and polythetic. In turn, the number of disorders dramatically increased 2.8 fold from the first to the most recent version of the DSM (Suris et al., 2016). In its current form, the DSM-5 (American Psychiatric Association, 2013) contains approximately 300 diagnoses across 20 types of disorders. The advent of labeling a new psychiatric disorder for inclusion in the DSM is a complicated and imperfect process, with many more questions than there are definitive conclusions. When should a newly emergent constellation of syndromes be considered a unique disorder? If a newly defined condition has underlying neurophysiological features, should it be considered as a psychiatric disorder? And, what can clinicians do when patients present for clinical services with distressing and impairing symptoms of a newly defined condition, for which there are no known treatments?

In the case of misophonia, a newly described condition characterized by neurophysiological and behavioral responses to specific sounds (e.g., chewing), these are all questions with significant implications. The purpose of this paper is to critically explore whether and when it may be scientifically justified to propose that misophonia formally become a new diagnosis in the next iteration of the DSM. We begin by introducing misophonia and reviewing the nascent scientific literature exploring its etiology, features, and relationship to psychiatric disorders. Next, to provide pragmatic clinical suggestions for practitioners treating individuals with misophonia, we review assessment measures and treatment approaches, recommending a multi-disciplinary model of clinical services and two examples of behavioral interventions grounded in clinical psychological science. Finally, we conclude with suggestions for a research agenda to rapidly accelerate scientific knowledge about misophonia in service of determining if, and when, this newly described condition can reasonably be proposed as a new psychiatric disorder in the next edition of the DSM.

M. Zachary Rosenthal, Ph.D.

What is Misophonia?

Although the word misophonia could be defined narrowly to denote individuals with a hatred (miso) of sounds (phonia), emerging scientific research suggestive of its phenotypic complexity indicates that this translation is inappropriately simplistic and unwarranted. Broadly construed, misophonia is characterized by unpleasant and impairing affective, neurophysiological, and behavioral responses to specific aversive sounds usually made by others (Swedo et al., 2021). The term first appeared in the medical literature in 2001; other similar terms have included “selective sound sensitivity,” “soft sound sensitivity symptom,” and “sound-rage” (Jastreboff & Jastreboff, 2001; Schwartz et al., 2011). Despite being a newly coined condition, misophonia has gained attention in the popular press in recent years, appearing in articles from, for example, the New York Times, CNN, and Washington Post, as well as a 2016 crowd-

Clair Cassiello-Robbins Ph.D.

funded documentary (Gould, 2017). Concurrently, academic research has accelerated since the first research studies investigating misophonia in 2013 (Edelstein et al., 2013; Schröder et al., 2013). For example, over 100 citations containing the word “misophonia” in the title were found in a Google Scholar search in the first 6 months of 2021.

In the last eight years, a number of studies have begun to shed scientific light on the nature and features of misophonia. Cues (often described as “triggers”) commonly are repetitive oral (e.g., crunching, smacking lips) or nasal (e.g., heavy breathing, nose blowing; Jager et al., 2020) stimuli that are usually generated by other people, but can be made by inanimate objects (e.g., wind chimes) or animals (e.g., dogs barking; Swedo et al., 2021).

When triggered, individuals with misophonia report subjectively aversive sequelae, including state negative affect, commonly experienced as irritation, anger, anxiety, and disgust (for a review, see Brout et al., 2018). Defensive motivational system activation is elicited, including central processes (e.g., attention, emotion, and interoception; Eijsker et al., 2021; Kumar et al., 2017) and peripheral autonomic arousal (i.e., sympathetic nervous system activation; Edelstein et al., 2014). This activation is accompanied by overt behaviors congruent with freeze (e.g., hypervigilance), flight (e.g., escape and avoidance behavior), and fight (verbal aggression toward individuals generating triggers) responses (e.g., Brout et al., 2018; Jager et al., 2020; Rouw & Erfanian, 2018; Swedo et al., 2021). When triggered by misophonic cues, individuals may experience unpleasant cognitions congruent with their affective state, including, for example, anger-related (e.g., “He is making those noises on purpose to bother me”) and disgust-related thoughts (e.g., “I can’t believe he is clearing his throat like that”). Although it has received relatively less empirical attention than other emotions such as anger and anxiety, it is possible that disgust in misophonia may be both biologically- (e.g., “That sound she makes while eating is gross”) and socially-mediated (e.g., “She knows better than to make that sound in this kind of setting”). After the offset of triggering cues, individuals with misophonia may regard their reactions as unreasonable and experience cognitions involving shame, such as “I’m ashamed of being this way, but I don’t know how to stop” (Edelstein et al., 2013; Rouw & Erfanian, 2018; Schneider & Arch, 2017; Taylor, 2017).

Although sufferers often attempt to avoid, escape, or otherwise control situations with triggering sounds, there are contexts in which such preferred responses are difficult or impossible. In the event the individual is triggered and such cues cannot be escaped from or discontinued, people with misophonia may attempt to mimic the sound (e.g., eating something crunchy when triggered by someone crunching near them; Swedo et al., 2021). Mimicry has not been well studied in misophonia. However, there are at least several possible hypotheses for the function of mimicry in misophonia. For example, mimicry may function to down-regulate negative emotions via negatively reinforced distraction or avoidance, limiting exposure to the offending stimulus. Alternatively, mimicry could function to enhance self-efficacy, leading to the subjective experience of being able to control the otherwise uncontrollable situation, thereby resulting in the reduction of negative emotions. Another possibility is that mimicry could have a communication function as an indirect expression of aggression (i.e., being “passive-aggressive”) toward the source of the misophonic cue. Finally, mimicry in misophonia may be the result of heightened neural responses to triggering sounds in systems regulating orofacial behavior, suggestive of a possible role of mirror neuron responses underlying reactions to triggering cues (Kumar et al., 2021).

Misophonia is associated with functional impairment ranging from mild to severe, including interpersonal, academic, and occupational dysfunction (e.g., Swedo et al., 2021; Wu et al., 2014). For example, sufferers may have difficulty concentrating at work or may work during off-hours or at home to avoid contact with triggering stimuli. Individuals may limit their social activities by, for example, avoiding movie theaters, restaurants, or meals with family members, straining valued relationships and causing psychological distress. Anger and irritation in anticipation and response to triggering cues can cause arguments with others, including loved ones. In extreme cases

of impairment we have seen in our clinic, individuals with misophonia may be unable to work or maintain close relationships.

Although the prevalence of misophonia is unknown, studies with university students in the United States, China, and the United Kingdom have reported that 12% to 20% of adults had moderate or higher symptoms of misophonia (Naylor, et al., 2020; Wu, et al., 2014; Zhou et al., 2017). Higher symptoms of misophonia are positively correlated with a wide range of vulnerability factors for psychopathology, including but not limited to anxiety, trait neuroticism, perfectionism, and difficulties with emotion regulation (Cassiello-Robbins et al., 2020; Jager et al., 2020; McKay et al., 2018; Quek et al., 2018; Wu et al., 2014). The association between greater misophonia symptoms and problems with mental health has been reported in a growing number of countries, including China, Singapore, Brazil, Spain, Poland, the Netherlands, the United Kingdom, and the United States. Although little is known about the influence of cultural factors on the etiology, course, or prognosis of misophonia, the empirical evidence to date suggests it is found among many diverse countries and cultures. Additionally, studies have been conducted using online samples (e.g., Rouw & Erfanian, 2018), university and medical students (Naylor et al., 2020; Wu et al., 2014; Zhou et al., 2017), community samples (e.g., Cassiello-Robbins et al., 2020; Cassiello-Robbins et al., 2021) and treatment seeking individuals (Ferrer-Torres & Giménez-Llort, 2021; Jager et al., 2020; Quek et al., 2018; Schröder et al., 2013). The diversity of sampling approaches is further evidence that misophonia can be studied in the general population.

Research investigating the relationship between misophonia and psychiatric disorders has rapidly accelerated since 2013. Early studies concluded, prematurely, that misophonia should be considered an obsessive-compulsive psychiatric disorder (Schröder et al., 2013). Over time, the empirical data has pointed toward the possible conclusion that misophonia is not uniquely associated with any one specific psychiatric disorder or class of disorders (Erfanian et al., 2019; Jager et al., 2020). Instead, it appears to co-occur with higher symptoms of psychopathology across a growing list of psychiatric disorders, including anxiety, mood, trauma-related, obsessive-related, eating, and personality disorders (Cassiello-Robbins et al., 2020; Cassiello-Robbins et al., 2021; Claiborn et al., 2020; Erfanian et al., 2019; Jager et al., 2020; Rouw & Erfanian, 2018). That said, early findings suggest that anxiety may have a prominent role in the relationship between misophonia and psychopathology (e.g., Cassiello-Robbins et al., 2021; Siepsak et al., 2020). As an example, one study found that anxiety significantly mediated the relationship between misophonia symptoms and rage (Wu et al., 2014). These findings are congruent with research indicating that sensory over-responsivity is a vulnerability factor associated with higher anxiety (Carpenter et al., 2019; McMahon, et al., 2019).

There are a host of methodological problems limiting the conclusions that can be made about which psychiatric disorders are most-likely to co-occur with misophonia. No studies have been done with children, and no psychometrically validated assessment measures have been published in support of research examining the onset, course, and co-occurrence of other disorders in children with misophonia. This, despite data indicating that the average age of onset of misophonia may be between the ages of 10-12 years (Kumar et al., 2014; Rouw & Erfanian, 2018). In addition, little research has been done with men, minoritized individuals, and individuals with low education. These are major limitations that preclude clear inferences about the nature and features of misophonia.

In addition, with few exceptions (Jager et al., 2020), most studies exploring the relationship between misophonia and psychiatric disorders have recruited small samples (e.g., Cassiello Robbins et al., 2021) or relied on self-report of select psychiatric diagnoses (e.g., Rouw & Erfanian, 2018). Self-report is an inexpensive and convenient yet problematic method for the reliable and valid assessment of psychiatric disorders. Chief among the many limitations is the problem that participants do not always know which specific diagnoses they have been given by mental health or medical providers in their lifetime. Because they include behaviorally specific probes to clarify symptoms and can include assessments of all psychiatric disorders, psychometrically validated interviewer-rated measures are advantageous over self-report approaches.

