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President Column

SCP Invests in the Future
Prioritizing Leadership Development

Donna LaPaglia, PsyD, ABPP

Leadership is not a stand-alone competency in psycholotraining. The APA Competency Benchmarks in Professional Psychology list leadership within the systems cluster, the 15th out of sixteen competencies, as sidenote to management. At SCP we believe leadership development is central to identity formation for professional psychologists, and helps ECPs find professional direction, clarity of purpose, and confidence to pursue professional goals that increase one's effectiveness across pursuits. The Education and Training committee led by Drs. Allison LoPilato and Mischa Bogamaz, in conjunction with the Division 12 board, have created a leadership program that focuses on developing leadership identity through enhancing self-awareness of an individual's existing leadership talents and competencies. In so doing we are expanding our focus to center our community on the inclusion, support, and mentorship of young psychologists. Our goal is to come along side our fellows and support the gifts, talents, and unique perspectives they already possess and to facilitate the development of a strong psychologist-leadership identity. Our hope is that these fellows will be future leaders of the division and will enrich the division 12 community moving forward. And after reading their narratives, you will see that there is much to be excited about.…

Meet the 1st LEAD Fellow Cohort for Division 12's Society of Clinical Psychology on the next page!

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Qimin Liu, PhD

Qimin Liu, PhD, is an Assistant Professor at Boston University in the Department of Psychological and Brain Sciences. Dr. Liu earned his Ph.D. in Psychological Sciences (Clinical Science & Quantitative Methods) from Vanderbilt University. He completed a Health Service Psychology Internship at the University of Illinois at Chicago Department of Psychiatry. Before that, he received a Master's degree in applied and computational mathematics and statistics from the University of Notre Dame and Bachelor's degrees in philosophy, psychology, and mathematics from the University of Washington. Dr. Liu's research focuses on (1) emotional disturbances across development (e.g., irritability, depression, suicide), (2) statistical method and software development (e.g., intensive longitudinal data models, data mining algorithms), (3) intersectional marginalization and health equity (e.g., sexual and gender minority health). Dr. Liu has diverse clinical experiences (e.g., mood and trauma/ stressor-related disorders) across settings (e.g., academic medical center, VA). At Boston University, Dr. Liu currently provides clinical services through the Center for Anxiety and Related Disorders and directs the Quantitative Psychopathology Laboratory.

Praise Iyiewuare, MPH, PhD

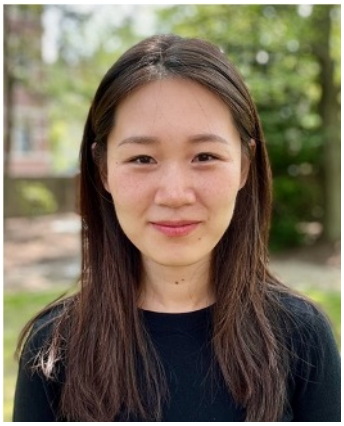
Praise Iyiewuare, MPH, PhD is a Lyman T. Johnson Postdoctoral Research Fellow at the University of Kentucky. She earned her doctorate in clinical psychology from the University of Vermont and completed her predoctoral internship at the University of Pennsylvania. She also holds a Master of Public Health degree from Columbia University with a concentration in sociomedical sciences. Her research focuses on pleasure as central to healing for Black women, particularly as related to sexual and reproductive health, experiences of trauma, and mood disorders. She has worked on a diverse array of topics in mental and public health, contributing to studies of: Black women's sexual health and wellbeing, mechanisms of treatment for seasonal affective disorder, delivery of prolonged exposure to individuals with opioid use disorder, integration of medication assisted treatment for substance use within primary care settings, and quality of mental health and substance use care for Veterans and military servicemembers. Praise's clinical approach is grounded in CBT and ACT frameworks with an eye towards cultural humility and explicit exploration of the impact of systematic oppression. Her clinical experience includes working with women with mental health concerns related to reproductive life events (e.g., pregnancy, childbirth, menopause), victims of violent injury (e.g., gunshot and/or stab wounds), immigrants and refugees, and cancer patients and their caregivers.

