CONTENTS

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PRESIDENT'S COLUMN

Kalyani Gopal, PhD, HSPP

Dear Members,

These past few months have been very busy with our board meeting in April where your board was successful in creating pathways for increasing diversity and inclusion within our leadership and our membership. During this year, we have increased student involvement and enhanced engagement. We also bridged the gap between clinical practice and clinical scientific research and created a Task Force for examining cross-cultural assessments, therapeutic practices. Many of you attended the Division 12 SCP Multicultural Summit that was hosted on September 9, 2022 and witnessed the global reach of our clinical community bringing diversity and inclusion into the forefront. The well attended Summit has had actionable next steps which we hope you will find pragmatic and applicable within your day-to-day clinical work.

During the past few months, we have chosen Liaisons to APA Committees to represent our efforts and the interests of Division 12. If you need to contact any of them please connect with Tara Craighead, SCP's fulcrum of an Executive Director who not only has our historical archives, but also maintains our listservs, coordinates with APA and Divisional administration, ensures we are compliant with the IRS and regulates the smooth functioning of our day to day activities.

The APA Elections for APA President-Elect, and Board of Directors is currently being voted on. Please consider how each candidate supports the values of our Division of Clinical Psychologists and how best they would fit given their work history, ability to reach across multidisciplinary fields, and ability to influence legislation that supports our clinicians mainly in private practice and our academics in teaching and research.

Mark your calendars for September 21st!! Our Membership Committee will be hosting the Inaugural BOOK CLUB hosted by Dr Jane Conron who has vast media, film, and book club hosting experiences. She will be engaging Bruce Perry, MD, PhD in an in-depth discussion on his most recent book. Sign up at https://div12.org/book-club/ "What Happened to You?"

Looking forward to continuing to make life easier for us as clinical psychologists!

Warm regards,

Kalyani Gopal, PhD, HSPP
President, Division 12, SCP

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SOCIETY OF CLINICAL PSYCHOLOGY

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Planning Treatments Collaboratively: The Shared Decision-Making Approach

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Standards of practice - especially evidence-based practice - dictate establishing, at the outset of treatment, a treatment plan (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents, 2008). Ideally, this treatment plan draws upon a solid case conceptualization that reflects the client's unique presentation, high-quality psychological theory, and the best available evidence (Christon, McLeod, & Jensen-Doss, 2014). Typically, clinical texts assume the clinician will design the treatment plan. Perhaps this is with good reason - clinicians are trained professionals who have clinical experience and expertise in (or at least, one hopes, familiarity with) the evidence base. However, one critical question remains unanswered: *What is the client's role in designing a treatment plan?* Is it restricted to completing an intake assessment to provide information the clinician needs to plan treatment? Do clients answer their clinicians' questions about their preferences and priorities? Is it the client's responsibility (and right) to approve a treatment plan, in addition to providing consent for psychological treatment more broadly? *If our aim is to empower clients to be equal partners in their treatment, how can we, as clinicians, work collaboratively with our clients to design treatment plans that are responsive to their preferences, values, and unique needs?*

Shared decision-making (SDM) is an approach to treatment planning in which clients and providers collaborate on decisions related to the client's treatment (Charles et al., 1997; Langer et al., 2015). This ongoing, collaborative process centers the client in their care to encourage their active involvement, as well as involvement from the client's family when indicated (Langer & Jensen-Doss, 2018). SDM has been studied more broadly in medicine for many years and its more recent expansion to the mental health field has shown similar promising outcomes (Alegria et al., 2018; Langer et al., 2022). An overarching goal of SDM is to promote the client's agency, and this can

David A. Langer, PhD

be facilitated by providing high quality information to the client and supporting deliberation about their options (Elwyn et al., 2012). A review by Clayman and Makoul (2009) identified some of the core elements of SDM, including an exchange of information, identification of client values and preferences, discussion of treatment options, and agreement on a treatment plan. This approach allows for providers and clients to share the best available evidence so that clients can develop informed preferences about their care (Elwyn et al., 2012) and use those preferences to work with their clinician in treatment planning.