Unfortunately, no studies have used comprehensive interviewer-rated psychiatric diagnostic measures to assess the prevalence of mental health disorders in a large community sample of individuals with misophonia. The largest sample to date found relatively low rates of co-occurring disorders among a treatment-seeking sample of Dutch adults (Jager et al., 2020). However, in this sample, the interview used to assess psychiatric disorders did not include all psychiatric disorders, and participants were excluded if they reported many psychiatric co-morbidities during study enrollment. Taken together, limitations in the methodologies of most research studies have yielded inadequately limited inferences about the precise relationship between misophonia and psychiatric disorders. Until additional rigorous research is done using structured and psychometrically validated psychiatric diagnostic interviews (e.g., Erfanian et al., 2019; Jager et al., 2020) for children, adolescents, and adults, it is premature to arrive at definitive conclusions about the nature of the relationship between misophonia and psychiatric disorders.

Considering Misophonia as a New Psychiatric Diagnosis

Misophonia is not a diagnosis in the International Classification of Diseases-10th edition (ICD-10) or the DSM-5 (American Psychiatric Association, 2013). Should it be a new psychiatric diagnosis in the next iteration of the DSM? As of now, there are insufficient scientific data from methodologically limited studies to warrant a new diagnosis. That could change with significant investments in funding from philanthropic, foundation, and government stakeholders. Indeed, the Misophonia Research Fund was recently launched to fund projects dedicated to the study of misophonia. This is a major step, but likely will need to be followed by more funding entities around the world for research to yield the amount and quality of data needed to justify misophonia as a new psychiatric disorder.

Significantly more research is needed to elucidate the etiology, underlying mechanisms, correlates, and course of misophonia. Without such data, it is difficult to imagine how misophonia could reasonably be considered as a unique diagnostic entity. Further, it is unknown whether misophonia should be appropriately considered for inclusion into the psychiatric nosology, or that of another discipline. Indeed, the original clinical descriptions of misophonia were observed during the treatment of hearing disorders, such as tinnitus and hyperacusis, unrelated to psychiatric disorders (Jastreboff & Jastreboff, 2001). As a neurophysiological condition commonly labeled as a disorder of sound intolerance, it is important to question whether it should be considered a mental health problem. While research is conceived and conducted examining misophonia, it will be beneficial to prevent the tail from wagging the proverbial dog on this topic. To do this, studies are needed using multi-disciplinary perspectives not limited to mental health (e.g., audiology, occupational therapy, cognitive, affective, and social neuroscience). In addition, as the nature of misophonia is empirically investigated in this manner, it is critical that studies are done using assumptions from both a traditional medical model and unconventional dimensional models.

What to Do Without a Diagnosis? Considerations for Assessing and Treating Misophonia

Given the novelty of the condition and the lack of evidence-based principles defining best practices for assessing and treating misophonia, one of the guiding principles we suggest is to take a multidisciplinary approach. Misophonia appears to have roots in audiological, neurological, and emotional systems. Therefore, providers including (but not limited to) audiologists, neuropsychologists, primary care doctors, occupational therapists, and clinical psychologists can offer diverse perspectives with regard to assessment and treatment planning. Given our own expertise, we will focus on the role clinical psychologists and other mental health providers can play in this process.

Assessment. Assessment of a newly described clinical presentation like misophonia poses practical challenges. In the absence of objective measures and formal diagnostic criteria, clinicians rely on a combination of idiographic assessment (e.g., functional analysis) and nomothetic self-report assessments. To date, however, most self-report measures of misophonia have not been developed using rigorous psychometric approaches. Next, we provide an overview of several commonly used and recently developed self-report measures of misophonia.

The Misophonia Questionnaire (MQ; Wu et al., 2014) was created based on a literature review and clinical experience, and has three subscales: (a) frequency of specific trigger sounds, (b) frequency of certain emotions and behavioral responses to trigger sounds, and (c) overall perception of severity of sound sensitivities. This last subscale is a single item ranging from 1 to 15 that asks the participant to indicate how severe the impact of their sound sensitivity is on their life, with higher scores indicating greater impact. The authors suggest a score above 6 indicates clinically significant symptoms. The authors sampled college students and reported good internal consistency and preliminary convergent and discriminant validity. Although the initial psychometrics for the MQ are promising, the use of a university sample renders its generalizability unclear to the broader population of misophonia sufferers. Additionally, the use of a

single self-reported severity item limits psychometric evaluation. Despite these limitations, the MQ has been widely used in recent studies (Cassiello-Robbins et al., 2020; Daniels et al., 2020; Frank & McKay, 2019; Frank et al., 2020; McKay et al., 2018; Zhou et al., 2017) and has been influential in the early scientific findings in this field.

The Amsterdam Misophonia Scale (A-MISO-S; Schröder et al., 2013; AMISO-Revised; Jager et al., 2020) has 6 items using a Likert-type scale that assess, during the past week: time occupied by misophonic sounds, interference with daily functioning caused by trigger sounds, distress caused by misophonic sounds, efforts to resist thoughts about trigger sounds, control over thoughts about misophonic sounds, and avoidance caused by misophonia. A final item is used for free responses and assesses the worst feared consequence of not being able to avoid misophonic triggers.

The revised A-MISO was preliminarily validated in a sample of medical students and demonstrated good internal consistency (α = .81; Naylor et al., 2020). Items were not generated and refined using psychometric analyses. Instead, items were adapted from the Yale-Brown Obsessive-Compulsive Scale (Goodman et al., 1989) to be aligned with the assessment of obsessive-compulsive disorder (OCD). Although Schröder and colleagues (2013) reported that misophonia is associated with higher symptoms of obsessive-compulsive disorders, others have found that misophonia is negatively correlated with some features of OCD, and positively correlated with other features, suggesting a complex relationship between misophonia and OCD symptoms (McKay et al., 2018). Put more simply, misophonia does not appear to be uniquely and specifically related to OCD (Jager et al., 2020). Still, the original A-MISO-S and A-MISO-R have been widely used in misophonia research, and the instrument is promising as a useful and brief measure (Eijsker et al., 2019; Erfanian et al., 2018, 2019a, 2019b; Jager et al., 2020; Kluckow et al., 2014; Natalini et al., 2020; Naylor et al., 2020; Quek et al., 2018; Rouw et al., 2017; Schröder et al., 2014).

The MisoQuest (Siepsiak et al., 2020) was created based on proposed criteria for a diagnosis of misophonia (Schröder et al., 2013), and used exploratory factor analysis, confirmatory factor analysis, and item response theory (IRT) analyses. There are 14 items, with higher scores indicating greater misophonia severity, and the authors suggest a score of 61 be used for clinical cut off. Initial reports suggest good reliability (.96) and test-retest reliability (.84). Although this measure is psychometrically robust, the item pool was limited to one proposed set of diagnostic criteria. Other diagnostic criteria for misophonia have been proposed (Dozier et al., 2017; Swedo et al., 2021), and, to date, the nature and boundaries around the construct of misophonia continue to be undefined (Taylor, 2017). In addition, this measure was written and validated with a Polish sample, rendering it unknown whether the MisoQuest is a reliable and valid measure for individuals with English as a first language. Because it was developed with rigorous attention to psychometric validation, the MisoQuest is a measure warranting further cross-validation in English-speaking and other diverse samples.

The Selective Sound Sensitivity Syndrome Scale (S-Five; Vitoratou et al., 2020) is new self-report measure under development and in pre-print form. This scale was developed by the authors and has undergone three large waves of data collection and psychometric evaluation using community samples of adults. The S-Five has been subjected to rigorous psychometric analyses and consists of five factors: internalizing appraisals, externalizing appraisals, perceived threat and avoidance behavior, outbursts, and impact on functioning. In light of the extensive psychometric procedures being used in its development, this new measure holds promise and should be further studied.

Most recently, the Duke Misophonia Questionnaire (DMQ; Rosenthal et al., 2021) was developed using qualitative feedback from multiple stakeholders (sufferers, family members, experts) to derive and refine items before conducting factor analyses and IRT analyses in a large community sample of adults. The DMQ was constructed for clinicians or researchers to assess any or all of the following subscales: (1) trigger intensity, (2) cognitive, physiological, affective, and behavioral responses to triggers, (3) coping strategies before, during, and after being triggered, (4) beliefs associated with misophonia, and (5) functional impairment caused by misophonia. The manuscript is in pre-print form, and reports excellent reliability and construct validity for the overall scale, subscales, and composite subscales measuring overall symptoms and impairment.

The development and evaluation of these measures is a critical step needed to characterize the nature of misophonia. However, there can be a long gap in time between when a construct is defined and measures are validated to when a diagnosis is officially accepted by the clinical community in the DSM. The study of nonsuicidal self-injury (NSSI), for example, began as a construct and symptom in borderline personality disorder and evolved into nonsuicidal self-injury disorder (NSSI-D), now defined in the DSM-5. Although clinical interest in NSSI dates at least back to Karl Menninger's work around self-mutilation in the 1930s (Menninger, 1935), the terms and definitions have changed in recent years. Over time, defining the parameters of NSSI helped to study samples of interest, obtain more accurate prevalence rates, and pave the way for entry in the DSM-5 as a distinct clinical condition. Concurrent to this evolution were the development and validation of self-report and interview measures to assess NSSI, which followed the progression of how NSSI was defined and classified (Gratz et al., 2015).

In approaching the assessment of misophonia, a helpful first step is to define the aims of assessment. Whereas the goal in evaluating an established disorder, such as major depressive disorder, may involve assessment of diagnostic criteria, the goals in evaluating a new condition like misophonia are different. In our own clinic and research studies, the aims in assessing misophonia are twofold: firstly, learning what misophonia is and what it is not; and secondly, creating useful tools for clinicians to understand relevant symptoms among those with misophonia. Many of our participants report telling healthcare providers about misophonia and receiving mixed responses, ranging from possible misdiagnoses to blank stares and shrugged shoulders. Introducing tools for providers to use when patients endorse symptoms of this under-recognized condition can provide validation to the patient, as well as lend helpful insight into case conceptualization and treatment approaches.

To achieve our first aim of better understanding misophonia, we are conducting a large-scale phenotyping study assessing mental health conditions that may or may not overlap with misophonia. Prevalence rates of co-morbid disorders gathered from the Structured Clinical Interview for DSM-5 (SCID-5; First et al., 2016) can help establish nomothetic overlap and divergence from other existing disorders. For example, through prevalence rates of co-morbid conditions, we are beginning to see data suggesting that misophonia is distinct from any specific disorder (similar to what was observed in Jager et al., 2020) and that a large number of adults with high misophonia symptoms meet criteria for an anxiety disorder.

