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“Trying Your Best in That Moment with That Person”:  
Maintaining Feelings of Efficacy and Relevance in the Therapeutic Relationship  
with Community Mental Health Clients Experiencing Psychosis

by Carolyn A. Solo

2024

Submitted to the Faculty of Bryn Mawr College  
in partial fulfillment of the requirements for  
the Degree of Doctor of Philosophy  
in the Department of Social Work and Social Research

Doctoral Committee:

Dr. David Byers, Advisor

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## Abstract

Community mental health clients who experience psychosis, particularly Black and Latinx clients, are subject to numerous barriers to competent clinical care. The fundamental challenges of community mental health settings can be detrimental to clinicians' belief that they can be effective while providing care to clients with psychosis in alignment with the common factors of therapeutic treatment and the principles of trauma-informed care. This dissertation proposes a grounded theory based on 16 participant interviews with community mental health clinicians in Philadelphia who have worked in outpatient settings with clients with psychosis. Using the frameworks of self-efficacy theory (Bandura, 1977), the common factors in therapy (Wampold, 2001), the principles of trauma-informed care (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023), and critical whiteness theory (Okun & Jones, 2016), but primarily relying on the findings of study participants, this dissertation provides evidence for the following grounded theory: When clinicians do not believe that they have the skills or ability to provide care to clients with psychosis, they may sacrifice the core elements of a safe therapeutic relationship and devalue empathic connection with clients in service of actions that give the therapists a sense of agency. Clinicians engage in behaviors that may be counter to the common factors of relational psychotherapy and trauma-informed care principles to achieve a sense of efficacy in their work with psychotic clients, because the environment in which they work, and its multiple and conflicting pressures hamper their ability to provide the care they need.

**Keywords:** *psychosis, community mental health, clinician self-efficacy, trauma-informed care, common factors, critical whiteness theory*

## **Dedication**

To my parents, Beverly and John Shank,  
who have supported me and believed in me on this journey  
since June 8, 1980

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## **Chapter 1: Introduction**

Community mental health clients who experience psychosis, particularly Black and Latinx clients, are subject to numerous barriers to competent clinical care. There is limited research on the impact of the structural and institutional barriers on the care clinicians can offer in community mental health settings. Clinicians in community mental health are often new to the field and face numerous obstacles as they attempt to provide competent care to psychotic clients. High caseloads, limited training, poor supervision, high-risk clients, onerous paperwork requirements, and their own inexperience – create fundamental challenges to clinicians’ belief that they can be effective while providing care in alignment with the common factors of therapeutic treatment and the principles of trauma-informed care. This dissertation will report findings providing evidence for a grounded theory informed by self-efficacy theory, the research literature on common factors in therapy, perspectives on trauma-informed care, and critical whiteness theory (Bandura, 2001 & 1997; Wampold, 2001; Substance Abuse and Mental Health Services Administration [SAMHSA], 2023; University of Buffalo, 2023; Bendall et al., 2021; McIntosh, 2003; Miller et al., 2015; Okun & Jones, 2016) to examine the treatment of psychosis in community mental health centers (CMHCs).

The structural and institutional barriers present in CMHCs can complicate clinician implementation of the common factors of relational therapy and the principles of trauma-informed care in the treatment of psychosis. Trauma-informed care is not typically situated within the framework of common factors, or within the literature on improving treatment outcomes for clients with psychosis, but they build on one another in that both stress client autonomy, creating safety in the relationship with clients, and a

collaborative therapeutic alliance (Wampold, 2001; SAMHSA, 2023; University of Buffalo, 2023; Bendall et al., 2021; Miller et al., 2015). Also implicit in trauma-informed principles and the common factors, though rarely discussed in either case, is the clinician's sense of self-efficacy. Self-efficacy is a concept most theorized by Bandura (2001, 1997, & 1977) and suggests that an individual's ability to accomplish a task or goal not only requires skill and ability, but also a belief in oneself as a necessary antecedent to the confidence and motivation needed to accomplish a task or goal. When clinicians do not believe that they have the skills or ability to provide care to clients with psychosis, they may sacrifice the core elements of a safe therapeutic relationship and devalue empathic connection with clients in service of actions that give the therapists a sense of agency. These actions can conflict with clinician belief in the principles of trauma-informed care.

The demographic realities of client populations in the urban CMHC's in Philadelphia mean that clients are very likely to have a white therapist. Approximately 67% of all individuals enrolled in Medicaid – a requirement for accessing community mental health services in Philadelphia - identify as Black or African American (PA.gov, 2023). The next highest racial group of Philadelphia's Medicaid enrollees are white individuals – approximately 20% (PA.gov, 2023). The mental health workforce in the United States is overwhelmingly white, with over 86% of workers identifying as white, and only 4% identifying as Black (Lin et al., 2018). How traits of whiteness operate as norms and markers of wellness may challenge clinical dyads to achieve common factors in treatment. In addition, the characteristics of white supremacy culture and institutions, which can overlap with actions clinicians take to feel effective, can obstruct clinician



attempts to provide trauma-informed care. The primary research question of this study is: How do clinicians in community mental health agencies preserve their feelings of efficacy, agency, and relevance in the treatment relationship with clients who experience psychosis?

I completed a modified grounded theory study in which I interviewed 16 outpatient mental health therapists in CMHCs in Philadelphia who work with BIPOC clients who have experienced psychosis. There is limited research on the clinical interaction with clients with psychosis more generally, and even more limited research on how issues of structural inequality impact therapist perception of client symptomology and therapist approach to client treatment, particularly in CMHCs. The research on self-efficacy theory and its impact on clinician work with clients with psychosis is almost nonexistent. The perspective of social workers, who are ethically and professionally obligated to address structural and institutional forces and their impact on an individual's experience, is vital to the understanding of the experience of providing critically conscious treatment to those who experience psychosis.