Jared Boot-Haury, PsyD

Dr. Boot-Haury (he they) is a licensed clinical psychologist, AASECT Certified Sex Therapist, and adjunct professor in the School of Nursing and Health Professions Clinical Psychology PsyD program at the University of San Francisco. They are passionate about educating the next generation of psychologists and serve as president-elect of APA Division 12's Graduate Students and Early Career Professionals Section. Jared also serves as a certified mentor for individuals seeking certification through the World Professional Association of Transgender Health. In addition, Dr. Boot-Haury works in private practice, seeing couples and individuals using acceptance and commitment therapy and emotionally focused couples therapy interventions, and works as an LGBTQ+ Research Fellow at Palo Alto University. Dr. Boot-Haury has authored several publications and has presented locally, nationally, and internationally on mental health and health disparities among LGBTQ+ communities and LGBTQ+ cultural competency training best practices. Their research to date has focused on improving mental health care experiences for LGBTQ+ communities and exploring minority stressors within LGBTQ+ populations with an emphasis on asexual individuals; they were awarded the 2023 APA Division 44 Transgender Research Award for their work. Dr. Boot-Haury also serves as the Policy and Government Affairs Committee Chair of GLMA: Health Professionals Advancing LGBTQ+ Equality, where he focuses on translating research into practice through policies and positions that encourage more affirming healthcare practices for health professionals who work with LGBTQ+ people.

Claudia Hristova, PhD

Claudia Hristova is beginning a two-year Clinical Postdoctoral Fellowship in Neuropsychology, Cognitive Aging, and Alzheimer's Disease and Related Dementias at the Banner Sun Health Research Institute. She has worked with the South Florida Institute of Aging and continues her involvement with the Alzheimer's Association. She has also taught introductory psychology courses to undergraduate and master's students at Ho Chi Minh University in Vietnam. Her research interests are centered on Alzheimer's and other dementias, particularly new treatments and early diagnosis methods. During the COVID-19 pandemic, she presented posters on the impact of COVID-19 on dementia progression and caregiver burden. Claudia's major project involved developing a Telehealth treatment manual for caregivers of patients with neurodegenerative diseases, incorporating positive psychology and well-being therapy to provide therapeutic services at home. Passionate about working with older adults, Claudia is dedicated to addressing the unique challenges they face and advancing the field of neuropsychology and geropsychology.



Evelyn Cho, PhD

Dr. Evelyn Cho is a postdoctoral fellow at Harvard University and an incoming assistant professor at the University of Oregon's Ballmer Institute for Children's Behavioral Health and the Department of Psychology. She received her training as a clinical child psychologist at the University of Missouri and completed her predoctoral internship at the UCLA Semel Institute. Her work aims to support high-quality delivery of evidence-based practice (EBP) to youths and families in everyday clinical settings. As a mental health services researcher, her primary research interests are to (1) understand the process and key mechanisms through which providers learn to deliver EBPs; and (2) develop implementation support tools that enhance EBP implementation for youth mental health providers. Her work has focused on gauging community providers' use of evidence-based treatment and assessment strategies, developing clinician support tools to enhance EBP adherence, and evaluating treatment outcomes for minoritized youths. Clinically, she has received training in manualized EBPs for child and adolescent anxiety, depression, disruptive behavior, and trauma at the University of Missouri's Center for Evidence-Based Youth Mental Health and the UCLA Semel Institute. As a postdoctoral fellow for the NIMH-funded Youth FIRST Study, she has received training in FIRST, a transdiagnostic, principle-guided treatment for youth internalizing and externalizing concerns, and provides consultation to community clinicians in their delivery of FIRST.

Isabelle Lanser, PhD

Dr. Isabelle Lanser is a licensed clinical psychologist and co-founder of Cypress Mental Health. She is currently a Social Justice Policy Analyst at the UCLA Depression Grand Challenge working to improve the scalability and accessibility of mental health services and reduce inequities in mental health services and research. Dr. Lanser earned her B.A. from University of North Carolina at Chapel Hill before completing M.A. and Ph.D. in Clinical Psychology at the University of California Los Angeles (UCLA). Dr. Lanser trained extensively in cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), and psychodynamic therapy at the UCLA Psychology Clinic and the UCLA Screening and Treatment for Anxiety & Depression (STAND) Clinic. Dr. Lanser completed her predoctoral internship at UCLA Counseling and Psychological Services where she specialized in short-term, evidence-based treatments for students with eating disorders, unipolar and bipolar depression, anxiety, grief/loss, cannabis use disorder, and traumatic disorders. She completed her postdoctoral training at the UCLA Anxiety and Depression Research Center where she examined mindfulness as a preventative treatment for youth at risk for developing depression and anxiety disorders. Dr. Lanser has conducted research on loneliness in young adults, focusing on how mental illnesses can disrupt relationships by taking young people out of their social worlds and making it difficult for them to maintain or re-establish interpersonal connections.