To achieve the second aim of clinical utility, we are developing multimodal assessment tools (the DMQ and a similarly structured semi-structured clinical interview, which we have called the Duke Misophonia Interview and is currently be psychometrically validated) to quantify relevant symptoms in misophonia. These tools are meant not only to continue sculpting our understanding of misophonia by gathering qualitative information from people with the condition, but also to serve as useful for healthcare providers with varying familiarity of the condition. Given that cut-points do not exist for diagnostic thresholds, we have used dimensional coding schemes integrating frequency and intensity ratings. Not only does dimensionality help overcome the challenge of assessing an undefined disorder, but assessment on a spectrum is also in line with the National Institute of Mental Health's Research Domain Criteria initiatives.

In addition to defining and classifying underrecognized disorders, an important outcome of measure development for novel conditions involves treatment. Psychological processes of change identified in assessment can then be further examined through treatment development. The constructs studied through assessment may then become theory- and data-driven processes of change, enabling analyses of both moderators and mediators of treatment effects. As such, assessment informs thoughtful interventions, wherein we can begin to answer questions about which treatments work for whom, and why, among individuals with misophonia.

Treatment: Applying Evidence-Based Processes to Novel Conditions

Practical challenges accompany the delivery of psychological interventions to novel conditions. If a presenting problem has an unfamiliar name, it can be challenging for clinicians to determine treatment approaches most likely to help. This can lead to clinicians not being willing to treat the individual, using a treatment known to work for a condition that seems superficially similar (e.g., exposure therapy works for anxiety disorders, misophonia occurs with high anxiety, therefore use an exposure therapy for misophonia), or use an approach that is not tailored to the individual in a rigid manner (e.g., always use X sessions of cognitive therapy, muscle relaxation, counterconditioning, and the like).

Preliminary treatment studies for misophonia have been conducted, primarily using cognitive behavioral therapies (CBTs). Case studies (Altınöz et al., 2018;

Bernstein et al., 2013; Muller et al., 2018; Schneider & Arch, 2017), case series (Frank & McKay, 2019), open trials (Schröder et al., 2017), and one randomized controlled trial using a waitlist control (Jager et al., 2020) support the use of evidence-based strategies for behavior change including interventions within the broad family of CBTs. Moreover, behavioral interventions grounded in models of classical conditioning have begun being developed and tested for misophonia that use a range of counterconditioning procedures (e.g., Dozier, 2015a, 2015b; Frank & McKay, 2019; Jastreboff & Jastreboff, 2014).

CBTs include a large number of psychological interventions, including those that are primarily behavioral (e.g., assertiveness skill training) or cognitive (e.g., cognitive therapy), as well as those that represent earlier (e.g., conditioning-based procedures) and more recently developed (e.g., cognitive diffusion, inhibitory learning-based exposure) therapies. Because emerging evidence suggests misophonic sounds are associated with a range of emotional responses, most often anger, anxiety, and disgust (Cassiello-Robbins et al., 2021; Edelstein et al., 2013; Frank & McKay, 2019; Jager et al., 2020), one reasonable approach to treatment is the use of interventions in the family of CBTs that target changes in emotional functioning and associated process (e.g., conditioning, learning, attention). Most psychiatric disorders shown to be associated with misophonia are characterized by difficulties with emotion, including anxiety, depressive, obsessive-compulsive, and personality disorders (Cassiello-Robbins et al., 2021; Frank & McKay, 2019; Jager et al., 2020). Further, the lack of association between misophonia and one specific disorder or class of disorders suggests the condition may be related to transdiagnostic psychological processes, rather than a specific set of symptoms. Indeed, preliminary evidence suggests misophonia is associated with

Table 1. UP Modules Applied to Misophonia

Module	Module Focus	Relevance to Misophonia
Motivation Enhancement	Setting goals, increasing motivation for treatment	Build motivation for treatment
Psychoeducation	Psychoeducation about the adaptive nature of emotions	Reduce the perception of emotions associated with misophonia as uncontrollable or unacceptable
Mindful Emotion Awareness	Non-judgmental, present-focused awareness of emotions	Improve ability to deploy attention, reduce hypervigilance toward misophonic cues
Cognitive Flexibility	Developing balanced, flexible thinking	Reduce unhelpful attributions of self and others when hearing or anticipating misophonic sounds
Countering Emotional Behaviors	Changing the action tendencies associated with strong emotions	Respond to emotions in ways that are consistent with long-term goals
Awareness and Tolerance of Physical Sensations	Interoceptive exposure	Reduce need to escape situations due to physical discomfort
Emotion Exposure	Reduce avoidance of emotion-provoking stimuli	Engage in valued activities that were previously avoided due to misophonia
Relapse Prevention	Planning for continued practice	Maintain gains once treatment ends

neuroticism and difficulties regulating emotions (Cassiello-Robbins, Anand, et al., 2020), which are often considered vulnerabilities for developing a range of psychiatric conditions (Aldao, 2012; Barlow et al., 2014; Brown & Naragon-Gainey, 2013). When it comes to psychological treatment, we recommend that mental health providers help patients moderate their emotional responses and cope with misophonic cues in a way that is aligned with their values and long-term goals. It is reasonable to hypothesize that a transdiagnostic treatment targeting core, underlying processes relevant across difference diagnoses may be beneficial. We are currently exploring the acceptability, feasibility, and preliminary efficacy in two such treatments: The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow, 2018) and process-based therapy for misophonia (PBT; Hofmann & Hayes, 2019).

The Unified Protocol Applied to Misophonia. The UP is a transdiagnostic, emotion-focused cognitive behavioral treatment that intervenes on a functional model of emotional disorders. In this model, emotional disorders are characterized by: (1) the experience of frequent, intense emotions, (2) the perception of these emotions as uncontrollable, unacceptable, or aversive, and (3) engagement in efforts to escape, avoid, or control the emotions (Sauer-Zavala & Barlow, 2014). These avoidance-based emotion regulation strategies typically provide short-term relief from strong emotions but interfere with patients' functioning in the long-term. To intervene on this model, therapists in the UP teach patients empirically supported cognitive and behavioral skills (e.g., mindfulness, cognitive flexibility) to cultivate an accepting attitude toward the experience of strong emotions, in order to reduce the perception of these emotions as aversive and subsequent reliance on avoidance-based emotion regulation strategies that are ultimately ineffective. This treatment is comprised of eight modules that cover commonly taught skills in across CBTs (see Table 1). A full description of the UP is beyond the scope of this paper and can be found in Wilamowska et al. (2010). Evidence, including a meta-analysis and a systematic literature review, support the use of the UP to treat heterogeneous emotional disorders including anxiety, depressive, and related (e.g., obsessive-compulsive, trauma-related) disorders, as well as problems that often co-occur with these conditions (e.g., substance misuse, self-injurious behavior), and problems with emotional functioning that do not meet diagnostic criteria for a DSM-5 disorder (e.g., dysregulated anger; Cassiello-Robbins, Southward, et al., 2020; Sakiris & Berle, 2019).

Accumulating evidence suggests misophonia may be a condition congruent with the described model of emotional disorders. Patients with misophonia report strong emotions in response to misophonic cues (Edelstein et al., 2013; Frank & McKay, 2019; Jager et al., 2020; Rouw & Erfanian, 2018). Further, they report these emotions, particularly anger, are very upsetting to them, suggesting the emotions are perceived as aversive (Edelstein et al., 2013; Schröder et al., 2013). Finally, a number of studies highlight that individuals with misophonia often engage in avoidance-based emotion regulation strategies in response to misophonic cues (Frank & McKay, 2019; Jager et al., 2020). Thus, from a theoretical standpoint there is an emerging rationale supporting the experimental use of the UP when treating individuals with misophonia. Further, the heterogeneity of conditions that co-occur with misophonia, and the UP's demonstrated ability to target a wide range of psychiatric disorders, also suggest the UP may be an appropriate treatment for misophonia.

Table 1 provides an overview of how the UP skills can apply to misophonia. The flexibility inherent within this protocol makes it possible to target misophonia as well as co-occurring conditions or problems that may take priority (e.g., self-harm, problematic substance use, severe anxiety). Currently, there are studies underway to explore the acceptability, feasibility, and preliminary efficacy of the UP applied to misophonia (e.g., Lewin et al., 2021).

Process-Based Therapy (PBT) for Misophonia. In contrast to manualized treatments like the UP, which typically follow a prescribed sequence of interventions applied to all patients, a PBT approach uses evidence-based processes of change where therapists apply a wide range of interventions (including but not restricted to those in the UP), while offering flexibility in the selection, timing, and presentation of these skills (Hofmann & Hayes, 2019). Unlike branded evidence-based treatments (e.g., Dialectical Behavior Therapy; Linehan, 1993; Acceptance and Commitment Therapy; Hayes, Strosahl, & Wilson, 1999), PBT provides an overarching framework for interventions that is not limited to a specific protocol. Instead, it is guided by several principles. As outlined by Hayes, Hofmann, and Wilson (2020), processes of change in PBT are: (1) theory-based, (2) dynamic, (3) progressive, (4) contextually bound and modifiable, and (5) multi-level.

PBT for misophonia would be theory-based, insofar as the interventions used would be explicitly linked to testable hypotheses with transdiagnostic mediating variables affecting change. This could, for example, include using progressive muscle relaxation as a therapeutic procedure in order to reduce autonomic arousal in certain contexts, with the hypothesis that reduced arousal will subsequently cause reductions in aggressive behavior. Second, PBT for misophonia would be dynamic, as processes of change may have feedback loops that are non-linear. An example of this could be the use of mindfulness practice when anticipating being triggered, with increases in mindful awareness of the present causing increased distress initially, followed by recursive loops of gradually reducing distress as mindfulness continues to be used. Third, PBT for misophonia is progressive, with interventions sometimes needing to be sequentially arranged to achieve the desired outcome. As an example, for some patients, cognitive reappraisal or diffusion may need to be learned first to optimize the effects of inhibited learning models of exposure in an acceptable manner to patients. Fourth, because PBT for misophonia is contextually bound and modifiable, processes of change will need to be adapted and tailored to align well with the clinician or clinical setting. PBT interventions need to be feasibly disseminated, and cannot be out of reach for clinicians. Finally, PBT for misophonia is multilevel, as some processes of change may be nested as constituent parts in relation to other processes. As an example, in order to decrease inhibitory behaviors under the control of certain affective states (e.g., anger), patients with misophonia may first need to learn to become aware of and learn to differentiate emotional experiences (e.g., discriminate anger from shame, anxiety, or disgust).