This study proposes a modified grounded theory informed by the theoretical frames of self-efficacy theory, the common factors of therapeutic treatment, critical whiteness theory, and the principles of trauma-informed care, but primarily originating from the findings shared by study participants. When clinicians do not believe that they have the skills or ability to provide care to clients with psychosis, they may sacrifice the core elements of a safe therapeutic relationship and devalue empathic connection with clients in service of actions that give the therapists a sense of agency. Clinicians engage in behaviors that may be counter to the common factors of relational psychotherapy and

trauma-informed care principles to achieve a sense of efficacy in their work with psychotic clients, because the environment in which they work, and its multiple and conflicting pressures hamper their ability to provide the care they need.

### **Problem statement**

Community mental health clients who experience psychosis, particularly Black and Latinx clients, are subject to numerous structural and institutional barriers to compassionate, trauma-informed, and anti-oppressive care. There is limited research on the impact of structural barriers on the diagnosis and treatment of clients experiencing psychosis. Although much of the history and present of diagnosis and treatment of psychosis views symptoms through medicalized pathology, emergent research argues for a biopsychosocial approach to psychotic diagnoses (Alvarez et al., 2011; Alvarez et al., 2021; Metzl, 2011; Morera et al., 2017; Morgan et al., 2006; Moskowitz et al., 2011).

Most people seeking mental health care in community-based agencies are Medicaid recipients. In 2018, 28.3% of people over the age of 18 diagnosed with a mental illness received Medicaid (Kaiser Family Foundation, 2017). Severe mental illness correlates highly with living in poverty, and therefore, a significant proportion of the community mental health client population suffers from debilitating mental health conditions (SAMHSA, 2017). Psychotic symptoms may be viewed as protective and normative responses to the trauma of racism and poverty (Anglin et al., 2014; Fanon, 1963; Pearce et al., 2019; Sweeney et al., 2015; Topor et al., 2014). Almost 73% of social workers in the United States are white (Salsberg et al., 2017). Fanon's (1963) concept of the "white gaze" that dehumanizes Black, indigenous people, and other people of color

(BIPOC) increases the chances of white clinicians in community mental health viewing these protective responses to trauma as symptoms of disorder and illness.

In this project, I consider how trauma-informed models of care (SAMHSA, 2023; University of Buffalo, 2023; Bendall et al., 2021) and feelings of self-efficacy, relevance, and agency (Bandura, 2001; Bandura, 1997; Coll et al., 2012; Larson, 1998; Larson & Daniels, 1998; Stoltenberg, 1998) impact clinicians working with psychotic clients in these settings. I also bring together critical whiteness theory and the research literature on common factors in therapy (McIntosh, 2003; Miller et al., 2015; Okun & Jones, 2016; Wampold, 2001) to examine the treatment of psychosis in CMHCs. Trauma-informed care is a framework for examining how service providers and the organizations at which they work, across the human services field, can provide competent care for clients who have experienced traumatic experiences (University of Buffalo, 2023). A foundational component of trauma-informed care is the idea that, more often than not, clients presenting to treatment or for services have a history of trauma and, therefore, agency and service provider interactions with clients need to take this into account (SAMHSA, 2023; University of Buffalo, 2023; Bendall et al., 2021). In this study, I look to see how clinicians balance the constraints of their settings with the components of trauma-informed care: safety, choice, collaboration, trustworthiness, and empowerment (SAMHSA, 2023; University of Buffalo, 2023).

The literature on common factors examines the commonalities that exist across therapeutic modalities, including the importance of the therapeutic alliance, engagement, client and therapist factors, and the therapeutic setting and frame (Miller et al., 2015; Wampold, 2001). Critical whiteness theory critiques how traits of whiteness operate as

norms and markers of wellness and are used to pathologize emotional, behavioral, and psychological norms of other races and ethnicities (McIntosh, 2003; Okun & Jones, 2016). How traits of whiteness operate as norms and markers of wellness may influence the ability in clinical dyads to achieve common factors in treatment. This study also examines how the characteristics of white supremacy culture in institutions influence the dynamics of clinical work with psychotic clients.

Self-efficacy theory (Bandura, 1995) is defined as “beliefs in one’s capabilities to organize and execute the courses of action required to manage prospective situations” (p. 2). Bandura (1997) theorized that individuals’ ability to accomplish a task or goal not only requires skill and ability, but also a belief in oneself as a necessary antecedent to the confidence and motivation needed to accomplish a task or goal. Counselor self-efficacy (CSE) theory is based closely on Bandura’s model for self-efficacy; that is, a clinician’s belief in their ability to achieve positive results in therapy with clients determines their ability to do so (Coll et al., 2012; Larson & Daniels, 1998). CSE gives insight into how therapists manage the often-opposing tensions of their work environment and the trauma-informed values by which they wish to practice.

As informed by these theoretical frames, the primary research question of this study is: How do clinicians in community mental health agencies preserve their feelings of efficacy, agency, and relevance in the treatment relationship with clients who experience psychosis? I hope my results will ultimately lead to more anti-oppressive, compassionate and trauma-informed approaches to clinical work with community mental health clients who experience psychosis.

### **Clinical Dyads in Community Mental Health**

As almost 73% of social workers (Salsberg et al., 2017) and over 86% of all mental health workers (Lin et al., 2018) are white, and urban CMHCs most frequently serve Black clients, the most likely therapeutic dyad in an urban CMHC is a Black client with a white clinician (CSWE, 2017; Kaiser Family Foundation, 2017). Not only do BIPOC clients frequently work with white therapists, but they are also subject to the relational instability of frequent changes in therapists. High turnover, resulting in unexpected transitions and ruptured attachments for clients, is a common feature of CMHCs (Glisson et al., 2008; Green et al., 2013). Annual turnover rate for clinicians in CMHCs can range from 30% to 70% (Bukach et al., 2017). This practice setting offers much to social workers and early-career mental health clinicians, who quickly assume great amounts of responsibility and gain extensive experience. However, they take this experience, often for higher pay and less stressful work environments, and leave clients behind when they leave (Yanchus et al., 2017).