Rita Rivera, PsyD

Rita M. Rivera, PsyD, is a clinical psychology postdoctoral fellow at Yale University School of Medicine. She earned her Doctorate in Clinical Psychology with a concentration in Neuropsychology at Albizu University and completed her clinical residency at Duke University. Dr. Rivera has clinical & research experience working with multicultural & multilingual individuals, immigrant populations, college students, patients with neurological conditions, and trauma survivors in the United States and Latin America. Her clinical interests include anxiety and depressive disorders, trauma, neurocognitive presentations, and cross-cultural adjustment. Dr. Rivera adheres to a biopsychosocial model & integrates cognitive-behavioral, trauma-informed, and relational-cultural frameworks. Currently, she serves as the Early Career Psychologist Representative of the American Academy of Clinical Psychology (AACP) and as a board member of the APA's Society of Group Psychology and Group Psychotherapy (Div. 49). Dr. Rivera is a Hispanic/Latina/Honduran clinician, a first-generation immigrant, and a former international student.

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Utility of the Hierarchical Taxonomy of Psychopathology (HiTOP) System in Diverse, Underrepresented, and Epistemically Excluded Populations

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The standard of diagnosing and categorizing mental disorders has long been based on a categorical approach, codified within the Diagnostic and Statistical Manual of Mental Disorders in the USA (e.g., DSM-5-TR; American Psychiatric Association, 2022) and the International Classification of Diseases in much of the world (e.g., ICD-11; World Health Organization, 2019). But this categorical approach has been criticized due to limited reliability, validity, and clinical utility (e.g., Conway et al., 2019; Widiger et al., 2018); the Hierarchical Taxonomy of Psychopathology (HiTOP) was introduced in 2017 as a potential solution to some of the DSM's limitations (Kotov et al., 2017, 2022; Conway et al., 2021b; Ringwald et al., 2023). Briefly, the HiTOP model is a quantitatively-derived reorganization of the signs, symptoms, and traits reflective of mental illness based on their patterns of covariance and comorbidity. The result is a phenotypic hierarchy that conceptualizes the structure of psychopathology along increasingly broad/more aggregated dimensions based on the patterns of co-occurrences of those signs, symptoms, and traits (Caspi et al., 2014; Kotov et al., 2017, 2022). For readers new to the HiTOP model, we recommend consultation of The Clinical Psychologist's Winter 2021 issue where Conway and colleagues (2021a) offer an introduction to the model.

Of particular relevance to this readership is literature related to clinical utility and clinicians' perceptions of the HiTOP model. Research reveals a marked lack of participation in standard diagnostic processes in the mental health field, with providers largely using diagnosis as a means of billing insurance companies for services, and rarely offering diagnostic feedback to clients or applying a formal diagnostic classification system to inform treatment decisions (Cassels, 2017; Ruggero et al., 2019). One survey found that in a sample of over 6,000 USA healthcare workers, 55% denied incorporating the diagnostic manual into their practice at all, including 40% of surveyed psychologists (Cassels, 2017). Among mental health providers, there is evidence of extensive dissatisfaction with the DSM, and preliminary research suggests that clinicians prefer a dimensional approach—congruent with the HiTOP model—over the DSM and its categorical approach (Balling et al., 2023; Bornstein & Natoli, 2019; Hansen et al., 2019; Samuel & Widiger, 2011). For instance, in a recent study by Balling and colleagues (2023), a sample of 143 actively practicing clinicians (including 77.6% self-identified clinical psychologists) rated both the DSM and HiTOP approaches on seven indices of clinical utility. Among these clinicians, the dimensional HiTOP approach was rated more favorably when compared with the traditional, categorical DSM approach along the domains of 1) forming a treatment plan, 2) communicating with clients, 3) comprehensively describing psychopathology, 4) describing global functioning, and 5) ease of application. There was no preference between HiTOP and the DSM for communicating with other mental health providers, and the DSM was not rated more favorable than HiTOP for any clinical utility outcome. These results replicated even in a subsample of clinicians who had never heard of the HiTOP model prior to the study.