In PBT, a collaborative decision-making model is used which is informed by the therapist's case conceptualization and patient preference to determine the sequence of interventions for each patient. Thus, the specific interventions can be tailored well to each patient based on what the patient needs and clinician capabilities. After an initial psychosocial evaluation, PBT for misophonia commonly begins with functional analyses, hypothesis testing, idiographic data collection (e.g., self-monitoring), and collaborative treatment planning. When using PBT for misophonia, the first sessions also are spent developing rapport and a strong therapeutic alliance by learning about the patient's goals for treatment, orienting the patient to treatment, addressing potential treatment interfering problems, and conducting functional analyses of misophonic experiences to inform case conceptualization. Functional analyses focus on understanding what is happening with the patient's attention, behavior, cognition, physiology, and interpersonal processes before, during, and after exposure to misophonic cues across a range of contexts (See Table 2). The result is the emergence of a case formulation that is contextually derived, yielding problematic patterns (e.g., confrontational behavior when anticipating being triggered) driven by maladaptive psychological processes (e.g., impulsive aggression when emotionally aroused) that can be intervened upon using transdiagnostic and empirically supported procedures (e.g., emotional awareness and differentiation, cognitive reappraisal, diffusion).

Based on a shared understanding of common patterns related to misophonia-related distress, the therapist and patient collaboratively identify priorities for treatment targets, identifying capabilities associated with a prior learning history using a strengths-based approach. Accumulating literature suggests starting treatment with a skill that builds of a patient's existing strengths leads to more efficient treatment (e.g., Cheavens et al., 2012). For example, if a patient indicates they are already using some informal cognitive restructuring when triggered, yet is still bothered by the thoughts they have when hearing misophonic sounds, the therapist and patient may agree to start with cognitive skills such as cognitive diffusion or cognitive reappraisal.

As sessions continue in PBT for misophonia, data are collected and used to evaluate whether targeted adaptive psychological processes are resulting from therapeutic procedures, and whether targeted outcomes are being achieved. Prioritized patterns for change can be modified at any point in time, and the planned sequence of therapeutic interventions can change during the course of treatment. Sessions therein include (a) review and problem-solving efforts to implement and generalize newly learned responses in contexts associated with functional impairment, (b) functional analysis of target patterns, (c) shared decision-making about the prioritized pattern to change, (d) relevant psychological process implemented to intervene on the prioritized pattern via appropriate evidence-based therapeutic procedures, and (e) assigning and troubleshooting home practice applications of the therapeutic intervention in relevant naturalistic contexts. To further illustrate this approach, two examples of PBT for misophonia treatment plans are outlined in Table 3. PBT has been recommended as a framework for integration of empirically supported interventions as part of moving beyond the medicalized model of manualized branded treatment approaches for specific psychiatric disorders (Ong et al., 2020). No studies using a PBT model of treatment for misophonia have been conducted, though case studies using interventions that align well with PBT have been conducted (Schneider and Arch, 2017), and our group is currently conducting a pilot trial using a single case series design while developing and initially evaluating the feasibility and acceptability of PBT for misophonia.

Table 2. Example Patterns and Priorities Worksheet in PBT for Misophonia

PATTERNS		*TIME IN RELATION TO BEING TRIGGERED*		
		Before Trigger Starts	**During Trigger**	**After Trigger Stops**
SKILL AREAS	**Attentional** (where you look and focus)	Hypervigilant and unable to focus 2	Unable to turn away from triggering cues 2	Hypervigilant and unable to focus 9
	Behavioral (what you do)	Avoidance Headphones	Freeze Escape Impulsivity 4	Isolate or avoid people 6
	Physiological (how your body feels)	Tension rising Breathing shallow 3	Tension in shoulders Bite lip Chest tighten 3	Body feels tense, on edge 10
	Interpersonal (how you communicate)	Say nothing, inhibit, and pretend I am OK	Indirect aggression Confront partner verbally 5	Say something to block another trigger 8
	Cognitive (what and how you think)	Worry rumination 7	Why can't it stop? Why does he/she/they do this? 8	Hopelessness Self-criticism 1

*Notes. Each box reflects a problematic pattern identified through functional analyses. Numbers reflect relative priorities for targeting specific patterns. Priorities are determined collaboratively, based on patient reported level of distress, impairment in functioning, and motivation to change. Priorities can change during treatment as needed and in alignment with patient goals. Some patterns may not be prioritized for change, and others may have same priority value. Each pattern can be addressed using transdiagnostically empirically supported interventions.

Research Agenda

We have argued that scientific research has not yielded a clear and compelling conclusion that misophonia warrants a unique diagnosis in any nosology. This, despite the exciting discoveries made about the clinical features (Jastreboff & Jastreboff, 2001), phenotypic characteristics (Erfanian & Rouw, 2018; Dozier, 2017, Jager et al., 2020, McKay et al., 2018) possible neural underpinnings (Eijsker et al., 2021; Kumar et al., 2017; Kumar et al., 2021), and the first randomized trial showing promise using a CBT-based group therapy for misophonia (Jager et al., 2021). Indeed, an extensive amount of scientific research must be done in order to replicate and extend these initial studies in order to more definitively pinpoint the unique features, etiology, course, and treatment of misophonia.

Below are 10 suggested steps needed as part of a research agenda to advance insights about misophonia needed to discern if misophonia should

Table 3. Two Examples of Possible PBT Treatment Plans for Misophonia

Session Number	Treatment Plan	
	Patient 1	Patient 2
1	Introduction to treatment, goal setting, begin functional analysis	Introduction to treatment, goal setting, begin functional analysis
2	Continue functional analysis	Continue functional analysis
3	Mindfulness of thoughts after triggered	Values clarification and psychoeducation
4	Mindfulness of impulsive urges when triggered	Cognitive reappraisal when triggered
5	Reducing vulnerability to emotion regulation difficulties (e.g., exercise, medication compliance)	Cognitive reappraisal before triggered
6	Reducing emotional arousal before triggered using muscle relaxation	Cognitive reappraisal after triggered
7	Cognitive defusion after triggered	Cognitive defusion anticipating triggers
8	Cognitive reappraisal after triggered	Behavioral activation in valued contexts with possible triggers
9	Cognitive reappraisal before triggered	Behavioral activation in valued contexts with possible triggers
10	Emotion differentiation and exposure to emotions (anxiety) when not triggered	Inhibitory learning-based exposure
11	Emotion differentiation and exposure to emotions (anger) when not triggered	Inhibitory learning-based exposure
12	Communication skills before triggered	Inhibitory learning-based exposure
13	Communication skills when triggered	Inhibitory learning-based exposure
14	Distress tolerance after triggered	Inhibitory learning-based exposure
15	Family member/partner psychoeducation and problem-solving	Cognitive defusion around sense of self
16	Relapse prevention	Relapse prevention

be a unique diagnosis. Across recommendations, studies need to ensure that findings are attributable to misophonia, and not to related but dissimilar phenomena.

First, we recommend studies use large and diverse samples, with particular attention to understudied individuals in research investigating misophonia, including men, diversity in gender and sexuality, Black, Hispanic, and other under-represented minorities, and people with lower education and lower income. Findings from studies with such diverse and representative samples would help clarify if the results are generalizable from previous studies using largely college-educated White women. Second, we recommend studies use clinical control groups or controlling for clinically-relevant features, traits, or related conditions using other experimental or statistical methods. This is a glaring omission in the extant research on misophonia. Until studies control for clinical confounds (e.g., general psychological distress, negative emotions, trait neuroticism, anxiety, and so on), it will be difficult to interpret findings from studies to be unique to misophonia.

Third, we recommend the use of prospective, longitudinal, and epidemiological research, as there are no published studies examining the natural course, variability, incidence, or prevalence of misophonia. Without such information, it will be difficult to understand the onset, trajectory, and scope of the problem in the general population. Fourth, studies are needed with children and adolescents, as little is known scientifically about the onset and course of misophonia, though it may begin in childhood or early adolescence for most people. Fifth, studies examining misophonia need to use psychometrically validated measures, as most of the measures used to date have little to no demonstrated reliability or validity.
Sixth, studies are needed using models of psychopathology that consider both a medical model and dimensional approaches to characterize the nature of misophonia. It should not be assumed that the features of misophonia conform to the assumptions of the current model undergirding the DSM. Seventh, studies are needed that use laboratory-based and ecologically valid naturalistic methods (e.g., ecological momentary assessment, passive monitoring via mobile phones) to identify candidate neurobiological and behavioral markers that are sensitive and specific to misophonia. Eighth, research is needed across countries and cultures, to broadly understand variations in the expression of misophonia cross-culturally. Nineth, etiological and translational studies using paradigms from genetics, developmental psychology, neuroscience, psychiatry, audiology, and occupational therapy are needed to discover the range of biological and environmental influences on misophonia. This research would help avoid the tail wagging the dog, wherein the nature of misophonia becomes constrained by the assumptions and methods used by those who study it from within the biases of their trained discipline.

Finally, treatment studies are needed using multi-disciplinary approaches and discipline-specific interventions tested using contemporary methods for randomized controlled trials (e.g., adaptive designs). In light of the wide range of co-occurring disorders, treatment approaches should not rely on narrow theoretical models suited for those with no co-occurring psychiatric disorders. Additionally, we contend that treatments tested should be aligned with principles of population health models of care delivery (e.g., brief, easy to administer, measurement-based), in order to enhance scalability and dissemination efforts.

Conclusions

Misophonia is a newly defined constellation of symptoms that recently received a consensus definition by experts (Swedo et al., 2021). Despite recent advances in understanding misophonia, key limitations in the methodologies from previous research studies must be overcome before clear and definitive conclusions about the nature of misophonia are warranted. Although inclusion as a disorder in any nosology could be advantageous for many stakeholders (e.g., patients, loved ones, clinicians, researchers), at present, it is premature. Considerably more rigorous research is needed using, for example, interdisciplinary teams, larger and more diverse samples, psychometrically validated measures of misophonia, clinical control groups, prospective models, and experimental designs capable of inferring possible causality.