Rationale for SDM

An SDM approach to treatment planning aligns with our society and our field's values. This principles-based argument asserts that, irrespective of any potential measurable outcomes, SDM should be implemented because it promotes client autonomy and patient-centered care. Support for this proposition is clear in the most prominent national policies, priorities, and legislation (e.g., Patient Protection and Affordable Care Act, 2010; National Institute of Mental Health, 2022). Even if engaging in SDM does not result in treatment process or outcome gains, clients should still have a right to make informed decisions about their mental health care and receive treatment that is aligned with their personal values and preferences (Langer & Jensen-Doss, 2018).

Whereas the principles-based argument for SDM - that our values necessitate empowering and engaging clients in the treatment planning process - focuses on the moral imperative to plan treatments collaboratively, the outcomes-based argument proposes that SDM improves treatment processes, treatment outcomes, or both. Fortunately, there is a growing body of evidence that planning treatments collaboratively with clients can impact treatment processes and outcomes.

SDM interventions have been evaluated for a wide range of health- and mental health-related concerns (Légaré et al., 2018), with most research on SDM and mental health treatment occurring in the

past couple decades (see Slade, 2017). Many findings have been encouraging. First, people seeking mental health care (e.g., O'Neal et al., 2008). Second, multiple studies have demonstrated that interventions intended to increase the use of SDM in clinical practice are effective at increasing client engagement in

Juliana M. Holcomb, BA

treatment planning (e.g., Langer et al., 2022; Alegria et al., 2018), though this is far from a universal finding, with the effectiveness of implementation efforts varying widely, likely related to implementation approach and provider/client populations under study (Légaré at al., 2018). Third, using SDM to plan mental health treatments has resulted in improved client knowledge about treatment options (e.g., Hamann et al., 2006), satisfaction (e.g., Malm et al, 2003), treatment adherence (e.g., Loh et al., 2007), and client-perceived quality of care (e.g., Alegria et al., 2018). Langer and colleagues (2022) demonstrated that planning treatments using SDM for youth mental health, engaging caregivers and youth, is both feasible and promising, leading to significantly higher satisfaction with treatment planning decisions and lower decision-related conflict and regret.

How might SDM look in psychotherapy?

Although there are many ways clinicians can engage clients in an SDM treatment planning process, it is commonly accepted that high-quality SDM (see Makoul & Clayman, 2006) will include a discussion of what are the presenting problems (and consequent therapy targets), treatment options available, pros and cons of each treatment option (e.g., empirical support, costs, ability to follow through with treatment tasks), and how each treatment option fits with the client's preferences and values. Clinicians should continually check their clients' understanding and clarify as needed. Clinicians should also share any recommendations they may have, and then work with their client to make the necessary decisions to form an initial treatment plan (or explicitly defer decisions) and a plan to follow up to assess treatment efficacy and make changes as needed.

The common thread throughout these ideal SDM elements is the "spirit" of SDM - respectful collaboration in which the clinician brings to the table their and the field's expertise of case conceptualization and treatment options, and the client brings their equally important expertise in their lived experience, identities, preferences, values, and goals. Engaging clients in a high-quality SDM

process does not require a specific set of steps or the use of an established protocol or manual. Indeed, though specific SDM protocols have been developed for SDM-focused research studies (e.g., Langer et al., 2022), creating a protocol that would capture the unique needs of a wide range of treatment settings would be challenging at best. Clinicians can find decision-making tools to help structure treatment planning discussions, however, such as the Ottawa Hospital Research Institute's patient decision aids toolkit (https://decisionaid.ohri.ca/).

To engage clients (and any relevant caregivers, spouses, etc.) in treatment planning for psychotherapy, an important first step is to orient the client to the concept of treatment planning. Many clients may not recognize that there are different ways to go about therapy and may not be aware of the options available. Typical decision points might be what are the target problems going to be, who will participate in treatment, treatment logistics (e.g., session frequency), and treatment approach (e.g., theoretical orientation, which skills will be covered). Orienting clients to the process of SDM will also provide space to discuss how engaged the client would like to be in treatment planning. Some clients may feel empowered and enjoy learning about and discussing available options. For other clients, many decisions may be overwhelming, and it will be more important to distill the most important decisions that would benefit from client engagement. Similarly, some clients value receiving a lot of information, whereas other clients may like to hear most about the clinician's recommendation and only the most evidence-based options.