### **Racism and Psychosis**

Although much of the history and present of diagnosis and treatment of psychosis views symptoms through medicalized pathology (Alvarez et al., 2011; Alvarez et al., 2021; Morera et al., 2017; Morgan et al., 2006; Moskowitz et al., 2011), emergent research argues for a biopsychosocial approach to psychotic diagnoses (Alvarez et al., 2011; Alvarez et al., 2021; Corstens & Longden, 2013; Varese et al., 2012). Black people are more likely to experience racism and consequently more likely to experience psychosis (Anglin et al., 2014; Pearce et al., 2019). Experiencing a greater range of discriminatory events – for example, police abuse; being discouraged from education; job-related issues like being fired, not being hired, and being denied a promotion; being

denied a loan; neighborhood exclusion; neighbor harassment - is associated with increasing risk of psychotic symptoms (Oh et al., 2016). Possible explanations for the relationship between discriminatory events and increased risk of psychotic symptoms include the discriminatory event's likelihood of increasing daily stressors, the increased emotional impact of daily stressors, and the potentially life-altering or threatening consequences of these discriminatory events – for example police brutality - all of which may contribute to the development of psychosis (Kanner et al., 1981; Myin-Germeys et al., 2003; Oh et al., 2016, Pearlin et al., 1981).

Psychotic symptoms may, in certain instances, be viewed as protective and normative responses to the traumas of racism, poverty, and community violence (Olbert et al., 2018; Wilson et al., 2016). Alvarez et al. (2011, 2021) found, in a study of 102 patients with schizophrenia, schizoaffective disorder, or bipolar disorder that almost half (47.5%) reported a history of child abuse, and also identified a relationship between child abuse and more severe psychosis. Black, Indigenous, and other people of color (BIPOC) are more likely to be diagnosed with severe mental illnesses, including schizophrenia, bipolar disorder, and depression (Watkins et al., 2006). In particular, the diagnosis of schizophrenia is greatly overrepresented in Black people (Metzl, 2011; Olbert et al., 2018). Halvorsrud et al. (2019) reported that, in a meta-analysis and systematic review of research on incidence on affective and non-affective psychoses in England, Black African and Black Caribbean research subjects have a significantly elevated risk of diagnosis of affective and non-affective psychoses. Berg et al. (2014) found that Norwegians with “visible minority status” were much more likely to be given a schizophrenia diagnosis than white immigrants or Norwegians. For Black Americans, perceived racism is

associated with the development of nonclinical paranoia (Combs et al., 2006), although what is considered clinical paranoia likely varies from provider to provider and is also likely subject to the influences of the provider's own biases. The combined impacts of structural, institutional, and interpersonal racism all contribute to the development of severe mental illness and psychosis (Bresnahan et al., 2007; Halvorsrud et al., 2019; Nazroo et al., 2020).

Fanon's (1963) work on the psychological conceptualization of colonialism as a force that is destructive to the ego of the colonized contextualizes the relationship between racism and psychosis. He argues that psychosis – the splitting of the ego – is a natural response to the terror and trauma of colonization. He calls the sequelae of colonization “reactionary psychoses... a mass attack against the ego” (Fanon, 1963, p. 206). This ego splitting is engendered by living in a world that forces marginalized communities to devalue and erase their identities (Fanon, 1963). The concept of the “white gaze” (Fanon, 1963), and relational sequelae of colonialism and whiteness help us to conceptualize possible harm that white clinicians can cause when working with chronically traumatized people of color.

### **Poverty and Psychosis**

People experiencing poverty are diagnosed with psychosis at higher rates than the general population (Sweeney et al., 2015). Neighborhood deprivation correlates especially with negative symptoms like depression and paranoia (Wickham et al., 2014). Normative means of coping with the experience of poverty – for example, isolation due to lack of resources, or spending money on small luxuries viewed by others as irrational - are often pathologized as symptoms of severe mental illness or psychosis (Topor et al.,

2014). Low socioeconomic status (SES) has been linked with early-onset psychosis (EOP), and the interaction of low SES and EOP appears to significantly increase the risk of developing certain types of schizophrenia (Gallagher & Jones, 2017). Lack of educational opportunities, income inequality, and neighborhood deprivation have all been indicated to increase the likelihood for the development of psychosis (Bhavsar et al., 2014; Boydell et al., 2004; Burns et al., 2014; Lasalvia et al., 2014; Vargas et al., 2020). The lack of access to material resources and the lack of social capital that accompany poverty are substantial roadblocks to psychological well-being and have been causally linked to the development of psychosis (Read et al., 2013).

### **Impact of COVID-19**

The interviews conducted for this study took place from March 2022 to May 2023. Many of the clinicians in the study reflected on how their ability to provide care was hampered by the realities of the COVID-19 pandemic. The impact of COVID-19 on the client population of CMHCs in this study has been particularly severe. People living in poverty and people who identify as Black or Latinx are at much greater risk of contracting, being hospitalized, and dying from COVID-19 (Centers for Disease Control (CDC), 2020). People experiencing psychosis are often less likely to access medical care (Erllich et al., 2015; Holt, 2011), which could compound the likelihood of complications from COVID-19 (Devakumar et al., 2020). Finally, clients with psychosis may be less likely to have access to telehealth (Borzekowski et al., 2009; Brunette et al., 2012; Naslund et al., 2015) and may be less comfortable using technology to access their physical and mental health care (Miu et al, 2020; Torous & Keshavan, 2020). Looking at how clients with psychosis and social workers are managing the multiplicity of



complications to good mental health care in the era of COVID-19 is a crucial area of study, particularly since telehealth will likely continue to be part of therapeutic services (Geller, 2020). In this study, many clinicians grappled with the availability of crisis resources and with staffing challenges at their agencies during the height of the COVID-19 pandemic.

## **Chapter 2: Literature Review and Conceptual Frame**

### **Introduction**

This study explores how clinicians' sense of efficacy, relevance, and agency can impact their desire to provide trauma-informed care to clients with psychosis in CMHCs. The study also examines how the racial dynamics of the therapeutic relationship and of the institutions that provide care can complicate clinicians' ability to provide competent treatment that aligns with the common factors of effective therapy. This literature review will first examine clinician sense of efficacy, relevance, and agency, based on Bandura's theory of self-efficacy (2001). Next, this review will provide an overview of the literature on trauma-informed care. The literature on common factors and its relevance to how clinicians provide care to clients with psychosis will be the next area of focus. Finally, this chapter will provide an overview of critical whiteness theory and its impacts on clinical care. This chapter will also identify gaps in the literature that this study addresses.