In the interim, we recommend using assessment measures that are reasonably psychometrically validated and aligned with the expert consensus definition of misophonia (Swedo et al., 2021), including the MisoQuest (Siepsak et al., 2020), S-five (Vitoratou et al., 2020), and Duke Misophonia Questionnaire (Rosenthal et al., 2021). Despite the absence of scientific knowledge, reasonable treatments must be used to help people currently presenting for treatment with misophonia. We recommend, where possible, beginning with a multi-disciplinary framework for

evaluation and treatment recommendations. This approach could include evaluations from audiology (assessment and interventions for sensitivity to sounds), occupational therapy (assessment and interventions for multi-sensory sensitivity), and mental health (assessment and interventions for problematic patterns of behavior, cognition, physiological arousal, attention, and interpersonal functioning). Behavioral therapies using empirically supported transdiagnostic procedures are recommended. This could include branded therapies such as UP or ACT, or the more flexibly and individually tailored PBT model of care.

References

Aldao, A. (2012). Emotion regulation strategies as transdiagnostic processes: A closer look at the invariance of their form and function. Revista de Psicopatología y Psicología Clínica, 17(3), 261–277. psyh. https://doi.org/10.5944/rppc.vol.17.num.3.2012.11843

Altınöz, A. E., Ünal, N. E., & Altınöz, Ş. T. (2018). The effectiveness of Cognitive Behavioral Psychotherapy in misophonia: A case report. Turkish Journal of Clinical Psychiatry, 21, 414–417.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Publishing.

Barlow, D. H. (2017). Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide (2 edition). Oxford University Press.

Barlow, D. H., Sauer-Zavala, S., Carl, J. R., Bullis, J. R., & Ellard, K. K. (2014). The Nature, Diagnosis, and Treatment of Neuroticism: Back to the Future. Clinical Psychological Science, 2(3), 344–365. https://doi.org/10.1177/2167702613505532

Bernstein, R. E., Angell, K. L., & Dehle, C. M. (2013). A brief course of cognitive behavioural therapy for the treatment of misophonia: A case example. The Cognitive Behaviour Therapist, 6, E10. doi:10.1017/S1754470X13000172

Brout, J. J., Edelstein, M., Erfanian, M., Mannino, M., Miller, L. J., Rouw, R., Kumar, S., & Rosenthal, M. Z. (2018). Investigating Misophonia: A Review of the Empirical Literature, Clinical Implications, and a Research Agenda. Frontiers in Neuroscience, 12, 36. https://doi.org/10.3389/fnins.2018.00036

Brown, T. A., & Barlow, D. H. (2009). A proposal for a dimensional classification system based on the shared features of the DSM-IV anxiety and mood disorders: Implications for assessment and treatment. Psychological Assessment, 21(3), 256–271. psyh. https://doi.org/10.1037/a0016608

Brown, T. A., Campbell, L. A., Lehman, C. L., Grisham, J. R., & Mancill, R. B. (2001). Current and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a large clinical sample. Journal of Abnormal Psychology, 110(4), 585–599. https://doi.org/10.1037/0021-843X.110.4.585

Brown, T. A., & Naragon-Gainey, K. (2013). Evaluation of the Unique and Specific Contributions of Dimensions of the Triple Vulnerability Model to the Prediction of DSM-IV Anxiety and Mood Disorder Constructs. Behavior Therapy, 44(2), 277–292. https://doi.org/10.1016/j.beth.2012.11.002

Cassiello-Robbins, C., Anand, D., McMahon, K., Brout, J., Kelley, L., & Rosenthal, M. Z. (2021). A preliminary investigation of the association between misophonia and symptoms of psychopathology and personality disorders. Frontiers in Psychology, 11, 3842.

Cassiello-Robbins, C., Anand, D., McMahon, K., Guetta, R., Trumbull, J., Kelley, L., & Rosenthal, M. Z. (2020). The mediating role of emotion regulation within the relationship between neuroticism and misophonia: A preliminary investigation. Frontiers in Psychiatry, 11.

Cassiello-Robbins, C., Southward, M. W., Tirpak, J. W., & Sauer-Zavala, S. (2020). A systematic review of Unified Protocol applications with adult populations: Facilitating widespread dissemination via adaptability. Clinical Psychology Review, 78, 101852. https://doi.org/10.1016/j.cpr.2020.101852

Cheavens, J. S., Strunk, D. R., Lazarus, S. A., & Goldstein, L. A. (2012). The compensation and capitalization models: A test of two approaches to individualizing the treatment of depression. Behaviour Research and Therapy, 50(11), 699–706. https://doi.org/10.1016/j.brat.2012.08.002

Conway, C. C., Forbes, M. K., Forbush, K. T., Fried, E. I., Hallquist, M. N., Kotov, R., Mullins-Sweatt, S. N., Shackman, A. J., Skodol, A. E., & South, S. C. (2019). A hierarchical taxonomy of psychopathology can transform mental health research. Perspectives on Psychological Science, 14(3), 419–436.

Cooksey, E. C., & Brown, P. (1998). Spinning on its axes: DSM and the social construction of psychiatric diagnosis. International Journal of Health Services, 28(3), 525–554.

Copeland, W. E., Angold, A., Costello, E. J., & Egger, H. (2013). Prevalence, Comorbidity, and Correlates of DSM-5 Proposed Disruptive Mood Dysregulation Disorder. American Journal of Psychiatry, 170(2), 173–179. https://doi.org/10.1176/appi.ajp.2012.12010132

Dozier, T. H. (2015)a. Counterconditioning treatment for misophonia. Clinical Case Studies, 14(5), 374-387.

Dozier, T. H. (2015)b. Treating the initial physical reflex of misophonia with the neural repatterning technique: A counterconditioning procedure. Psychological Thought, 2193-7281.

Dozier, T. H., & Morrison, K. L. (2017). Phenomenology of misophonia: Initial physical and emotional responses. American Journal of Psychology, 130(4), 431-438.

Edelstein, M., Brang, D., Rouw, R., & Ramachandran, V. S. (2013). Misophonia: Physiological investigations and case descriptions. Frontiers in Human Neuroscience, 7. https://doi.org/10.3389/fnhum.2013.00296

Eijsker, N., Schröder, A., Smit, D. J., van Wingen, G., & Denys, D. (2021). Structural and functional brain abnormalities in misophonia. European Neuropsychopharmacology, 52, 62-71.

First, M. B., Williams, J. B., Karg, R. S., & Spitzer, R. L. (2016). User's guide for the SCID-5-CV Structured Clinical Interview for DSM-5® disorders: Clinical version. American Psychiatric Publishing, Inc.

Forbes, M. K., Sunderland, M., Rapee, R. M., Batterham, P. J., Calear, A. L., Carragher, N., Ruggero, C., Zimmerman, M., Baillie, A. J., & Lynch, S. J. (2021). A detailed hierarchical model of psychopathology: From individual symptoms up to the general factor of psychopathology. Clinical Psychological Science, 9(2), 139–168.

Frank, B., & McKay, D. (2019). The Suitability of an Inhibitory Learning Approach in Exposure When Habituation Fails: A Clinical Application to Misophonia. Cognitive and Behavioral Practice, 26(1), 130–142. https://doi.org/10.1016/j.cbpra.2018.04.003

Gratz, K. L., Dixon-Gordon, K. L., Chapman, A. L., & Tull, M. T. (2015). Diagnosis and characterization of DSM-5 nonsuicidal self-injury disorder using the clinician-administered nonsuicidal self-injury disorder index. Assessment, 22(5), 527–539.

Gould, J. S. (Director). (2017). Quiet Please [Film]. Action Media Productions.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. Psychotherapy: Theory, Research, Practice, Training, 43(4), 531–548. https://doi.org/10.1037/0033-3204.43.4.531

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A Meta-Analysis of Cultural Adaptations of Psychological Interventions. Behavior Therapy, 47(6), 993–1014. https://doi.org/10.1016/j.beth.2016.09.005

Hayes, S. C., Hofmann, S. G., & Wilson, D. S. (2020). Clinical psychology is an applied evolutionary science. Clinical Psychology Review, 81, 101892.

Hinton, D. E., & Lewis-Fernández, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. Depression and Anxiety, 28(9), 783–801. https://doi.org/10.1002/da.20753

Hofmann, S. G., & Hayes, S. C. (2019). The Future of Intervention Science: Process-Based Therapy. Clinical Psychological Science, 7(1), 37–50. https://doi.org/10.1177/2167702618772296

Huey, S. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The Contribution of Cultural Competence to Evidence-Based Care for Ethnically Diverse Populations. Annual Review of Clinical Psychology, 10(1), 305–338. https://doi.org/10.1146/annurev-clinpsy-032813-153729

Insel, T. R. (2014). The NIMH research domain criteria (RDoC) project: Precision medicine for psychiatry. American Journal of Psychiatry, 171(4), 395–397.

Jager, I., de Koning, P., Bost, T., Denys, D., & Vulink, N. (2020). Misophonia: Phenomenology, comorbidity and demographics in a large sample. PloS One, 15(4), e0231390.

Jastreboff, M. M., & Jastreboff, P. J. (2001). Components of decreased sound tolerance: Hyperacusis, misophonia, phonophobia. ITHS News

Lett, 2(5–7).

Jastreboff, P. J., & Jastreboff, M. M. (2014). Treatments for decreased sound tolerance (hyperacusis and misophonia). Seminars in Hearing, 35(02), 105–120. Jastreboff, P. J., & Jastreboff, M. M. (2014, May). Treatments for decreased sound tolerance (hyperacusis and misophonia). In Seminars in Hearing (Vol. 35, No. 02, pp. 105-120). Thieme Medical Publishers.

Karter, J. M., & Kamens, S. R. (2019). Toward Conceptual Competence in Psychiatric Diagnosis: An Ecological Model for Critiques of the DSM. In S. Steingard (Ed.), Critical Psychiatry (pp. 17–69). Springer International Publishing. https://doi.org/10.1007/978-3-030-02732-2_2

Krueger, R. F. (2005). Continuity of Axes I and II: Toward a Unified Model of Personality, Personality Disorders, and Clinical Disorders. Journal of Personality Disorders, 19(3), 233–261. https://doi.org/10.1521/pedi.2005.19.3.233

Kumar, S., Tansley-Hancock, O., Sedley, W., Winston, J. S., Callaghan, M. F., Allen, M., Cope, T. E., Gander, P. E., Bamiou, D.-E., & Griffiths, T. D. (2017). The Brain Basis for Misophonia. Current Biology, 27(4), 527–533. https://doi.org/10.1016/j.cub.2016.12.048

Lewin, A. B., Dickinson, S., Kudryk, K., Karlovich, A. R., Harmon, S. L., Phillips, D. A., ... & Ehrenreich-May, J. (2021). Transdiagnostic cognitive behavioral therapy for misophonia in youth: Methods for a clinical trial and four pilot cases. Journal of Affective Disorders, 291, 400-408.