SDM is most fitting when there are multiple treatment options that are available and appropriate. If a treatment option isn't available (either in a current treatment setting or at all), there will likely be little benefit to discussing it. Furthermore, engaging in SDM is not the same as providing all conceivable options to the client and letting the client choose. It is a collaborative process in which the clinician and client only consider options that are reasonable and relatively equally efficacious (or, at minimum, will not clearly have a deleterious impact). Although there is growing evidence that engaging in an SDM

Morgan S. Mitcheson

process is possible for clients with serious mental illness (Thomas et al., 2021) and varying developmental levels (Langer et al., 2022), how that process will look is likely to change. Similarly, in crisis situations, the time to engage in SDM treatment planning will be limited, and the number of available and appropriate treatment options may be too.

Katherine I. Escobar, BA

Commonly perceived barriers

Naturally, engaging in new practices invites hesitation and scrutiny. Légaré and Thompson-Leduc (2014) captured many frequently raised concerns (which they, clearly conveying their perspective, labeled "myths") regarding SDM. One of the most common concerns, also noted above, is that using SDM means clients are solely responsible for making the treatment decisions. However, SDM aims to optimize treatment planning by incorporating each stakeholder's perspectives and expertise (and, centrally, the empirical evidence), with the clinician guiding the process throughout. Clinicians providing their recommendations, in addition to presenting evidence and reaching mutual agreement, are core and ideal SDM elements across the most prominent SDM conceptualizations (Makoul & Clayman, 2006).

Another concern - perhaps the most frequent concern (Légaré et al., 2008) - is that SDM will take too much time. Unfortunately, there are limited data on the time it takes to use SDM to plan psychotherapy, though a systematic review showed (across medical encounter types) that SDM changed the consultation time by -8 to +23 minutes (median 2.5 minutes; Stacey et al., 2014). We expect that a detailed SDM discussion about the treatment plan will certainly take additional time, whether conducted entirely at the start of treatment or broken down into smaller discussions spread across several sessions. But we argue that such a discussion is important regardless (client empowerment and patient-centered care are core to our field's values), and that a clear and agreed upon treatment plan may still reduce overall treatment length.

Building competence in SDM and future directions

For clinicians interested in incorporating SDM in their practices, several trainings and web-based resources are available. Among these are the Evidence-Based Behavioral Practice training module on SDM with

individual clients (https://ebbp.org/training/individualmodule), the Ottawa Hospital Research Institute's patient decision aids toolkit (https://decisionaid.ohri.ca/), and the Agency for Healthcare Research and Quality (AHRQ)'s SHARE Approach curriculum tools and training program (https://www.ahrq.gov/health-literacy/professional-training/shared-decision/tools/index.html), which guides clinicians in the essential steps of SDM. However, these resources are geared towards SDM more broadly, given the relatively recent shift towards using SDM to plan psychosocial treatments. Unfortunately, training opportunities in implementing SDM in a psychotherapy practice are more limited and represent an important area for future research and development. This work could continue to examine the use, acceptance, and efficacy of SDM for psychotherapy clients across the lifespan, including the use of SDM with youth and parents as well as geriatric clients and caregivers. Involving multiple consumers (e.g., client and caregiver) in the SDM process may also require navigating disagreement across stakeholders and treatment decisions. Furthermore, continued investigation into how to describe psychosocial treatment options, expanded accessibility of relevant empirical evidence for clinicians and clients to use in treatment planning, and expanded access to evidence-based treatments will support the use of SDM to generate effective treatment plans.

Finally, to date, research on SDM in mental healthcare has primarily focused on adult populations in predominantly Western countries in Europe and North America. It is imperative that the impact of SDM is investigated across cultures and contexts, especially within marginalized and minoritized communities in which the provider-client power differential may be more pronounced due to differences in social location and histories of institutionalized discrimination and oppression in medical settings (Alegría et al., 2018; Dovidio et al., 2008; Simmons et al., 2021).