### **Clinician feelings of efficacy, relevance, and agency**

For the purposes of this study, I define these terms as follows. *Clinician sense of efficacy* is based on Bandura's (2001) concept of *self-efficacy*, a person's confidence in his or her capability to develop, organize, and execute an action required to complete a set goal. Bandura (1997) suggested that individuals' ability to accomplish a task or goal not only requires skill and ability, but also a belief in oneself as a necessary antecedent to the confidence and motivation needed to accomplish a task or goal. Bandura's social cognitive theory, on which his self-efficacy theory is predicated, indicates that human achievement is based on the interaction of three variables: behavior, personal factors, and environmental factors (Bandura, 1977). The environment provides cognitive

representations that influence behavior, and personal factors are self-beliefs – like self-efficacy – that facilitate a regulatory measure of control over behavior (Bandura, 1977). The environment in which clinicians work – their limited training, settings with poor resources, inadequate supervision, high caseloads – can impact their belief in their own efficacy, and then their behaviors and clinical decision-making as a result.

Bandura’s conceptualization of self-efficacy has been applied to the development of the counselor’s sense of effectiveness (CSE). Larson & Daniels (1998) define CSE as “one’s beliefs or judgments about her or his capabilities to effectively counsel a client in the near future” (p. 180). Therefore, the clinician sense of efficacy is procedural and goal-oriented, focusing on the clinician’s ability to carry out the tasks required of them to produce positive clinical results. Larson (1998) states that

Self-efficacy beliefs... serve as the causal link between knowing what to do and executing the action... people with higher self-efficacy beliefs will tend to have more self-aiding thoughts; experience anxiety as challenging rather than debilitating; and set more realistic, moderately challenging goals (p. 221).

Bandura (2006) explicitly connected the concepts of self-efficacy and agency. He posited, “Efficacy beliefs are the foundation of human agency. Unless people believe they can produce desired results and forestall detrimental ones by their actions, they have little incentive to persevere in the face of difficulties” (p. 170). In community settings, settings in which the structural and institutional challenges can be debilitating, clinicians can struggle to feel that their actions can produce desired results. Self-efficacy as a construct is undeniably relevant to the unique demands of therapeutic relationships with clients with psychosis in CMHC and has not been explored in the literature.

## **Self-efficacy in clinical and educational contexts**

Self-efficacy has been studied in a variety of clinical counseling and educational contexts. In a study of mental health clinicians providing services to trauma-exposed youth, training in a trauma treatment modality, access to training in a variety of formats (in person training, supervision, virtual training), and training in more than one trauma treatment modality were all positively associated with greater clinician self-efficacy (Becker-Haimes et al., 2021). Bardhoshi and Ulm (2018) found that self-efficacy can serve as a mediating variable in the relationship between job resources and school counselor burnout. In the nursing education literature, academic self-efficacy predicts efficacy in learning clinical management software and other online technologies, skills that are particularly relevant in the post-COVID-19 digital care era (Calaguas & Consunji, 2022). The counseling literature has devised a measure of counselor's sense of effectiveness (Larson & Daniels, 1998; Melchert et al., 1996), the Counseling Self-Efficacy Scale (CSES), to quantify the level of effectiveness that counselors and counseling students experience in their work with clients. The CSES scale, based on Bandura's constructs, is a 20-item self-report instrument that assesses counseling trainees' competency regarding key counseling tasks for group and individual counseling (Melchert et al., 1996). It is important to note that in its initial conceptualization, the CSES specifically evaluates competencies for counseling trainees, not for clinicians who have completed their graduate education. However, the scale has been used to measure self-efficacy in a number of post-graduate settings (Lent et al., 2006; Schiele et al., 2014; Pace et al., 2021).

In a study exploring self-efficacy in school counselors as they attempt to prepare students for college and career readiness, Parikh-Foxx et al. (2020) found that school counselors with more training and fewer barriers to accessing training in college and career readiness experienced more feelings of self-efficacy. Mitchell et al. (2020) examined the relationship between sufficient training and feelings of self-efficacy for clinicians engaged in decision-making regarding suicidality and crisis management. The more training clinicians reported they had received in crisis management and suicidality, the lower were their feelings of cognitive and somatic anxiety, their avoidance of discussion of risk management, and their discomfort with the topic (Mitchell et al., 2020). Participants completed a five-section self-report measure, the Suicidal Patient Comfort Survey (Jahn et al., 2016). The self-efficacy portion is titled the Suicide Risk Management Self-Efficacy scale, which is grounded in Bandura's (2006; 2001; 1997) self-efficacy theory and is based on the CSES developed by Larson and Daniels (1998).

A great deal of the literature on counselor self-efficacy focuses on clinician training and supervision. In a systematic review of communication skills training in social work education, Reith-Hall and Montgomery (2023) found studies referencing Bandura's theory of self-efficacy (Bandura, 2001; Bandura, 1997), indicating that students' self-efficacy beliefs could impact the teaching and learning of communication skills in social work education (Rawlings, 2008; VanCleave, 2007). A systematic review of 17 empirical studies found that clinical supervision positively impacts the self-awareness and self-efficacy of the supervisee (Lohani & Sharma, 2023). The studies in the review examined supervision of both psychotherapists and counselors, as well as students still in training (Lohani & Sharma, 2023). The studies also indicated that

supervision positively impacts skill development and maintenance of supervisees, leading to improved client outcomes (Lohani & Sharma, 2023). Latorre et al. (2023) studied how mindfulness and self-compassion interventions could impact doctoral-level psychology trainees' assessment of their competency and self-efficacy. Study findings indicated that higher levels of mindfulness were associated with greater levels of self-compassion, and higher levels of self-compassion were associated with greater levels of counselor self-efficacy and self-assessed professional competency (Latorre et al., 2023).

