President’s Column: Every Cloud has a Silver Lining

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.
Mental Health Needs Increase During and After Disasters

At this 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 curve” 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.
LEAD ARTICLE: Misophonia

Misophonia: New disorder, or needs more research?

M. Zachary Rosenthal, Ph.D. (1, 2)
Clair Cassiello-Robbins Ph.D. (1)
Elizabeth Stone, Ph.D., RN, FAEN, CPEN, CHSE (3)
Rachel Guetta, BA (1, 2)
Jacqueline Trumbull, BA (1, 2)

1. Center for Misophonia and Emotion Regulation, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC, United States
2. Department of Psychology and Neuroscience, Duke University, Durham, NC, United States
3. School of Nursing, The University of North Carolina at Chapel Hill, Chapel Hill, NC, United States

Since the 20th century inception and recursive iterations of Kraepelian classification models for disorders and psychiatric conditions, there has been a significant impact on the DSM. Indeed, over 70 years the Diagnostic and Statistical Manual (DSM) transformed from, among other things, being 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 in the DSM is a complicated and imperfect process, with many more questions than answers and contrasting conclusions. When should a newly discovered syndrome 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), there 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 is a newly defined condition 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 the translation of 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.

What is Misophonia?

Although the word misophonia could be defined narrowly to denote individuals with a hatred (miso) of sounds (phonia), emerging scientific research suggests of its phenotypic complexity indicates that this translation is inappropriately simplistic and may be constrained. Broader construal, 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 crowdfunded documentary (Gould, 2017). Concurrently, academic research has accelerated exploration 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 exploring 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 and 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; Eijskens 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 free-floating (e.g., hypervigilant state 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; Row et al.; Swedo et al., 2021). When triggered by misophonic cues, individuals may experience unpleasant cognitions congruent with their affective state, including, for example, anger-related (“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 these responses have received relatively less empirical attention than other emotions such as anger and anxiety, it is possible that misophonia may be both biologically- (e.g., “That sound she makes while eating is gross”) and socially-mediated (e.g., “She knows better than not to make that noise here!”). 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; Row & Erfanian, 2018; Schneider & Aker, 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 the crunching sound they want to avoid) (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. Cues (often described as “triggers”) may serve 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 individual’s ability to control their environment 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 people who are triggering for them. During off-hours and weekends, sufferers may have difficulty socializing, attending social events, eating and drinking, doing household chores, or engaging in other activities. For example, avoiding movie theaters, restaurants, or meals with family members, changing valued relationships and causing psychological distress. Anger and irritation in anticipation and response to triggering cues may vary depending on the relationship with others, including loved ones. In extreme cases
LEAD ARTICLE: Misophonia (continued)

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). The empirical data 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., 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-Llot, 2021; Jager et al., 2020; Rouw et al., 2018, Schröder et al., 2018). 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., 2018). However, 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; 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 correlated with 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, or that of another discipline. Indeed, the original contributors to the DSM-5 (American Psychiatric Association, 2013). Misophonia is not a diagnosis in the International Classification of Diseases-10th edition (ICD-10) or the DSM-5 (American Psychiatric Association, 2013).

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

Given the novelty of the condition and the lack of evidence regarding the reliability, validity, and usefulness of assessing and treating misophonia, one of the guiding principles we suggest is to take a multidisciplinary approach. Misophonia appears to have roots in auditory, 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., Naylor et al., 2014) to determine whether misophonia symptoms would benefit from 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 diagnostic entity. Further, it is unknown whether misophonia should be appropriately considered as a unique diagnostic category or that of another discipline. Indeed, the original clinical descriptions of misophonia were observed during the treatment of hearing disorders, such as hearing loss and 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 multidisciplinary perspectives not limited to mental health (e.g., audiolog, 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.

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 movements and behavioral responses to trigger sounds, and (c) overall perception of severity of sound aversion disorder. This MQ consists of 20 items on a 5-point scale 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 administered the MQ to college students and reported high 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 limited to the general 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 research (Cassidy & Robbins et al., 2020; Daniels et al., 2020; 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 assesses, 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 preliminary 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, and 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 obsessive symptoms, other studies have found that misophonia is negatively 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 tool for treatment assessment. The Selective Sound Sensitivity Syndrome Scale (S-Five; Vitoratou et al., 2020) is a 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 analysis 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 an item response theory (IRT) approach, which is a patient-driven technique that tests patients, suffers, 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) quality of life, 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 DSM. To achieve the second aim of clinical utility, we are working on the development of a comprehensive MQ and a similarly structured semi-structured clinical interview, which we have called the Duke Misophonia Interview and is currently being psychometrically evaluated to quantify the condition. Given 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 levels of expertise. To achieve our first aim of better understanding misophonia, this new MQ provides a score of 61 be used for clinical cut-off. Initial reports suggest good reliability (.96) and test-retest reliability (.88) with a high degree of internal consistency (α = .78). Overall, the item pool is a robust, the item pool was limited to one proposed set of diagnostic criteria. Other diagnostic criteria for misophonia have been proposed (Dzierzinski 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 cross-culturally valid. Previous studies using this scale in 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.