McKay, D., Kim, S.-K., Mancusi, L., Storch, E. A., & Spankovich, C. (2018). Profile Analysis of Psychological Symptoms Associated With Misophonia: A Community Sample. Behavior Therapy, 49(2), 286–294. https://doi.org/10.1016/j.beth.2017.07.002

Menninger, K. A. (1935). A psychoanalytic study of the significance of self-mutilations. The Psychoanalytic Quarterly, 4(3), 408–466.

Muller, D., Khemlani-Patel, S., & Neziroglu, F. (2018). Cognitive-behavioral therapy for an adolescent female presenting with misophonia: A case example. Clinical Case Studies, 17(4), 249–258.

Parens, E., Johnston, J., & Carlson, G. A. (2010). Pediatric mental health care dysfunction disorder? New England Journal of Medicine, 362(20), 1853–1855.

Rosellini, A. J., & Brown, T. A. (2014). Initial interpretation and evaluation of a profile-based classification system for the anxiety and mood disorders: Incremental validity compared to DSM-IV categories. Psychological Assessment, 26(4), 1212–1224. psyh. https://doi.org/10.1037/pas0000023

Rouw, R., & Erfanian, M. (2018). A Large-Scale Study of Misophonia. Journal of Clinical Psychology, 74(3), 453–479. https://doi.org/10.1002/jclp.22500

Sakiris, N., & Berle, D. (2019). A systematic review and meta-analysis of the Unified Protocol as a transdiagnostic emotion regulation based intervention. Clinical Psychology Review, 72, 101751. https://doi.org/10.1016/j.cpr.2019.101751

Sauer-Zavala, S., & Barlow, D. H. (2014). The case for borderline personality disorder as an emotional disorder: Implications for treatment. Clinical Psychology: Science and Practice, 21(2), 118–138. psyh. https://doi.org/10.1111/cpsp.12063

Schneider, R. L., & Arch, J. J. (2017). Case study: A novel application of mindfulness-and acceptance-based components to treat misophonia. Journal of Contextual Behavioral Science, 6(2), 221–225.

Schröder, A. E., Vulink, N. C., van Loon, A. J., & Denys, D. A. (2017). Cognitive behavioral therapy is effective in misophonia: An open trial. Journal of Affective Disorders, 217, 289–294. https://doi.org/10.1016/j.jad.2017.04.017

Schröder, A., Vulink, N., & Denys, D. (2013). Misophonia: Diagnostic Criteria for a New Psychiatric Disorder. PLOS ONE, 8(1), e54706. https://doi.org/10.1371/journal.pone.0054706

Schwartz, P., Leyendecker, J., & Conlon, M. (2011). Hyperacusis and misophonia: The lesser-known siblings of tinnitus. Minnesota Medicine, 94(11), 42–43.

Stringaris, A. (2011). Irritability in children and adolescents: A challenge for DSM-5. European Child & Adolescent Psychiatry, 20(2), 61–66.

Suris, A., Holliday, R., & NOfth, C. S. (2016). The evolution of the classification of psychiatric disorders. Behavioral Sciences, 6, 5. http://doi.org/10.3390/

Diversity Spotlight on Sheehan David Fisher, Ph.D.

Randy Salekin, PhD

This Diversity Spotlight is on Dr. Sheehan David Fisher. Dr. Fisher is unique within the field of psychology because his research career focuses on the effects of perinatal and subsequent parental mental health on infant/child health outcomes with a specialization in the emerging field of father mental health. This is a valuable new area for research and Dr. Fisher is cutting new clinical and research paths to advance knowledge. Dr. Fisher's work with diverse populations examines: 1) the biopsychosocial risk factors for parental psychopathology, 2) the impact of parental psychopathology on parenting behaviors and the family environment, and 3) the combined effect of the family environment on infant/child medical and emotional health outcomes. His aim is to re-conceptualize parental mental health research to integrally involve fathers to differentiate the etiology, course, and potential interactivity of paternal and maternal mental health and, in turn, the longitudinal associations with child medical and mental health. Dr. Fisher's research dovetails with his perinatal clinical practice, including being the Clinical Director of the Fathers' Mental Health Specialty Clinic. This clinic is focused on providing tailored clinical care to fathers during the perinatal period and beyond, for a variety of mental disorders that have an elevated rate during parenthood. He is also the director of the Perinatal and Women's Mental Health Clinical Psychology Scholar Program. Ultimately, Dr. Fisher's goal for his research is to optimize the health and effectiveness of the parental team to positively influence the child health trajectory starting from infancy. His research has a clear emphasis on reducing disparities in health outcomes.

Dr. Sheehan D. Fisher, Ph.D., is currently an Assistant Professor at Northwestern University, Feinberg School of Medicine in the Department of Psychiatry and Behavioral Sciences. Prior to his work at Northwestern, Dr. Fisher received his undergraduate degree from Rutgers University and his doctoral degree from the University of Iowa. In speaking with Dr. Fisher to learn more about his research and clinical trajectories, Dr. Fisher reported that his high school teacher, Mr. Moses, initially inspired him to get started in Psychology as a way to consider clinical work. He stated that Mr. Moses was a motivating teacher who made Psychology and Sociology appealing to students. However, Dr. Fisher stated that he had always had an interest in psychology and the mind even prior to his high school classes. Similar to Dr. Frances Collins, Director of NIH, neuroscientists, and other professionals, Dr. Fisher currently refers to the mind as "the last frontier" which he says makes "work in this area quite valuable and worthwhile."

Sheehan David Fisher, Ph.D.,

Dr. Fisher's research advanced in a major way when he reached the University of Iowa under the mentorship Dr. Michael O'Hara. Dr. O'Hara provided Dr. Fisher his first big opportunity when he allowed Dr. Fisher to include fathers in his broader research program. This expanded Dr. Fisher's and the O'Hara lab's research scope. Dr. Fisher stated that "mothers were already involved in treatment but lacked support from fathers." Even when fathers were included in interventions, Dr. Fisher noticed that they were infrequently examined with a scientific lens regarding mental health issues. These factors led Dr. Fisher to put the focus on father involvement (and father behavior) with the initial aim of reducing any mental health problems in each parent and increasing mental health for the broader family. These initial efforts were initiated at the phase when parents were about to have, or had just welcomed newborns. Dr. Fisher stated "without mental health for parents, there is much less opportunity for health for the offspring." Dr. Fisher further stated "consequently, there is a continuation of mental health problems potentially for generations."

Other research findings confirmed what Dr. Fisher had already anticipated. For example, some of this research showed mothers were more likely to experience internalizing disorders and fathers were more likely to experience externalizing disorders.1 Therefore, according to Dr. Fisher, interventions had to be individually tailored to the gender of the parent. In addition, Dr. Fisher noted that individuals from minority backgrounds suffered from some of the mental health conditions to a higher degree. Dr. Fisher published some of his research findings while at the University of Iowa. Following his work as a graduate student at the University of Iowa, Dr. Fisher moved to Chicago where he completed his internship and his postdoctoral training at Northwestern University/Feinberg School of Medicine. During his internship and post-doctorate studies, Dr. Fisher became even more convinced that additional work was required with parents, if health outcomes for families were to improve. His research and clinical interests along with those of his colleagues resulted in the development of two specialty clinics at

the medical center and federal funding for his research.

Dr. Fisher's current research grant from the National Institute of Mental Health Disparities (NIMHD) is focused on "How to Treat Mother's Depression by Changing Fathers' Behavior." The idea that Dr. Fisher developed for his research proposal was that if you could provide fathers education in a variety of areas it may help with the overall mental health of the family. This first step, he informed me, helps on a number of fronts. For instance, Dr. Fisher noted that it likely helps the father, it also greatly helps the mother, but also helps the clinician deliver a more efficacious treatment. He stated that "If the fathers are on board with the treatment, and are provided education in needed areas, they can generally be more effective and involved with the treatment itself, as well as participate in, and help with, specific intervention tasks such as behavioral homework." According to Dr. Fisher, this notion and innovative research has proven, at least initially, to be promising. Dr. Fisher's treatment protocol involves several ingredients that he expects will facilitate change. These include: 1) teaching the fathers about mental health (and mental illness), 2) teaching the fathers about behavioral activation, 3) enhancing parental communication skills, and 4) teaching equitable distribution of household responsibilities. Dr. Fisher is currently running this program through a randomized clinical control trial (RCT), where one arm of treatment is the experimental intervention and a second arm is treatment as usual (TAU). Dr. Fisher recruits for his study nationwide to get a broad representation of the United States. His work focuses on disparities and he plans to expand his work to include other underrepresented groups including sexually diverse groups. Additionally, Dr. Fisher stated that he has been broadening his work on an international level to improve mental health and reduce disparities across the world.

Because his expertise is growing, Dr. Fisher is providing a variety of services to the field to further grow and improve research and clinical practice. For instance, with the National Institutes of Health (NIH), Dr. Fisher provides reviews of proposals for funding which helps improve research projects and increase innovation in treatment protocols. In addition, Dr. Fisher was recently voted on the board of the Marcé of North America (MONA) organization. This organization has an interest in broadening diversity within perinatal health workers of North America. At the international level, Dr. Fisher is the chair of the Fathers Special Interest Group for the International Marcé Society that continues to recruit interested members from around the world.

Dr. Fisher says that if we are to be serious about mental health, and reducing disparities, in the future we need to consider the possibility of: 1) parental leave for both parents regardless of gender, and 2) more services that permit fathers access to training. There is also a need in the future for perinatal mental health training for psychologists and other mental health professionals. These initiatives will help with family health and ultimately global health.

In closing, Dr. Fisher says that his work helping fathers adjust to the prenatal period has been valuable and he still sees more room to grow his work. While his research focus has turned to fathers in recent years for the funded project, Dr. Fisher continues to see new cases of mothers in need of mental health treatment in his private practice while he is operating his clinical trial. And, he finds that his clinical work always inspires his research endeavors to reduce disparity and enhance mental health. Dr. Fisher's goal for his research is to optimize the health and effectiveness of the parental team to positively influence the child health trajectory starting from infancy is, to say the very least, off to a terrific start. If you would like to learn more about Dr. Fishers research program, he can be reached at sheehan.fisher@northwestern.edu.