Regina Roberg, MS   **Jennifer S. Schild, MS**

References

Alegria, M., Nakash, O., Johnson, K., Ault-Brutus, A., Carson, N., Fillbrunn, M., Wang, Y., Cheng, A., Harris, T., Polo, A., Lincoln, A., Freeman, E., Bostdorf, B., Rosenbaum, M., Epelbaum, C., LaRoche, M., Okpokwasili-Johnson, E., Carrasco, M., & Shrout, P. E. (2018). Effectiveness of the DECIDE Interventions on Shared Decision Making and Perceived Quality of Care in Behavioral Health with Multicultural Patients. *JAMA Psychiatry,* 75(4), 325. https://doi.org/10.1001/jamapsychiatry.2017.4585017.4585

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist,* 61(4), 271–285. https://doi.org/10.1037/0003-066x.61.4.271

American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents. (2008). *Disseminating evidence-based practice for children and adolescents: A systems approach to enhancing care.* Washington, DC: American Psychological Association.

Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (Or it takes at least two to tango). *Social science & medicine,* 44(5), 681–692. https://doi.org/10.1016/s0277-9536(96)00221-3

Christon, L. M., McLeod, B. D., & Jensen-Doss, A. (2015). Evidence-based assessment meets evidence-based treatment: An approach to science-informed case conceptualization. *Cognitive and Behavioral Practice,* 22(1), 36–48. https://doi.org/10.1016/j.cbpra.2013.12.004

Clayman, M. L., & Makoul, G. (2009). Conceptual variation and iteration in shared decision-making: The need for clarity. In A. Edwards & G. Elwyn (Eds.), *Shared decision-making in health care (2nd ed., pp. 109-116).* Oxford, UK: Oxford University Press.

Dovidio, J. F., Penner, L. A., Albrecht, T. L., Norton, W. E., Gaertner, S. L., & Shelton, J. N. (2008). Disparities and distrust: The implications of psychological processes for understanding racial disparities in health and health care. *Social Science & Medicine,* 67(3), 478–486. https://doi.org/10.1016/j.socscimed.2008.03.019

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., ... & Barry, M. (2012). Shared decision making: a model for clinical practice. *Journal of General Internal Medicine,* 27(10), 1361-1367.

Hamann, J., Langer, B., Winkler, V., Busch, R., Cohen, R., Leucht, S., & Kissling, W. (2006). Shared decision making for in-patients with schizophrenia. *Acta psychiatrica Scandinavica, 114*(4), 265–273. https://doi.org/10.1111/j.1600-0447.2006.00798.x

Hamann, J., Leucht, S., & Kissling, W. (2003). Shared decision making in psychiatry. *Acta Psychiatrica Scandinavica, 107*(6), 403-409.

Langer, D. A., Holly, L. E., Wills, C. E., Tompson, M. C., & Chorpita, B. F. (2022). Shared decision-making for youth psychotherapy: A preliminary randomized clinical trial on facilitating personalized treatment. *Journal of Consulting and Clinical Psychology, 90*(1), 29-38.

Langer, D. A., & Jensen-Doss, A. (2018). Shared decision-making in youth mental health care: Using the evidence to plan treatments collaboratively. *Journal of Clinical Child & Adolescent Psychology, 47*(5), 821-831.

Langer, D. A., Mooney, T. K., & Wills, C. E. (2015). *Shared decision-making for treatment planning in Mental Health Care.* Oxford Handbooks Online. https://doi.org/10.1093/oxfordhb/9780199935291.013. 7

Légaré, F., Adekpedjou, R., Stacey, D., Turcotte, S., Kryworuchko, J., Graham, I. D., Lyddiatt, A., Politi, M. C., Thomson, R., Elwyn, G., & Donner-Banzhoff, N. (2018). Interventions for increasing the use of shared decision making by Healthcare Professionals. *Cochrane Database of Systematic Reviews, 2018*(7). https://doi.org/10.1002/14651858.cd006732.pub4

Légaré, F., Ratté, S., Gravel, K., & Graham, I. D. (2008). Barriers and facilitators to implementing shared decision-making in clinical practice: update of a systematic review of health professionals' perceptions. *Patient Education and Counseling, 73*(3), 526-535.

Légaré, F., & Thompson-Leduc, P. (2014). Twelve myths about shared decision making. *Patient Education and Counseling, 96*(3), 281-286.

Loh, A., Leonhart, R., Wills, C. E., Simon, D., & Härter, M. (2007). The impact of patient participation on adherence and clinical outcome in primary care of depression. *Patient Education and Counseling, 65*(1), 69-78.