### **Self-efficacy and psychosis**

The self-efficacy literature on psychosis focuses on feelings of self-efficacy of clients with psychosis, not on feelings of self-efficacy experienced by the clinicians providing care to those clients. Godoy Izquierdo et al. (2021) carried out a randomized controlled trial testing the impact of trainings on coping skills and on coping with stress self-efficacy on clients with schizophrenia or schizoaffective disorder. Outcomes tested included client belief in their coping with stress self-efficacy, perceived daily functioning with the use of coping skills, and general improved clinical status (Godoy Izquierdo et al., 2021). In the clinical sample, study participants showed clinically significant outcomes in all areas. One of the measures used to test self-efficacy was the Coping with Stress Self-Efficacy Scale, (CSSES), a scale based on Bandura's self-efficacy theory (Bandura, 2001 & 1997). A few studies have examined the relationship between negative psychotic symptoms, self-efficacy, and functioning (Cardenas et al., 2013; Kurtz et al., 2013; Pratt et al., 2005; Ventura et al., 2014; Vaskinn et al., 2015), and self-efficacy has been found to mediate the relationship between negative symptoms and global functioning in some of these studies (Pratt et al., 2005; Vaskinn et al., 2014). Chang et al.

(2017) found that, in a study of 326 Chinese adults presenting with first-episode psychosis, self-efficacy provided a mediating effect between the negative symptom of amotivation and neurocognitive impairment. No literature has been identified that explores clinician sense of self-efficacy and its impact on care for psychotic clients.

### **Race and self-efficacy**

There is limited research on the impact of self-efficacy and its interaction with race, and almost no research on how self-efficacy beliefs of providers can be impacted by racial dynamics. The existing research that examines relationships between self-efficacy and race tend to focus on the race of the client or student, and not on the race of the professional providing the care or service. There is a body of literature that looks at the self-efficacy beliefs of teachers and the impact on outcomes for students, with the race of students as a variable of study. Teacher self-efficacy was found to be associated with middle school mathematics student outcomes, but the race of students was not statistically significant – highly effective teachers positively impacted the outcomes of students of all races in the study (Hines, 2008). In this study, self-efficacy was evaluated by a teaching self-efficacy scale developed by Bandura (1977). Academic self-efficacy in African American college students has been shown to have a moderate positive effect on academic performance and class participation (Galyon et al., 2012).

Regarding self-efficacy and race in the counseling literature, a few studies exist. In a study of cross-racial counseling supervision relationships, in which supervisees identified as Black or Latinx and supervisors identified as white, perceived counseling self-efficacy, along with level of training and the supervisees' perceived level of prejudice of the supervisor, had a statistically significant impact on the supervisees'

experience of role ambiguity and role conflict in the relationship (Nilsson & Duan, 2007). Sheu and Lent (2007) developed a scale to assess counselors' "self-perceived capability to counsel racially diverse clients" (p. 31), – the Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MCSE-RD), based on Bandura's social cognitive theory and self-efficacy theory (Bandura, 2001, 1997, & 1977). Their development and initial validation of the MCSE-RD relied on a sample of undergraduate psychology students, graduate counseling students, and graduate counseling practicum students (Sheu & Lent, 2007). Barden & Greene (2015) found that higher levels of MCSE-RD positively correlated with the length of time spent in a graduate program and level of education, with doctoral students scoring higher on the MCSE-RD. Similarly, Owens et al. (2010) found that school counselors with more years of professional experience scored higher on the MCSE-RD. Finally, Holcomb-McCoy et al. (2008) found that counselors who scored lower on the MCSE-RD had less experience with a diverse client population, potentially minimized cultural concerns of clients and felt less comfortable working with racial or ethnic-minority clients.

### **Clinician sense of relevance and agency**

*Clinician sense of relevance* differs from efficacy in the sense that it refers to a clinician's belief that they have something meaningful to contribute to the therapeutic relationship. The definition of *relevance* is "pertinence to current or important issues, interests, needs, etc." (Oxford University Press, 2023). Clinical relevance – their pertinence - is multi-faceted in this study. Clinicians balance the difficult symptoms of clients with psychosis, the valuing of their role in treatment in a system that privileges medication, the racial dynamics of the clinical relationship, and their own feelings of



hopelessness and powerlessness in the relationship itself and in the context of agency- and system-wide policies. Clinicians might find themselves wondering if their relationship and alliance with their clients experiencing psychosis have any meaningful bearing on treatment outcomes.

*Clinician sense of agency* differs from efficacy and relevance in that it focuses on a clinician's ability and sense of empowerment to make decisions about treatment that can diffuse the hopelessness and powerlessness that they can feel in this treatment context. *Agency* is defined as the "ability or capacity to act or exert power" (Oxford University Press, 2023). "Exert[ing] power" is of particular significance in the context of participant responses, since the responses often name powerlessness in the wake of the challenges of their treatment environment.

### **Gaps in the Counseling Self-Efficacy Literature**

It is notable that much of the literature on counseling self-efficacy comes from the field of counseling and psychology, and not social work. In addition, many studies on self-efficacy draw their sample from doctoral and master's level students, who often are working in university clinics. The research on clinician self-efficacy does not include much discussion of clinicians in community mental health settings, nor does it include exploration of the work of clinicians with psychotic clients. Finally, the literature on counseling self-efficacy rarely addresses the dynamics of race in the clinical dyad. Therefore, the setting and sample of this study aims to address a crucial gap in the literature.