References

1. Fisher, S. D., Brock, R. L., O'Hara, M. W., Kopelman, R., & Stuart, S. (2015). Longitudinal contribution of maternal and paternal depression to toddler behaviors: Interparental conflict and later depression as mediators. Couple and Family Psychology: Research and Practice, 4(2), 61-73

SCP Member Spotlight on Stanley Sue, PhD

Please provide an overview of your work

I taught and conducted research as a faculty member at the University of Washington (10 years), UCLA (15 years), University of California, Davis (14 years), and Palo Alto University (part-time 6 years). My research primarily focused on culture, ethnicity, and race and the impact of these characteristics on mental health, adaptation, and treatment. In particular, I focused on the mental health of Asian Americans, the delivery of mental health services to various ethnic minority groups, and effectively adapting psychotherapeutic treatments for different groups. Not much was known about many of these issues, especially in the earlier part of my career, so I found the research exciting, challenging, and important. As a clinical psychologist, I also engaged in a small and sporadic clinical practice over the years. With my emeritus status, I now give some lectures and write articles.

Where did you complete your training (graduate school and area of emphasis, internship, post doc, etc.)?

I received a Bachelor's of Science degree from the University of Oregon (1966) and a Ph.D. in psychology from UCLA (1971).

What is your current position/occupation?

I am Distinguished Professor Emeritus at Palo Alto University and the University of California, Davis.

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

My interest in psychology developed early. In my high school science seminar class, the teacher allowed me to conduct a replication of a study that I read in my brother's college textbook. The study concerned retroactive inhibition in which information learned later hinders the memory of previously learned materials. I ran the study on fellow students, and it worked! I was hooked on psychology and naively believed that human beings are so predictable.

I told my parents that I wanted to become a clinical psychologist, not fully knowing what a clinical psychologist did. My father, who was born in China, said, "What is that?" He couldn't believe that people would pay me to listen to their problems. Indeed, he wondered if I could make a decent living. His reaction and that of my mother partly reflected cultural differences, a topic that was to later dominate my work. Even now, many Asian Americans are unfamiliar with the profession of psychology, preferring their children to enter medicine, engineering, or physics. In any event, I persisted in pursuing a career in psychology. Then my second oldest brother decided to become a psychologist; my oldest brother became a psychologist and married a psychologist. My parents were proud of our accomplishments but never came to understand what we do as psychologists.

Stanley Sue, Ph.D.

These experiences laid the foundation for my interest in studying cultural similarities and differences in various groups and in using psychology to address social issues.

How long have you been a member of Society of Clinical Psychology? Please indicate any past or present roles in Society of Clinical Psychology (e.g., leadership, committees, task forces, etc.)?

I have been a member of the Society (or APA Division 12) since the early 1970s.

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

I have served as President of various organizations such as the Western Psychological Association, APA Division 45, APA Division 9, and the International Association of Applied Psychology. Other positions included membership on the APA Board of Social and Ethical Responsibility, APA Board of Convention Affairs, and APA Board of Educational Affairs. I also served as Science Editor for U.S. Surgeon General and co-founder of the Asian American Psychological Association. In the Society of Clinical Psychology, I chaired the Science and Practice Committee.

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

During this time when fake news, conspiracy theories, and fake science are being promoted in some circles, I think it is vitally important for psychology to reassert the principles of science and the application of science to social problems. We must be guided by research

and facts. In addition, psychology must avoid the suppression of open discussions and investigations of topics involving race and other social issues.

What's something nobody would know about you?

I was a graduate student for five years at UCLA. During those five years, we won the NCAA basketball championship every year. I still harbor a fantasy that UCLA will come through again for five years.

What are your hobbies?

I spend time fooling around with computers and try to play the role of a handyman in fixing things at home—often unsuccessfully.

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Ethics Column

"Could You Write a Letter for Me….?": Ethical Considerations in Patient/Client Requests for Professional Letters

Adam Fried, Ph.D.

Clinical psychologists who provide treatment are frequently called upon by patient/clients to write professional letters in their capacity as a psychologist. These letters often serve important purposes, including assisting with and informing treatment and providing valuable information used by third parties for the patient/client benefit. The purpose and use of these types of letters can be quite broad, however, ranging from letters that simply confirm that the patient/client is receiving care to letters that may be used as psychological evaluations in legal proceedings. There are certain situations in which psychologists who are asked to write letters may be placed in ethical jeopardy.

Our professional titles are powerful and recommendations made by a licensed professional often carry weight. It's important to note that although the psychologist may believe that some of these letters may only be informational, they may actually be significantly impactful and consequential. These letters may be viewed as assessments or evaluations by others (such as courts), and may have significant economic, legal, and other implications for individuals.

Many of these requests may place the psychologist in an uncomfortable position; their desire to help, coupled with potential unawareness of the ethical consequences of the request, may lead to problematic situations. Often these patient/client requests do not involve personal gain for the psychologist; rather, a well-meaning psychologist wants to help the client/patient, but, by doing so, may be at odds with ethical codes of conduct, laws, and/or regulations. Psychologists may experience pressure to acquiesce to patient/client requests (or even demands) to write letters, leading to, perhaps at times, difficult moral dilemmas.

Below are some questions to consider when being asked to write a letter by a client/patient, as well as a few examples.

Have I examined the individual?

One area that has led to ethics board complaints is when psychologists make conclusions, determinations, or recommendations for individuals who they have not assessed or examined. Consider the following example: following a separation from her husband, a woman seeks services for her children to assist with adjustment and to process related anxiety and depression. The woman tells the clinician that her soon-to-be ex-husband behaves erratically and demonstrates symptoms consistent with bipolar disorder. She asks the clinicians to write a letter summarizing her description of her spouse, indicating a diagnosis of bipolar disorder, and commenting on parental fitness.

This example of a request is concerning for a number of reasons and has the potential to cause harm. For example, the woman in the above example could provide this letter to the court and may be used in making custody determinations. In the above example, one of the most important considerations is that the clinician has not examined the individual, and, therefore, is not be able to make the types of conclusions being requested. Section (b) of the APA Standard 9.01 (Bases for Assessments) states, "… psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations" (see also Standards 2.01, Boundaries of Competence , and 9.06, Interpreting Assessment Results). Limited exceptions to this occur when psychologists are conducting record reviews, consultation, or supervision, in which they clearly indicate the information and sources used upon which to base their conclusion(s) (see 9.01(c)).

Do I have enough information to make a determination being asked of me?

Another question that psychologists should ask before agreeing to write a letter is whether they have enough information. As noted above, determinations, conclusions and recommendations based upon insufficient assessment may significantly negatively impact individuals (Fisher, 2017; Nagy, 2011). In addition to interviewing the individual in question, requests that relate to certain types of diagnoses, conditions, or disabilities require specific information or assessments to be able to adequately address the relevant question. Standard 9.01 (a) states that, "Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings" (see also Standard 2.04, Bases for Scientific and Professional Judgments).

For example, a parent of an 11-year-old child receiving treatment for anxiety may ask the treating psychologist to write a letter on behalf of her child to gain entry into a special academic program or to receive accommodations. These recommendations usually call for determinations that require specialized assessment (see Standard 2.04 Bases for Scientific and Professional Judgments). Knapp, Younngren, VandeCreek, Harris, and Martin (2013) provide helpful examples and information about other

types of questions for which clinical psychologists may be asked to assess, including evaluations related bariatric surgery, disability, and occupational and employment related issues.

Do I possess the necessary competence to make this determination?

As noted above, many requests for letters actually involve some sort of assessment or evaluation. In addition to questions about the nature and methods of assessment, clinicians should evaluate their competence to make the determination requested. Some questions may be within our boundaries of competence, while others may not. For example, determinations regarding complex trauma or dissociation, especially those used for forensic purposes, require specialized knowledge and training (Rocchio, 2020). Other determinations, such as educational accommodation, intellectual disability, neurological impairment, and parental fitness, also require specialized knowledge and training (see Standard 2.01 Boundaries of Competence).

Is there a potential conflict in writing this letter?

Treating psychologists should determine if the request to write a letter places them in a potentially unethical multiple relationship. There are times when a patient/client may ask for a specific type of assessment, which places the clinician in the dual role of therapist and evaluator. These duals roles can sometimes lead to conflict and negative outcomes (see Standard 3.05 Multiple Relationships). Some requests may require an evaluation by an impartial third party. As a treating clinician, this is often an impossible role to take on. For example, determinations of competency or even emotional support animal requests (see the Ethics Column from Spring 2020 [Fried, 2020] for a discussion of issues related to these requests) may require the psychologist to assume an additional role that may be incompatible with their role as treating clinician.

Does the individual understand the implication of the letter?

One request that clinicians are increasingly receiving are letters of recommendation or to serve as a character reference (in support of a job application). This can be ethically problematic for a few reasons. The first is that a clinician has a specific relationship with the patient/client and may or may not be the best judge of whether or not that person may succeed in a specific type of academic program or vocation. Moreover, it is unclear how these letters may be viewed by admissions committees or employers, as clinicians may not be able to accurately attest to the patient/client's occupational strengths, educational achievements, or suitability for the position.

The second (and more concerning) issue has to do with understanding the implications of the letter, confidentiality, and disclosures. Using the above example related to letters of recommendation, clinicians considering these requests must address several ethical questions, including: (1) do these letters become part of the health care record and/or considered protected health information, (2) does the patient/client know exactly what information will be conveyed and to whom? Could they later be upset with the clinician because they did not realize the information that would be released or the possible negative effect on their application? And (3) can the patient/client waive their right to access, which is often a recommended option for applicants seeking admission to academic programs?

Conclusion:

Treating psychologists often receive requests for letters from patients/clients for a variety of reasons. Although they often have the best intentions and their desire is to accommodate what may seem like reasonable pleas, there are some types of requests that may place clinicians at increased ethical risk. In addition to the considerations listed above with regard to specific requests, it may be helpful to think about general policies regarding these types of requests. For example, psychologists may want to proactively address these types of requests in their informed consent documentation and/or initial discussions about services. For example, some clinicians state in their initial consent paperwork that they do not provide letters that put the treating psychologist in a dual role, such as conducting custody evaluations.

Finally, as a reminder, psychologists are well advised to obtain consents for any letters indicating that the patient/client understands the nature of the information to be released and consents to release it to a specific person (see Standard 4.01 Maintaining Confidentiality and Standard 4.05 Disclosures as well as Health Insurance Portability and Accountability Act [HIPAA] information about release of information form requirements). Psychologists should also ensure that information released is specific to the nature of the purpose (see Standard 4.04 Minimizing Intrusions on Privacy).