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 newly identified condition may be 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 that address some of the discrepancies between symptoms and misophonia, we have developed the Duke Misophonia Questionnaire (DMQ) to serve as a first step in defining and classifying underrecognized disorders, an important outcome of measure development for novel conditions. Psychological processes of change identified in assessment can then be further examined through to the individual in a rigid manner (e.g., always use counterconditioning, and the like). Misophonia, which 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;
LEAD ARTICLE: Misophonia (continued)

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 CBIs. 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 training or cognitive (e.g., cognitive therapy), as well as those that represent selective 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 (Cassio-lio-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 CBIs that target changes in emotional functioning and associated processes (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 (Cassio-lio-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 those transdiagnostic psychological processes, rather than a specific set of symptoms. Indeed, preliminary evidence suggests misophonia is associated with neuroticism and difficulties regulating emotions (Cassio-lio-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 (e.g., conditioning, learning, attention). Most long-term goals. It is reasonable to hypothesize that a transdiagnostic treatment targeting core, underlying processes relevant across different diagnoses may be beneficial. We are currently exploring the acceptability, feasibility, and preliminary efficacy of in such two 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 (e.g., mindfulness, cognitive flexibility) to cultivate an accepting attitude toward the experience of strong emotions, particularly anger, and disgust (Cassio-lio-Robbins, Anand, et al., 2020). Thus, from a theoretical standpoint there is an emerging rationale supporting the use of the UP to treat heterogeneous 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 & Efranian, 2018). Further, they report a range of emotions, particularly that is associated with 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 use of the UP to treat heterogeneous emotional disorders.

Finally, a number of studies highlight that individuals with misophonia often engage in avoidance-based emotion regulation strategies in response to misophonic cues. The UP 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.

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.

Table 1. UP Modules Applied to Misophonia

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

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.

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.

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.
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 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 on 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 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.

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 (Eijser et al., 2021; Erfanian & Rouw, 2018; Kamar et al., 2017; Kumar et al., 2017), 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 be prioritized for change, and others may have same priority value. Each pattern can be addressed using transdiagnostically empirically supported procedures (e.g., emotional awareness and differentiation, cognitive reappraisal, diffusion).
LEAD ARTICLE: Misophonia (continued)

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, and prevalence of misophonia, 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. Ninth, 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, large 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

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

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


Diversity Spotlight: 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 focuses on the effects of perinatal and subsequent parental mental health on infant/child health outcomes. He is the author of several research studies and has contributed significantly to the field of mental health counseling. In his work, Dr. Fisher has implemented innovative strategies to help parents deal with mental health concerns during pregnancy and the postpartum period.

Sheehan David Fisher, Ph.D., 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 focus on paternal involvement as an important aspect of treatment. In his research, Dr. Fisher has emphasized the importance of involving fathers in mental health care and has demonstrated that paternal involvement can improve mental health outcomes for both parents and children. Additionally, Dr. Fisher has conducted research on the impact of the family environment on infant/child mental health and has shown that paternal involvement can significantly improve mental health outcomes.

Other research findings confirmed what Dr. Fisher had anticipated. For example, some of this research showed that mothers were more likely to experience internalizing disorders and fathers were more likely to experience externalizing disorders. Furthermore, research has shown that paternal involvement can improve mental health outcomes for both parents and children. Thus, Dr. Fisher’s work has had a significant impact on the field of mental health counseling and has paved the way for future research on paternal involvement in mental health care.

Dr. Fisher continues to conduct research on paternal involvement in mental health care and has published numerous articles on the topic. He currently serves as an Assistant Professor at Northwestern University and has received several awards for his research. His work continues to have a significant impact on the field of mental health counseling and has helped to improve mental health outcomes for parents and children.
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 “Treating 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 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 responsibilities for household responsibilities. Dr. Fisher is currently running this program through a randomized clinical control trial (RCT), where one arm of the trial 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 Marce 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 Marce 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. Fisher’s research program, he can be reached at sheehan.fisher@northwestern.edu.
often unsuccessfully.

I spend time fooling around with computers and try to

What are your hobbies?

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.