Makoul, G., & Clayman, M. L. (2006). An integrative model of shared decision making in medical encounters. *Patient Education and Counseling, 60*(3), 301–312. https://doi.org/10.1016/j.pec.2005.06.010

Malm, U., Ivarsson, B., Allebeck, P., & Falloon, I. R. (2003). Integrated care in schizophrenia: A 2-year randomized controlled study of two community-based treatment programs. *Acta Psychiatrica Scandinavica, 107*(6), 415–423. https://doi.org/10.1034/j.1600-0447.2003.00085.x

National Institute of Mental Health. (2022). *The National Institute of Mental Health Strategic Plan*. https://www.nimh.nih.gov/about/strategic-planning-reports/goal-3-strive-for-prevention-and-cures

O'Neal, E. L., Adams, J. R., McHugo, G. J., Van Citters, A. D., Drake, R. E., & Bartels, S. J. (2008). Preferences of older and younger adults with serious mental illness for involvement in decision-making in medical and psychiatric settings. *The American Journal of Geriatric Psychiatry, 16*(10), 826–833. https://doi.org/10.1097/jgp.0b013e318181f992

Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111–148, 124 Stat. 119 (2010), Codified as Amended 42 U.S.C. § 18001.

Simmons, M., Farmer, J., & Filia, K. (2021). The need for representative research on Shared Decision making. Psychiatric Services, 72(11), 1245–1245. https://doi.org/10.1176/appi.ps.721102

Slade, M. (2017). Implementing Shared Decision Making in routine mental health care. World Psychiatry, 16(2), 146–153. https://doi.org/10.1002/wps.20412

Stacey, D., Légaré, F., Col, N. F., Bennett, C. L., Barry, M. J., Eden, K. B., Holmes-Rovner, M., Llewellyn-Thomas, H., Lyddiatt, A., Thomson, R., Trevena, L., & Wu, J. H. C. (2014). Decision aids for people facing health treatment or screening decisions. Cochrane Database of Systematic Reviews. https://doi.org/10.1002/14651858.cd001431.pub4

Thomas, E. C., Ben-David, S., Treichler, E., Roth, S., Dixon, L. B., Salzer, M., & Zisman-Ilani, Y. (2021). A Systematic Review of Shared Decision-Making Interventions for Service Users with Serious Mental Illnesses: State of the Science and Future Directions. Psychiatric Services (Washington, D.C.), 72(11), 1288–1300. https://doi.org/10.1176/appi.ps.202000429

APA Fall 2022 Research Spotlight

Interviewer: Nevita George

Interviewee: Vani Mathur, PhD

This spotlight highlights the scientific contributions of Dr. Vani Mathur. Dr. Mathur is an Assistant Professor of Diversity Science and Well-Being and Director of the Social Neuroscience of Pain Disparities Laboratory at Texas A&M University. She completed a PhD in cognitive neuroscience as a Society, Biology, and Health Fellow at Northwestern University, and interdisciplinary post-doctoral training in pain research at Johns Hopkins University and the University of Maryland, Baltimore. Taking a diversity science approach, her research focuses on understanding the sources and mechanisms of pain disparities. Pain disparities describe the unequal distribution of pain due to sociocultural factors, with minoritized groups having a heightened risk of experiencing chronic, debilitating pain. Dr. Mathur's ultimate goal is to identify novel targets to decrease pain inequity and injustice.

Dr. Mathur has dedicated her work to celebrating minoritized identities and increasing community-based collaboration. She conducts her research in a manner that is inclusive to individuals of all backgrounds and identities, and it is this dedication to equity that distinguishes her as scientist and researcher. I had the honor of speaking with Dr. Mathur about her path to promoting equity, diversity, and inclusion (EDI) throughout her career. A synopsis of her responses is bolded below.

Your commitment to highlighting the experiences of minoritized individuals is nothing short of inspiring. Could you tell us more about your entry into EDI work?