As the work of the HiTOP Consortium continues to expand and improve various facets of the model and its applicability for myriad purposes (e.g., clinical utility, improved measurement, etc.), another area of particular

particular importance for the HiTOP model—and indeed any psychiatric classification system—is how the system aligns with values related to diversity, equity, inclusion, and justice (DEIJ). Our goal for this article is to offer a brief summary of the state of the literature relating the HiTOP framework to diverse, underrepresented, and epistemically excluded populations (Settles et al., 2020; i.e., those populations who are typically excluded from mainstream quantitative psychology foci based on race, ethnicity, nation of origin, immigration status, sexual orientation, gender identity, sex assigned at birth, age, socio-economic status, disability, and neurocognitive status). We briefly discuss some of the advantages of the model specifically with respect to diverse and underrepresented populations. We also discuss some limitations of the model and avenues for future improvement.

Advantages of HiTOP for Underrepresented Populations

Early Focus on Generalizability

In the development of the HiTOP model, particular focus was placed on examining data from multiple countries to estimate the generalizability of the patterns of covariation of various psychiatric disorders (i.e., the patterns that underlie the dimensions espoused within the HiTOP model). From this, there is strong support for cross-national generalizability of the internalizing and externalizing—and to a lesser extent the thought disorder—spectra, as well as some of the syndromes within these spectra (e.g., Caspi et al., 2014; Kessler et al., 2011; Krueger et al., 2003; de Jonge et al., 2018; Slade & Watson, 2006). However, such epidemiological data typically overrepresent dominant populations. Even large, nationally representative samples can be unsuitable for examinations of generalizability among relatively smaller sub-groups. For example, among psychiatric epidemiology samples within the US, the sample sizes of sexual and gender minority individuals are frequently so small that they preclude appropriate focus on this underrepresented populations. Thus, a more concerted effort must be placed onto examining how these purportedly universal dimensions operate among diverse populations.

Measurement invariance research is an additional quantitative method for arbitrating generalizability of the HiTOP model; this statistical method aims to assess whether a given measure assesses the same construct in the same way across different groupings. For example, measurement invariance could assess whether a self-report scale of psychiatric symptoms (e.g., the PHQ-9) possesses the same psychometric properties across different sociodemographic groupings (e.g., racial/ethnic identity). If the scale indeed measures the intended construct regardless of group membership, it would be invariant of that grouping and allow confidence that any group mean differences observed were to due to differences in the underlying construct and not, for instance, due to differences in psychometric properties of the measure. To date, measurement invariance research of the HiTOP model has been limited to US samples. But, within these data the internalizing and externalizing—and to a lesser extent thought disorder—dimensions have demonstrated invariance across such grouping as race/ethnicity, sexual orientation, age, and sex assigned at birth (Afzali et al., 2018; Eaton et al., 2012, 2013, 2021; He & Li, 2021). That is, group-based differences on these dimensions are not due to variable psychometric properties associated with group membership, but due to relative elevations in the dimensions themselves. This type of approach has previously highlighted how differences in endorsement of even a single item between sexual and gender minority and cisgender heterosexual individuals creates illusory mean-level differences on dimensions of interest (Asadi et al., 2024). Together, this empirical evidence suggests broad generalizability of some of the major dimensions within the HiTOP model within US samples, meaning that there is a level of trust that these dimensions are equivalent among underrepresented and marginalized populations, who are not typically the focal groups within mainstream psychopathology research.