### **Trauma-Informed Care**

Trauma-informed care is a framework for examining how service providers and the organizations at which they work, across the human services field, can provide competent care for clients who have experienced traumatic experiences (University of Buffalo, 2023). A foundational component of trauma-informed care is the idea that, more often than not, clients presenting to treatment or for services have a history of trauma. Therefore, agency and service provider interactions with clients need to take this trauma history into account (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023; University of Buffalo, 2023; Bendall et al., 2021). The Adverse Child Experiences (ACEs) study provides important context for the need for trauma-informed care, suggesting that childhood trauma has a pervasive and lifelong impact across all of the dimensions of wellness, potentially even decreasing an individual's lifespan (Mahon, 2022; Shevlin et al., 2008; Read et al., 2007; Felitti et al., 1998). Research data suggests that up to 70% of individuals have experienced a single-incident trauma, while 30.5% of all individuals are estimated to have experienced four or more major traumatic events (Mahon, 2022; Kleber, 2019; Benjet et al., 2016). SAMSHA defines trauma-informed care in terms of the 4 R's: providers need to **Realize** the impact that trauma has on how clients access and experience care; **Recognize** the impact that trauma has on their clients; **Respond** to clients in a trauma-informed way; and **Resist** re-traumatizing clients (SAMHSA, 2023). SAMHSA also names five essential components of trauma-informed care: safety, choice, collaboration, trustworthiness, and empowerment (SAMHSA, 2023; University of Buffalo, 2023).

It is notable that many of these elements of trauma-informed care overlap with several of the common factors of effective therapy. The common factors essentially fall

into the following categories: engagement, setting and therapeutic frame, therapeutic alliance, client factors, and therapist factors (Kidd et al., 2017; Laska et al. 2014; Wampold, 2001). The trauma-informed care elements are all reflected in the common factors of setting and therapeutic frame and the therapeutic alliance in particular. Clinicians must consider how they create a therapeutic space and forge a therapeutic alliance through the provision of safety, choice, collaboration, trustworthiness and empowerment. In addition to how direct service workers should apply the principles of trauma-informed care, the trauma-informed care model also directs agencies and institutions to implement these principles as well (SAMHSA, 2023; University of Buffalo, 2023).

Regarding trauma-informed care and its relevance to clients experiencing psychosis, there is some limited research. The correlation between developmental and complex trauma and development of psychosis is well-documented (Maude et al., 2024; Pearce et al., 2019; Sweeney et al., 2015; Anglin et al., 2014; Topor et al., 2014; Shevlin et al., 2008; Garety et al., 2001; Hardy, 2017; Morrison, 2001; Morrison et al., 2003; Fanon, 1963); therefore, a trauma-informed approach to providing care to these clients is essential. There is evidence that trauma-informed care can reduce the incidence of restraints as an intervention at inpatient mental health facilities (Maude et al., 2024; Azeem et al., 2017). Unfortunately, clients experiencing psychosis are much more likely to be restrained in inpatient hospitalization than are individuals with other mental health diagnoses (El-Badri & Mellsop, 2002; Narita et al., 2019; Noda et al., 2013). This relationship has been shown to be consistent across different categories of restraint,

including physical restraint (Lykke et al., 2020; Schnitzer et al., 2020), medication (Hu et al., 2019), and seclusion (Jury et al., 2019; Tunde-Ayinmode & Little, 2004).

Thordarson and Rector (2020) argue that a lack of trauma-informed care for individuals with severe mental illness leads to increased rates of criminality and incarceration. Eggers (2024) argues for the importance of trauma-focused treatment for clients with psychosis, reviewing studies that evaluate the effectiveness of trauma treatment modalities for reducing psychotic symptoms. Eggers (2024) states that clients with psychosis have often been excluded from trauma treatment because their symptoms are thought to be too severe to respond and clients are seen as too vulnerable and fragile to withstand the stressors of trauma treatment, but the results from the review article show promising outcomes for trauma-informed, competent trauma treatment for clients who experience psychosis. Both the psychological and the medical research literature show that trauma exposure is a significant risk factor for the development of psychosis, with environmental stressors modulating biological pathways that lead to alterations in the expression of schizophrenia; therefore, a trauma-informed approach to treating psychosis is essential (Gianfrancesco et al., 2019).

A trauma-informed care perspective impacts how clinicians view their sense of relevance, efficacy, and agency. Clinicians in this study wrestle with the knowledge that their clients have significant trauma histories, but the perceived risks associated with psychosis – for example, the belief that psychosis predisposes individuals to violence - can influence clinicians to act in ways that may be counter to trauma-informed principles. The research literature on schizophrenia and violence is divergent and contradictory (Bo et al., 2011). In a systematic review of the literature on psychosis and violence, Bo et al.

(2011) found that there were a variety of factors contributing to an increased likelihood of violence, including the presence of positive psychotic symptoms, particularly during first-episode psychosis, psychopathy and personality disorders, mentalizing abilities, and substance abuse. Since schizophrenia and psychosis are so multi-determined, it is difficult to draw causal connections.

It is important to note that a very small proportion of societal violence is committed by individuals experiencing psychosis (Bo et al., 2011). Furthermore, Walsh et al. (2002) found that 99.97% of individuals with schizophrenia would not commit a violent act within a given year. In spite of the inconclusive research evidence on psychosis and violence, clinicians can still feel compelled to manage risk with these clients, even if that risk management does not align with trauma-informed care. Throughout this study, clinicians experience conflict about what efficacy and relevance really are – are they defined by treatment outcomes considered successful by agencies, or by the principles of trauma-informed care?

### **Common Factors in Therapy**

Over the past two decades, as the number of therapeutic interventions and modalities has continued to grow, researchers have examined what commonalities exist within these modalities, and what influence these commonalities have on therapeutic outcome. The research on common factors looks at exactly this – what are the “common factors” in therapy, and how effective are those factors at impacting the process of therapeutic change? Empirical research on this topic has identified a handful of these common factors and has continually shown that, in fact, they contribute more to outcome

variance in therapy than do any specific interventions or model protocols (Miller et al., 2015; Wampold, 2001).

Studies have provided different specific itemizations of these common factors, but generally, it is possible to group them as follows: engagement, setting and therapeutic frame, therapeutic alliance, client factors, and therapist factors (Kidd et al., 2017; Laska et al. 2014; Wampold, 2001). Engagement is characterized as the quality of the client's participation in treatment – consistent attendance, commitment to therapeutic goals, and desire to collaborate with the therapist to bring about change (Joe et al., 1999; Staudt et al., 2012; Wong et al., 2002). Study after study has found that engagement is the most important factor in determining therapeutic outcomes (Laska et al., 2014; Miller et al., 2015).