From an overarching perspective, EDI pervades all my scholarly efforts, including my teaching and service. However, my start in EDI work was driven by my research interests. I have always cared about pain research, and that passion is what first led me to this field. I knew I wanted to study pain from the time I was 12 years old, and my motivation to do so stemmed from a personal level as it affected my family. I witnessed first-hand the dearth of options for individuals living with pain. I saw how once it comes into existence, pain becomes intertwined with all aspects of life. However, I also quickly understood that while pain is common stance in American society, there were not many satisfactory solutions for pain management or resolution. Thus, my education and research have always been about understanding pain and the factors that may exacerbate or mitigate its effects. My earliest pain education came from people who are living with pain, and the stories that stick with me are those from people with pain that was not believed. At some point in

Vani Mathur, PhD

our lives, we are all going to experience pain. But having that pain and not having the belief and support from one's doctors, employers, friends, or family is a very salient part of the pain experience for too many. Therefore, for as long as I can remember, I have wanted to have a better understanding of who is not listened to and why. This led me to focusing on pain disparities in my research. Patterns of pain burden parallel those of societal hierarchy and oppression, implicating societal forces in the production of pain disparities. As I began to focus my research questions on upstream contributors to pain – thinking about structural, institutional, and cultural factors – I also recognized the compounding and overlapping disparities in society and our science. It became apparent that the people that were not believed by society, were also not represented in our research studies.

At this point of my career, I think deeply about the process and the structure of our science. I hope to aid in the effort to expand diversity and representation not only in my own pain research, but also in the field of pain, science, and psychology broadly. I have found that our systems are not structured to inherently support EDI initiatives. Thus, incorporating diversity and inclusion into our work means re-thinking the way we have always done things. I often return to and reflect upon questions about "reimagining" posed by a valued colleague, mentor, and friend – Dr. Jyotsna Vaid. For example,

"What would '[academia, our labs, our teams, our scholarship, etc.]' look like if EDI was ingrained in our systems from their inception?"

One area where I have worked to reimagine is in my conceptualization of collaboration. In other words, who has expertise and how is it valued? On the one hand, this is a natural extension of my transdisciplinary research. I love collaborating with scholars and practitioners who take different approaches or who see a different part of the same problem. But what voices are left out? My research team is currently working to envision and establish more equitable partnerships with people living with pain and members of our local community. While doing so, I continually strive to question my assumptions and the way I engage in all aspects of my work. So, my work and understanding in

in this area is ever evolving.

You so beautifully described the holistic way in which you engage in EDI initiatives. I'm curious as to what your own answer would be to the question you posed in your previous response. If everyone was included, what would "this" look like?

That is the hard, motivating question! Our recent research has sought to re-think how we approach cultural stereotypes and assumptions that impact how we treat people in pain. Many of these biases are baked into our basic assumptions, and they pervade our culture in ways that do not accurately represent individuals who bear a greater burden of pain and who are less likely to be believed for their pain. If everyone was included from the start, these assumptions might not be so ingrained. Therefore, in my own work this "start" includes evaluating who has expertise and how research teams look different when we value lived experience.

This work is challenging, and there are some structural barriers we've already encountered. When facing obstacles while executing a new or different research approach, I often challenge myself to ask, "what does that look like?" I do not know if I will ever feel like I have the answers to these questions, but I do start from the point of questioning the way I do things and the way things have always been done. This has helped me critically evaluate whether our methods are consistent with the end goal of our work. To eliminate pain disparities, we can't ignore that certain voices are being excluded, that structures of inequality are at play, and that injustice is often upheld by continuing with the status quo.

As you mentioned, this idea of "this" is everchanging, and its resolution requires constant innovation and interdisciplinary collaboration. For my next question, I want to understand more about your own journey within the field. How has your understanding of the field changed over the years and what misconceptions are you continuing to combat?

One thing that I talk about a lot (I teach it in my research methods courses and have been writing more about it) is that consideration of inclusion, representation, and diversity is a matter of scientific validity. I believe it is a misconception to frame EDI initiatives as a consideration strictly for researchers who engage in "that kind of work." The reality is that our current execution of science is not representative of the communities and individuals we strive to help. Inclusion and representation is foundational for generalizability and external validity of our research. Thus, integrating EDI initiatives into our scientific pursuits should be a venture we all care about. To do so, we must first recognize that EDI efforts have not

always been prioritized by the broader field. It is an area that requires collaborative growth, unity, and effort. This commitment is relevant for all of us. It is a part of scientific rigor and of the validity of the research we conduct as scientists.