Incorporating Social Determinants of Health

While generalizability research suggests that the dimensions within the HiTOP model apply widespread across diverse populations, another advantage of the HiTOP approach is its congruence with determinants of health that are important for understanding psychiatric disparities among diverse and marginalized groups. Crucially, minority stress processes impact the signs, symptoms, and traits of mental disorders (Brooks, 1981; de Lange et al., 2022; Frost & Meyer, 2023; Hoy-Ellis, 2021; Sattler & Zeyen, 2021). That is, the stressful experiences that individuals who hold minoritized identities face predict psychiatric malaise of various forms. However, this literature becomes unwieldy for the researcher and clinician. Because of the myriad categorical disorders, the accumulated research that takes a disorder-specific approach results in a piecemeal narrative of how different minority stressors are related to each of hundreds of categorical psychiatric disorders. Rather than approaching an understanding of some of the fundamental determinants of health for marginalized populations from such a fragmented approach, a dimensional approach more

congruent with the HiTOP model streamlines understanding of how social and contextual factors differentially impact minoritized populations.

Minority stress processes—like racial discrimination (Rodriguez-Seijas et al., 2015) and rejection sensitivity (Cohen et al., 2016; Rodriguez-Seijas et al., 2019b)—affect myriad psychiatric domains. The HiTOP approach, therefore, helps to streamline these disparate, disorder-specific literatures into a coherent narrative (Eaton et al., 2021). Further, this appears congruent with advances in transdiagnostic intervention approaches both generally (Barlow et al., 2017) and specific to marginalized populations (Pachankis et al., 2019; Rodriguez-Seijas et al., 2019b). However, while we believe that the HiTOP approach holds promise for better conceptualizing the widespread deleterious effects of minority stress processes, it is notable that the empirical literature on this topic to date has remained relatively limited (Rodriguez-Seijas et al., 2023). Indeed, the number of formal studies examining these social determinants of health and various HiTOP domains can be counted on one hand at this time.

Potential for Alleviating Diagnostic Bias

Clinical psychologists are generally aware of diagnostic bias associated with traditional diagnostic categories. Bias can manifest as a difference in the diagnostic labels applied to individuals based on their group membership rather than experienced psychopathology per se (e.g., Garb, 2021; Masuda et al., 2020). As examples, previous research demonstrates gender bias in the diagnostic criteria of various personality disorders (Jane et al., 2007; Morey, 2019), gender and ethnoracial bias related to eating disorder diagnoses among men or Black individuals (Schoen et al., 2018; Gordon et al., 2006), and ethnoracial disparities in diagnosing psychotic disorders (see literature review: Schwartz & Blankenship, 2014).

The HiTOP approach might help alleviate diagnostic bias. Here we detail an example. There is evidence of racial diagnostic bias when accounting for psychotic and mood disorder symptoms through a DSM lens; Black individuals are likelier to receive psychotic disorder labels with poorer prognosis (e.g., schizophrenia) compared with their White counterparts presenting with the same symptoms—who are likelier to be diagnosed with a mood disorder (e.g., major depressive disorders with psychotic features; Akinhanmi et al., 2018; Gara et al., 2019). By using a dimensional approach, congruent with the HiTOP model, however, the opportunity for diagnostic bias might be reduced. Indeed, data demonstrates that clinician biases are most evident in the final categorical diagnostic decision. Ratings of polythetic diagnostic criteria and dimensions of psychopathology appear less susceptible to clinician diagnostic bias related to a patient's possession of a marginalized identity (Morey & Benson, 2016; Morey & Ochoa, 1989; Rodriguez-Seijas et al., in press). By conceptualizing the symptoms of Black and White individuals through (theoretically) identical latent constructs, and by adopting a dimensional approach that covers a few psychopathology dimensions regardless of an individuals' presenting concern—rather than being dependent on the clinician to assess all of the hundreds of specific diagnostic categories or omit any others—it might be possible to better cover psychopathology across individuals regardless of sociodemographic grouping, helping to alleviate clinician bias.

Indeed, this is congruent with findings that categorical diagnostic disparities can be explained by a shared latent construct rather than varied, prolific disparities across categorical diagnoses (e.g., Eaton et al., 2021; Rodriguez-Seijas et al., 2019a). With a HiTOP framework, clinicians (and researchers) can consider bias at different levels of abstraction and across levels of the hierarchy, rather than collapsing this rich information into a single binary diagnosis. If there is evidence of reduced bias at certain levels, such as for the signs, symptoms, and traits of psychiatric illness, the validity of diagnostic determinations at those levels is more assured. Alternatively, if we translate hypotheses about the HiTOP model's statistical generalizability to this question of diagnostic bias, it is possible that higher levels of the hierarchy may show the least bias while lower levels exhibit the most (i.e., Cicero & Ruggero, 2020; He & Li, 2021). Again, however, these claims that the HiTOP approach can alleviate bias are based on relatively limited data but a strong theoretical rationale. More empirical research specifically devoted to this topic is warranted.