Setting and therapeutic frame encompass the therapist providing a holding environment in which the client feels safe to share thoughts and feelings, therapist projection of professionalism, competence, and hope, and therapist commitment to a treatment modality or approach – regardless of which - that prescribes a structure of “healing rituals” (Miller et al., 2015; p. 208) for the client and therapist to perform. Client factors include the client's race, culture, ethnicity, gender and sexual identity, class, and any other social or cultural identities; client's resources and social supports; and the client's premorbid functioning (Miller et al., 2015). Therapist factors include the person of the therapist - the use of self, the therapist's belief in and fidelity to a treatment approach, and therapist behavior in session (Miller et al., 2015). Therapist factors have been found to be as much as nine times more important than modality in determining treatment outcomes (Kim et al., 2006; Saxon et al., 2017). It is important to note that

these terms are difficult to operationalize, and therefore, to measure. There are some generally agreed-upon scales that tend to recur in these studies (for example, the Working Alliance Inventory (WAI); Horvath and Greenberg, 1989), but the nuances of these terms vary from study to study.

### **Critical Whiteness Theory**

Just as colonizers view the native inhabitants of a colonized nation as uncivilized (Fanon, 1963), Critical Whiteness Theory (CWT) presents whiteness as the mark of civilization, while other races, ethnicities, and cultures are deficient. CWT's constituent elements include whiteness as a norm, the invisibility of whiteness, and white privilege. Whiteness as a norm defines all other races and ethnicities as deficient to whiteness's own cultural norms. These norms and habits of whiteness influence and harm people of all races, both white people and BIPOC. For example, the norm of individualism and extreme self-reliance in white culture is viewed as superior to the value that other cultures place on collective support and collaboration (Okun & Jones, 2016). Okun and Jones (2016) discuss the subtle, yet pervasive ways in which habits of whiteness infiltrate organizations and are internalized by members of organizations; in CMHCs, agency staff, social workers, and even clients. These habits include perfectionism, urgency, quantity over quality, individualism, and either/or thinking, among others (Okun & Jones, 2016). The invisibility of whiteness is the white tendency to deny a white identity, thereby rendering white people unable to see how it operates as an oppressive force. Finally, white people are accorded privileges just for being white, and often do not wish to acknowledge these privileges (McIntosh, 2003).

There is an emerging body of research on whiteness as oppressive discourse in the therapeutic relationship. Existing studies show that therapists, of all races, unconsciously maintain whiteness as an invisible norm in their work with clients and in their assessment of client behavior (Lee & Bhuyan, 2013; Lee, 2014). Lee & Bhuyan (2013) and Lee (2014) use discourse analysis to show how a white therapist, through subtle and subconscious shifts in language, tone, and topic, privileges the white norm of individual autonomy over family interdependence. A father who mourns lost closeness with his teenage son is advised to invest more in his own interests, specifically soccer, since his son will be “off to university...in five years” (Lee, 2014, p. 17). Discourse analysis highlights client resistance to these norms: this father pushes back against the therapist suggestions that he play more soccer (“I stopped playing when I was 35,” (Lee, 2014, p. 17)). In response, the therapist presses her point, that he is likely a soccer fan due to his South American heritage, in order to justify her recommendation that he attend to his own identity development (Lee, 2014). This attempt at cultural competence erases the client’s desire to integrate his sense of self with that of his role as a father.

Racial microaggressions occur frequently in clinical encounters between white therapists and BIPOC clients (Lee et al., 2018). Lee et al. (2018), in a discourse analysis of transcripts of cross-cultural therapy sessions, found examples of almost all of the themes of microaggressions identified by Sue et al. (2007): alien in their own land, ascription of intelligence, color blindness, myth of meritocracy, pathologizing cultural values and communication styles, and being a second-class citizen. The cumulative impact of microaggressions has been shown to have significant deleterious impacts on the health and well-being of BIPOC individuals (Hollingsworth et al., 2017; Nadal et al.,



2014; Sue & Spanierman, 2020), and this cumulative impact is even more damaging than explicitly racist acts (Sue et al., 2007; Lee et al., 2018; Owen et al., 2014). Racial microaggressions in therapeutic interactions have been linked to damaging the therapeutic alliance and increasing the likelihood of the client dropping out of therapy (Davis et al., 2016).

### **Community Mental Health, Psychosis, and Common Factors**

Several studies have looked specifically at how the complexities of community mental health care settings impact the common factors. Clients with severe and chronic mental illness, including psychosis, comprise a large proportion of CMHC populations (Cusack et al., 2006) and often present with complex trauma histories, a variety of experiences with treatment across multiple systems, and structural barriers including racism, poverty, and other forms of discrimination (Kidd et al., 2017; Piat and Lal 2012). These experiences can present challenges to implementation of common factors like engagement, therapeutic alliance, a safe and consistent therapeutic frame, and client and therapist factors that impact treatment outcome.

Research on elements of common factors and their impact on work with clients with psychosis has shown mixed outcomes. Catty et al. (2010) found that therapeutic alliance did not have a robust impact on client outcomes for people with psychosis using clinical and vocational services. This study found that client rating of the therapeutic alliance with their primary clinical caseworkers was only predictive of slightly higher subjective quality of life, although the study looked at a wide variety of clinical and social outcomes (Catty et al., 2010). However, a systematic review and meta-analysis of 24 studies found that a stronger therapeutic alliance was associated with engagement in

therapy, and with a reduction in global and psychotic symptoms (Bourke et al., 2021). In addition, Shattock et al. (2017), in a systematic review of 26 studies, examined the quality of the therapeutic alliance between therapists and patients with psychosis, and also examined whether the strength of the alliance could predict therapeutic outcomes. This review included studies suggesting a relationship between the strength of the alliance and reduced risk of rehospitalization (Frank & Gunderson, 1990; Smerud & Rosenfarb, 2011).