References

American Psychological Association (2017). Ethical principles of psychologists and code of conduct (Amended January 1, 2017). Retrieved July 16, 2021 from https://www.apa.org/ethics/code

Fisher, C. B. (2017). Decoding the Ethics Code, Fourth Edition. Thousand Oaks, CA: Sage

Fried, A. L. (2020). Requests to provide emotional support animal certifications. The Clinical Psychologist, 72(2), 12-13.

Knapp, S., Younnggren, J. N., VandeCreek, L., Harris, E., & Martin, J. N. (2013). Assessing and Managing Risk in Psychological Practice: An Individualized Approach, Second Edition. Rockville, MD: The Trust.

Nagy, T. F. (2011). Essential Ethics for Psychologists: A Primer for Understanding and Mastering Core Issues. Washington, D.C.: American Psychological Association.

Rocchio, L. M. (2020, June 8). Ethical and professional considerations in the forensic assessment of complex trauma and dissociation. Psychological Injury and Law, Epub ahead of print. doi: 10.1007/s12207-020-09384-9

Younggren, J. J., Boness, C. S., Bryant, L. M., & Koocher, G. P. (2019). Emotional support animal assessments: Toward a standard and comprehensive model for mental health professionals. Professional Psychology: Research and Practice, 1-7.

News on Recent Diversity, Equity, and Inclusion Efforts: An Interview with PSIDE

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Efforts to promote and sustain diversity, equity, and inclusion (DEI) across research, therapy, and professional interactions are consistent with the goals of Division 12 and emphasized by the Diversity Committee and the Clinical Psychology of Ethnic Minorities (Section VI) of the Society of Clinical Psychology. In this interview article, we would like to draw attention to the important efforts of a relatively new, international organization called PSIDE - Psychology Students for Inclusion, Diversity and Equity. PSIDE brings together psychology students across the United States and Canada to bring attention to and engage in DEI initiatives. An electronic interview was conducted with PSIDE's leadership team* and is presented below.

What is PSIDE? What are PSIDE's goals?

Psychology Students for Inclusion, Diversity and Equity (PSIDE) is a grassroots organization of graduate students across clinical, counseling, school psychology and other clinically-oriented psychology disciplines. Overall, PSIDE aims to provide a platform for connection across pillars of learning, advocacy, and peer support. Our goal for learning and education is to deepen both self-knowledge and a broader, intersectional understanding of DEI related issues. We aim to organize concrete efforts to promote sustainable DEI initiatives across university departments. We also aim to provide a space for students to connect at a national level to share strategies and initiatives to enrich DEI efforts in their own institutions. All of these goals cut across domains of research, clinical work, and teaching.

Who are the members of PSIDE?

The members of PSIDE are graduate students from psychology programs across the United States and Canada. We are students who are diverse in gender, race, ethnicity, age, sexual identity, religion, socioeconomic background, and disability status. As a group, we value personal and professional growth and we work to promote a more inclusive field. Many of our members are involved in their own departmental DEI efforts and want to expand such efforts through peer feedback and collaboration.

Why was PSIDE started?

PSIDE developed organically in the summer of 2020, in the context of national mass uprisings for racial justice following the murders of George Floyd, Breonna Taylor, and others. At the time, many psychology graduate programs were grappling with (or failing to grapple with) issues of social justice in their own classrooms, clinics, and labs. As graduate students pushing for change, we were eager to connect with students in other programs across the country to join forces, compare notes, and build solidarity in our efforts. We started with a few cold emails to list-servs, just reaching out to connect over Zoom. Over time, we built a community of over 500 students across the US and Canada. The existence, name, mission, structure - everything about PSIDE - was developed in collaboration and community, and we're so proud of that. We hope the group will continue to serve its initial purpose of connecting graduate students across universities pushing for justice and change, while also evolving with the needs and interests of the community over time.

How does PSIDE conceptualize the role of promoting inclusion, equity, and diversity for clinical and counseling psychologists?

Issues related to diversity, equity, and inclusion are commonly treated as separate or additional to the primary duties of psychologists, and efforts to promote DEI have often been shouldered by historically excluded and marginalized individuals within the field. We conceptualize DEI as central to the core practices of clinical, counseling, and school psychologists and as a necessarily collaborative effort across institutional

boundaries. Furthermore, we hope to promote a self-sustaining model of DEI that is not subject to the issue of the current moment. Embedding inclusivity in our clinical practice, research, and teaching is critical to change the culture of psychology as a whole. We prioritize proactive methods over reactive behaviors.

In what ways does it seem like clinical and counseling psychology programs are currently doing good work in the areas of inclusion, diversity, and equity?

Students and faculty from universities across the country have demonstrated their commitment to DEI efforts in a number of ways. Many programs have developed new anti-racist working groups, petitioned for increased diversity represented in syllabi, and have demonstrated an unopposable need for better representation in faculty and graduate students. Additionally, many folks have attended educational seminars, had informal conversations within labs and across peers, and have attended rallies and protests to show commitment to fighting racial injustice. Programs that waived the GRE requirements have also taken an important step in making psychology more accessible.

In what ways does it seem like clinical and counseling psychology programs are currently missing the mark in the areas of inclusion, diversity, and equity?

We hope to contribute to a growing shift away from a culture within the field that relegates individual differences and DEI efforts as "add-ons" or separate parts of training. We believe that ethical graduate-level training in clinical research and practice must incorporate cultural humility and culturally responsive practices in all areas of training. Further, DEI efforts must move beyond the performative. We want programs to know that simply making a statement or creating a committee is not enough, and these actions should not be taken as a sign of "mission accomplished." We must critically evaluate the ways power and privilege operate within and beyond our committees and programs, and consistently and actively work to dismantle structures of oppression and those which uphold White supremacy.

What do you think are the biggest issues, or hurdles, for clinical and counseling training programs right now in reaching their inclusion, diversity, and equity-focused goals?

DEI has been deprioritized, financially and otherwise, within the system of academia. Too often DEI work falls on the shoulders of students, particularly students of color. DEI work rarely earns reward or recognition, and too often garners backlash. It has been difficult to engage students and faculty across the academic hierarchy in a sustainable manner due to lack of structural support and incentives for these endeavors, and real professional risk to challenging the status quo.

What do you see as the best actions/practices clinical and counseling programs can take right now to better promote inclusion, diversity, and equity-focused goals?

There are many actions programs can take right now. One, commit as a program (all faculty, students, and staff) to pursue DEI efforts as an integral part of training and practice. This is an active process - critically evaluate and revise current policies and practices to integrate DEI throughout program activities. Two, provide funding for DEI initiatives, particularly those led by historically excluded and marginalized students, faculty, and staff. For further recommendations, see Galan and colleagues' "A Call to Action for an Antiracist Clinical Science" (2021).

What effects has PSIDE had on particular psychology/counseling programs across the country?

Our primary success so far has been in organizing motivated students across programs in the country to pool our experiences in spearheading DEI efforts. We hope that creating a space for students to learn from one another and support each other will help DEI efforts to grow and flourish. We are excited to launch the second year of meetings for this group and look forward to the future effects of the work to come.

*** Who comprises the current leadership team of PSIDE?**

Sonalee A. Joshi, MS, University of Michigan

Alexandra R. Tabachnick, MS, University of Delaware

Gabriella T. Ponzini, MS, West Virginia University

Shannon M. Savell, MA, University of Virginia

Stephanie Torres, MA, University of Houston

We were pleased to have this opportunity to speak with PSIDE leadership during this interview and we hope you enjoyed learning about PSIDE if you were not already familiar. We hope PSIDE's efforts to bring together psychology students across the United States and Canada will only continue to grow, bringing with this growth the much needed attention and engagement in DEI initiatives across the field. Organizations like PSIDE are needed to continue DEI efforts around the globe that will positively impact the field of psychology and our communities. If you are interested in joining PSIDE, you can e-mail: psychstudentsforIDE@gmail.com or fill out the form at this link: https://forms.gle/T9g4yx435yGLVd7Y8.

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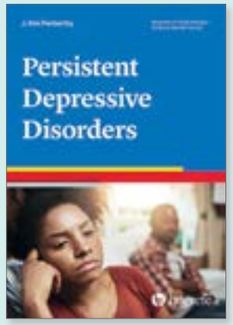

J. Kim Penberthy
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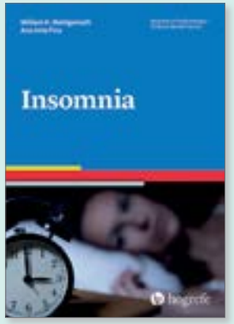
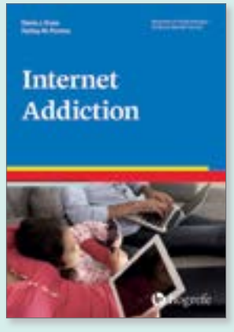


William K. Wohlgemuth / Ana Imia Fins
Insomnia

Vol. 42, 2019, viii + 94 pp.
ISBN 978-0-88937-415-7
Also available as eBook

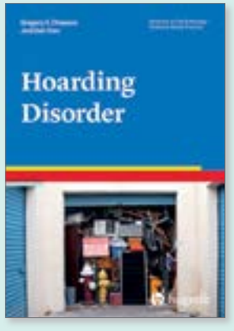
This concise reference written by leading experts for busy clinicians provides practical and up-to-date advice on current approaches to diagnosis and treatment of insomnia. Professionals and students learn to correctly identify and diagnose insomnia and gain hands-on information on how to carry out treatment with the best evidence base: cognitive behavioral therapy for insomnia (CBT-I). Copyable appendices provide useful resources for clinical practice.



Daria J. Kuss / Halley M. Pontes
Internet Addiction

Vol. 41, 2019, iv + 86 pp.
ISBN 978-0-88937-501-7
Also available as eBook

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

Vol. 40, 2019, viii + 76 pp.
ISBN 978-0-88937-407-2
Also available as eBook

Hoarding disorder presents particular challenges in therapeutic work, including poor treatment adoption. This evidence-based guide written by leading experts presents the busy practitioner with the latest knowledge on assessment and treatment of hoarding disorder. The reader gains a thorough grounding in the treatment of choice for hoarding – a specific form of CBT interweaved psychosocial approaches to ensure successful treatment. Printable tools help practitioners carry out therapy.

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