Future Directions for HiTOP with respect to Underrepresented Populations

The HiTOP model does not address all potential criticisms of the DSM (or any classification system) in relation to DEIJ issues. For example, there lacks an examination of cause or context for a client's psychiatric symptoms; the HiTOP consortium has aimed to remain agnostic regarding the etiology of psychopathology. A common sentiment among clinicians is the desire for a diagnostic approach that accounts for dynamic processes in treatment and unifies the objective outsider ("etic") with the subjective insider ("emic"; Verona, 2021). Clinicians desire causes and context, but at present, no diagnostic model provides this—nor necessarily can. The HiTOP model also does not distinguish between cultural differences in the associated

distress or impairment of symptoms, actual differences in psychiatric symptoms, nor biases in assessment methods. Further, the HiTOP model offers only a "deficit-focused" clinical assessment. The diagnostic information collected via HiTOP approach (and most gold-standard DSM assessments) lacks measurement of positive psychological constructs or psychological assets that might be crucial for case formulation and treatment planning. Given that marginalized or underrepresented groups are often over-pathologized (e.g., Eaton et al. 2021, Schwartz & Blankenship, 2014), it is even more important to acknowledge psychological strengths. Further, it is possible that behaviors considered forms of psychopathology might represent population-specific ways of adaptively responding to psychosocial stressors. These sorts of considerations reflect a broader conversation about the limitations of assessment and diagnosis in general. It would behoove the HiTOP consortium, as well as the developers, investors, or disseminators of any diagnostic system, to dedicate time to exploring how such processes and considerations might be integrated. Nonetheless, a major advantage of the HiTOP approach involves its ability to actively accommodate new and emerging research evidence. Thus, it is possible to strategically study many of these specific questions and concerns.

At present, the HiTOP consortium has generated a preliminary self-report measure meant to assess the various dimensions of the HiTOP model, though it awaits experimental validation (Simms et al., 2022). At this time, there are plans to increasingly collect data from members of minoritized groups to inform future refinement of the measure and development of practical tools such as group-based norms. However, as highlighted by Verona (2021), assessment items that are necessary and informative for persons from marginalized groups may have already been eliminated during earlier phases of the measure development process. Approaching marginalized groups as an extension or focal group after model development is not exclusive to HiTOP but is—unfortunately—reflective of the prototypical approach to psychopathology theory, research, and treatment within dominant models (Settles et al., 2020; Rodriguez-Seijas et al., 2024).

It is crucial to note that, like any diagnostic system, simply applying the HiTOP model to diverse populations is insufficient. Increased attention to the social, structural, and other determinants of health that shape the structure of "psychopathology" is crucial, as in any corner of the field. Future research within the consortium is tasked with assessing whether associations with ancillary components of the model actually vary across different populations. Further, integrating lived experience in assessment and diagnostic procedures is also critical; it would benefit any diagnostic approach to integrate members of all communities in the development process. Qualitative methods are particularly useful for such an objective. Consideration of personal expertise is invaluable for understanding context of "psychopathology," as well as how diagnostic dimensions map onto social and structural forces. These will elevate and accelerate efforts to reduce bias and improve generalizability in diagnostic models. Further, quests for establishing generalizability must be paired with consideration that a universal model of psychopathology might not exist. This leads to the possibility of making appropriate and necessary adjustments to the HiTOP model to reflect the structure of psychopathology as it varies across groups. A reasonable question among the consortium is if there is only one HiTOP hierarchy, or many?

While the representation of marginalized populations remains somewhat limited, two characteristics are noteworthy of the HiTOP approach to psychopathology. Firstly, the consortium houses a workgroup specifically devoted to diversity, equity, and inclusion-related issues. As members of this DEI workgroup, we are collectively focused on increasing the empirical literature pertaining to many of the topics we discussed above. Secondly, the HiTOP model has been designed to be an active model that is amenable to change as novel evidence becomes accumulated (Forbes et al., 2024). Thus, we believe that the model inherently permits a level of plurality that might not be as easily accessible in traditional, categorical classification systems. So, it is wholly possible that signs, symptoms, and dimensions within the model might differ based on group membership or in their association with various social determinants of health. In our opinions, this level of plurality is entirely possible and can be accommodated within the model.