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continued)

Psi SCP MEMBER SPOTLIGHT (continu...
types of questions for which clinical psychologists may be asked to assess, including evaluations related to 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 amount to some form of assessment. In addition to questions about the nature and methods of assessment, clinicians should evaluate their competence to make the determination requested. Some questions require greater depth of clinician's 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?

Treatying 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 a dual role of therapist and evaluator. These dual roles can sometimes lead to conflicts 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 completely decide which questions must be addressed. The 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 that information will be revealed and to whom? Could they later be upset with the clinician because they did not realize that the information would be released or the possible negative effect on their application? And (3) can the question warrant a right to access, which is often a recommended option for applicants seeking admission to academic programs?

Conclusion:

Treatying 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 requests, 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 be familiar 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


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

Haley Fitzgerald, M.A.
Boston University

Randall Salekin, Ph.D.
University of Alabama

Viviana Padilla-Martinez, PhD
Bay Pines VA Healthcare System

Michael Otto, Ph.D.
Boston University

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 of 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 consider these 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 expand our voices and our influence within our 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 in the process of failing to develop 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 our country to join forces, consider new ways to 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 membership.

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 historically been 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...
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: psychstudentsforeide@gmail.com or fill out the form at this link: https://forms.gle/T9g4yx435yGLVd7Y8.
The editors

Danny Wedding, PhD, MPH  
Distinguished Consulting Faculty Member, Saybrook University, Oakland, CA. Danny trained as a clinical psychologist at the University of Hawai‘i, and then completed a postdoctoral year of training at the University of Mississippi Medical Center. He retired from the University of Missouri School of Medicine and then taught at Alliant International University and the American University of the Caribbean. Dr. Wedding continues to write, lecture, and consult from his home in Berkeley, California.

Linda Carter Sobell, PhD, ABPP  
Professor in the Center for Psychological Studies, Nova Southeastern University, Ft. Lauderdale, FL.

Jonathan S. Comer, PhD  
Professor of Psychology and Psychiatry Director, Mental Health Interventions and Technology (MINT) Program Center for Children and Families Florida International University Miami, FL.

Kenneth E. Freedland, PhD  
Professor of Psychiatry and Clinical Health Psychology, Washington University School of Medicine, St. Louis, MO.

J. Kim Penberthy, PhD, ABPP  
Chester F. Carlson Professor of Psychiatry & Neuropsychobehavioral Sciences at the University of Virginia School of Medicine in Charlottesville, VA.

Visit https://www.hogrefe.com/us/apt to find out more about the series.
Volumes available for CE credits

Children & Adolescents
- Childhood Obesity by D. E. Wiltfey / R. J. Bokt / J. Cahil Holland / D. J. Van Buren (2019)

Anxiety and Related Disorders
- Hoarding Disorder by G. S. Chasson / J. Siev (2019)
- Obsessive–Compulsive Disorder in Adults by J. S. Abramwitz / R. J. Jacoby (2014)
- Generalized Anxiety Disorder by C. D. Marker / A. Aylward (2011)
- Social Anxiety Disorder by M. M. Antony / K. Rowa (2008)

Behavioral Medicine and Related Areas
- Alzheimer’s Disease and Dementia by B. T. Maa / B. P. Voight (2018)
- Chronic Pain by B. J. Field / R. A. Swarn (2008)

Methods and Approaches

Addictions and Related Disorders
- Internet Addiction by D. J. Kuss / H. M. Pontes (2019)
- Substance Use Problems, 2nd ed. by M. Earleywier / (2016)
- Binge Drinking and Alcohol Misuse Among College Students and Young Adults by R. P. Kowgrod / K. J. Zhu (2015)
- Problem and Pathological Gambling by J. P. Whelan / T. A. Steinberg / A. W. Meyers (2007)

Sexual Disorders
- Sexual Dysfunction in Women by M. Mica (2012)
- Sexual Dysfunction in Men by D. Rowland (2012)

Other Serious Mental Illnesses
- Persistent Depressive Disorders by J. K. Penbarty (2019)
- ADHD in Adults by B. P. Daly / E. Nicholls / R. T. Brown (2016)
- Depression by L. P. Rehm (2010)
- Suicidal Behavior by R. McKeon (2009)

Also available
- Phobic and Anxiety Disorders in Children and Adolescents by A. E. Grills-Taquechel / R. D. Linderfield (2012)

Order and price information

The volumes may be purchased individually or by Series Standing Order (minimum of 4 successive volumes). The advantages of ordering by Series Standing Order: You will receive each volume automatically as soon as it is released, and only pay the special Series Standing Order price of US $23.80 – saving US $5.00 compared to the single-volume price of US $28.80.