Regarding your identity as a scientist, what are some of your philosophies on EDI and how do they manifest in your work?

When things get difficult, I always return to my "why." I care about pain and the fact that many people are living with pain. So far, our societal response to pain has resulted in injustice within healthcare. This injustice leads to disability and a higher burden on those affected, which then results in all the downstream effects we discussed. In the end, the "problem" is something that I always return to. To answer your question, there are many different philosophies that have influenced the way I conduct research. I have learned so much from researchers in my own field as well as others who have been doing critical work in the EDI realm for a long time. It is their example that has influenced how I think about things. I also think that EDI is necessary for valid science, and therefore needs to be part of every aspect of my work. These considerations are necessary at every stage of the research process to support the impact and generalizability of our research. I spend a lot of time with my research team as well as in my teaching (Research Methods), critically thinking about and discussing who benefits from science and who is left out of that benefit. Ethical considerations include not only protection from risks involved in research, but also who equitable access to the benefits of science. The impacts of exclusion and lack of diversity in health research, for example, contributes to the exclusion or lack of appropriate treatment options for certain populations. When we exclude certain groups from the start of the research process, then we exclude them from the benefits research has to offer.

My own journey of learning has led to more upstream thinking about how systems must be a part of our targets for intervention to promote health equity. My hope for both students in my classes and the field collectively is that we continue to question pre-existing concepts and update our theories and approaches based on new scientific discoveries. So now the question is, where do we go from here?

You make a concentrated effort to increase collaboration within your local communities. Could you speak more about what the process of gaining community trust looks like in your research?

In medical literature, we hear a lot about mistrust or distrust. This phrasing often places blame on the people who have been abused by science . So, I

rather think of it as trustworthiness. Instead of assuming that community hesitation in research participation is due to distrust, we should ask how we can become trustworthy. This is an area in which we as a field require a lot more growth. Thus, my own approach to engaging in community-based research has focused on being trustworthy – earning and honoring trust. I want my work to benefit my neighbors, so I place intentionality into conducting community-based research to try to think about community on a much more micro level. To do so, I try to be present and understand community identified problems when it comes to their experiences with pain. This often looks like spending time with people who are living with pain who are not believed. In these conversations, I not only listen to their experiences but also ask questions about what they think we should do. Community-based research exists on a longer scale. My team and I are working to let go of our own questions in these efforts and start by just being good neighbors. There is a lot I can do as a (non-researcher) person to become a more present and trustworthy member of my community. My main goal is often just that, to be a good citizen and understand how we can best contribute to society on a local level.

You spoke so wonderfully about the power and importance of language in EDI initiatives. What has your journey with the ever-changing nature of language in research looked like?

Language is important. It is also not something that is static, and meanings - as well as our own understanding of historical and cultural meaning – change over time. I've said before that I wish I could go back in time and update my language choices in many of my manuscripts. But, as I know better, I strive to do better. I do not expect the language choices I make today to hold up or be the "correct term" for all time, but rather prioritize making thoughtful choices each time. My team and I spend a lot of time discussing terminology and are committed to re-evaluating our terminology on a regular basis. Then, after thoughtful and informed decisions, we work to be as transparent as possible. This often looks like either defining our terms or including an explanation for why we chose those terms in that moment in time within our presentations and manuscripts.

While this feels new in some ways – dedicating space to define our terms – I find it fits well within our scientific norms. For instance, we are used defining and justifying how we choose to operationalize variables and appreciate that these definitions may not be appropriate in every case and that specific consideration for each study is needed. Similarly, we can describe our terminology choices and processes for a given paper/study at a given time. This is particularly important when describing populations. In these efforts, I have learned so much from qualitative scientist and qualitative methodology – particularly in retaining and valuing the rigor of reflexivity in the scientific process.

How have events like the COVID-19 pandemic impacted your perspective on EDI initiatives? How has the recent increase in attention to EDI-research impacted your work?

The pandemic highlighted disparities that have always existed. I believe this awareness has led to increased public receptivity and acknowledgement of the role of systems in exacerbating health inequities. I have seen this shift within my own work as well. There has been an increased interest from society and research journals to consider EDI-oriented scholarship. It is important to recognize that this work is not new, but I think that in some arenas there may be an increased awareness of the importance of EDI and examining structural factors. For me, this has led to more opportunities to collaborate to change structures within our field to increase inclusion, diversity, and justice.