Conclusion

The generalizability of the HiTOP model remains in question for many groups. Available data offers some understanding of the generalizability of HiTOP based on race, ethnicity, nation of origin, age, sexual orientation, and gender identity. However, factors related to socio-economic status, disability, neurodiversity, and immigration status have received little to no attention in the literature. Further, the nuances within a given group are often lost in the available literature, such as erasing certain identities (e.g., intersex) or collapsing other marginalized groups together despite being distinct (e.g., treating trans, nonbinary, two-spirit, and genderqueer people as a homogenous group). Finally, focus remains on identity groupings themselves,

rather than on the social and contextual factors that are responsible for these groupings in the first place (e.g., racism is the cause of race, and not the converse; Williams, 2019). At present, mainstream psychopathology literature incorporates little of this very complex nuance.

Nonetheless, we believe that the HiTOP model shows promise for use among marginalized and systemically excluded clients, and more progress in necessary. The present article represents a high-level summary of some ideas presented by Rodriguez-Seijas and colleagues in our 2023 paper, "Diversity and the Hierarchical Taxonomy of Psychopathology (HiTOP)." We direct the reader to this publication for more detailed consideration of the application of the HiTOP model in diverse populations. For the clinician interested in incorporating HiTOP into their clinical practice, we recommend visiting the HiTOP Clinical Network page at https://www.hitop-system.org/the-clinical-network (HiTOP Consortium, 2024) where members of the HiTOP consortium have put together a multifaceted training program on the use of the HiTOP model for clinical purposes, including a module specific to using the model when considering diverse and marginalized populations. Audiences with a more clinical focus might also peruse the enlightening and ever-evolving implementation literature, including articles such as "Integrating the Hierarchical Taxonomy of Psychopathology (HiTOP) into Clinical Practice" (Ruggero et al., 2019), "Integrating Psychotherapy with the Hierarchical Taxonomy of Psychopathology (HiTOP)" (Hopwood et al., 2020), and, from the Clinical Psychologist, "The Hierarchical Taxonomy of Psychopathology (HiTOP): A Brief Introduction and Resource Guide for Clinical Psychologists" (Conway et al., 2021a).

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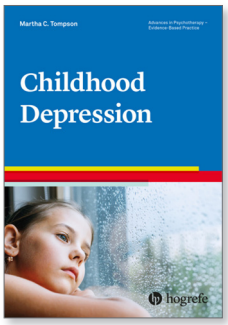

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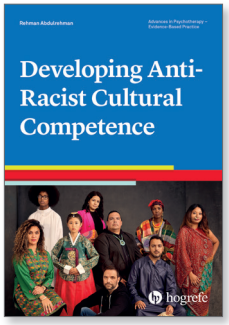

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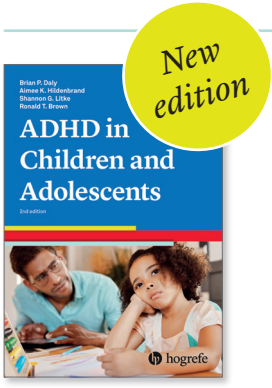

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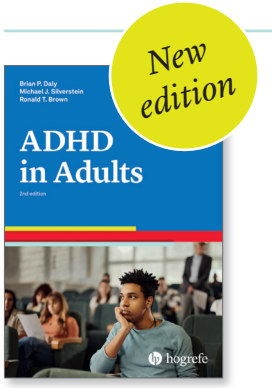

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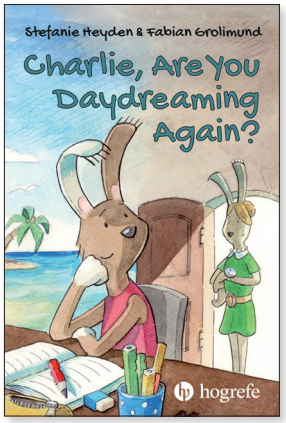

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