However, the negative impacts of the pandemic cannot be overstated. The pandemic has intensified disparities and placed additional burdens on those already facing societal inequity and injustice. Of course, as researchers, we've had to re-visit our risk-benefit analyses. Many of my studies remain paused as the very communities that were collaborating and participating in our studies continue to bear a greater burden of this disease. These considerations and conversations highlighted the need for a shift in priorities and approach, but also demonstrated the expansion of the very injustices we have documented in our research.

You have always taken an interdisciplinary perspective when conducting your work. How has this approach impacted the way you conduct, consider, and disseminate your research?

I am a problem-focused scientist. Therefore, engaging in interdisciplinary research was born out of a necessity. My path into my current position was non-linear and involved training across several fields to gain the tools I needed to approach my research questions about pain. While I always wanted to study pain, pain didn't live in a single discipline and most approaches to pain were not inclusive of social and cultural considerations. Thus, I trained across fields of physiology, neuroscience, psychology, sociology, and anthropology and worked in academic and medical contexts. These experiences taught me how to view the problem from a variety of angles and the importance of a team. All of my research is collaborative, which I find incredibly rewarding. I am

always learning, and love the types of questions, ideas, and ways of thinking that emerge from new partnerships.

Are there any departing words or thoughts you would like to share with the audience?

I am hopeful about the increased awareness of systematic and structural injustice that pervade our society and our science. To facilitate the humanitarian benefit of our science, I think it is worthwhile to recognize that this process of acknowledgement is long-term. The opposite of EDI - exclusion, oppression, and injustice - are baked into so many aspects of our research. So, I hope we see an increase in psychologists leading the way in this important work through collaborative action. It may feel uncomfortable, at first, to modify the way in which we have always practiced our science. However, to do so, to engage in this work, is so important to becoming better scientists, practitioners, and most importantly, citizens and neighbors within our communities.

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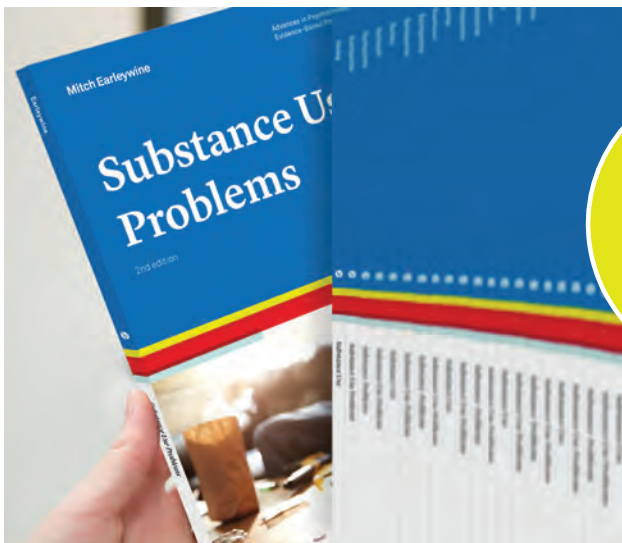
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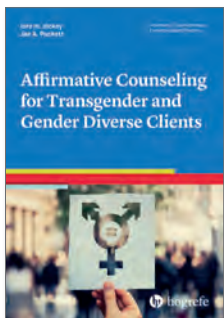PhD, ABPP

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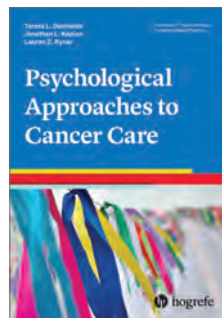
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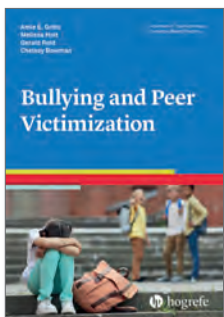
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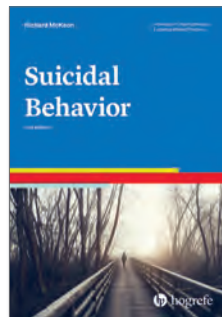
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New edition

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