David and Chan (2014) argue that common factors may be the most overlooked skill set when training clinicians to work with clients in community settings. David and Chan (2014) argue that building trust and rapport with this client population can be especially challenging, due to stigma and potentially harmful previous interactions with service organizations, but that it is the most vital skill for clinicians to acquire. Junghan et al. (2007) examined the relationship between staff-rated and client-rated unmet mental health needs and staff-rated and client-rated therapeutic alliance, finding that only a decrease in client-rated unmet need was associated with client-rated therapeutic alliance. Reducing staff-rated unmet need was not associated with client-rated therapeutic alliance (Junghan et al., 2007). Browne et al. (2019) undertook a narrative review of the relationship between the therapeutic alliance and a wide range of client variables in individual treatment for schizophrenia and psychosis, looking across various provider types and individual treatments. Some results of note include that the therapeutic alliance in this client population often goes beyond traditional psychotherapy, since treatment approaches are often multifaceted and include a number of services; and the frequent differences in provider-rated alliance and client-rated alliance (Browne et al., 2019). For

example, illness-related variables, including severity and type of symptoms, were negatively predictive of provider-rated alliance, but this relationship did not retain significance when examining client-related alliance (Browne et al., 2019).

The meaning of common factors and the therapeutic alliance with this population may look different from traditional definitions in the psychotherapy literature. A qualitative study comprised of in-person interviews with 33 users with serious mental illness (SMI) of community mental health services and content sourced from a systematic review of 48 articles of this population identified three primary themes regarding defining the working alliance between service users and service providers: building and negotiating trust, I'm on your side, and tools and strategies (Kirsh & Tate, 2006). These larger themes included subthemes, some of which point to the differences in the conceptualization of the working alliance for this particular client population. Building and negotiating trust, for example, included a subtheme of ensuring that basic needs are being met, an element of the working alliance that may not be of primary importance in a private practice therapeutic relationship (Kirsh & Tate, 2006). "Sharing and caring" was a subtheme under the larger theme of "I'm on your side," and included the idea that clients responded positively to clinicians who self-disclosed openly, particularly if they had experienced and overcome struggles similar to those of the client's (Kirsh & Tate, 2006). While sharing certain experiences with the client certainly could fall under the common factors category of therapist factors and self of the therapist, it would be unusual for a therapist to disclose at length about their own struggles with mental illness.

Bressi-Nath et al. (2012) also found, in their study of the nature of the therapeutic alliance in intensive case management with clients with SMI, that the definitions and

measures of the alliance traditionally used in psychotherapy research did not necessarily reflect how the structures and pressures of CMHCs and case management could influence alliance formation. Elements defining the dynamics of this unique alliance that emerged in this study include motivation, monitoring, creating dependency, and being there (Bressi-Nath et al., 2012). Monitoring of clients' goals and reducing access to desired resources to increase motivation - for example, controlling access to clients' money in order to increase participation, an intervention that would not be used in a traditional therapeutic setting – were both intended to improve the alliance, but often had the opposite effect (Bressi-Nath et al., 2012). Similar to the Kirsh and Tate study (2006), Bressi-Nath et al. (2012) found that providing concrete resources enhanced the alliance between clients and caseworkers.

A systematic review of the literature on common factors and the therapeutic alliance with clients experiencing psychosis returned a total of 13 articles from 1990 to 2013 (Farrelly & Lester, 2014). All of the articles were based in community treatment settings similar to the settings in which clinicians from this study worked. The review noted the dearth of literature in this area and identified the need for continued research. From the literature reviewed, the article identified three components of a beneficial therapeutic alliance and relationship with clients with psychosis: mutual trust, a demonstration of mutual respect, and the importance of shared decision-making (Farrelly & Lester, 2014). These components echo the common factors of a shared commitment to goals; client desire for collaboration with the therapist; the therapist's awareness of their own biases and countertransference; and the therapist's creation of a consistent therapeutic frame - a sense of safety and a comfortable holding environment. The review

did note the difficulty of achieving these elements in practice. Barriers identified included unclear treatment goals, poorly defined roles for client and clinician, and needs and desires for treatment outcomes that were potentially in opposition. Because of this potential opposition, clinicians de-emphasized interactions that were characteristic of the common factors, and prioritized interactions that attempted to “protect” the client and the clinician – for example, preventive hospitalization or prioritizing antipsychotic medication (Farrelly & Lester, 2014).

### **Intersection of Common Factors and Critical Whiteness Theory**

Research looking at the intersection of common factors and whiteness in therapeutic treatment is limited. Most studies in this area look primarily at race and ethnicity match between client and clinician and impacts on alliance. Some of these studies indicate that an ethnic and/or racial match will impact alliance positively and have positive impacts on treatment outcomes (Chang & Yoon, 2011; Chao et al., 2012; Hynes, 2019), although there are studies that do not show any significant impacts of racial and/or ethnic match on outcomes (Cabral et al., 2011; Ruglass et al., 2014). Some studies have looked at racial and/or ethnic minorities and common factors more generally: Koo et al. (2016) found, in their study of veterans with PTSD diagnoses, that therapeutic alliance, therapeutic bond, and agreement with providers on therapeutic goals were all rated as weaker by racial and/or ethnic minorities (REM) veterans than they were by white veterans. This study did not ask participants to report on the racial and/or ethnic identity of their service providers, so conclusions only could be drawn about differences between how REM veterans reported their treatment experiences as compared with how white veterans reported their treatment experiences. Kivlighan et al. (2019) found disparities in

treatment nonattendance - with attendance used as a measurement of treatment engagement - between REM clients and white clients, with white clients generally reporting more reliable attendance. Hayes et al. (2016) found that therapist effectiveness (operationalized as effectiveness in reducing general distress) at college counseling centers – a sample of 3,825 clients seen by 251 therapists at 45 college counseling centers – was rated as higher by white clients than it was by REM clients at a college counseling center.

A small number of studies have examined racial and/or ethnic match for specific racial and/or ethnic minorities. Davis et al. (2015) found that African American women in a substance use treatment center were more likely to remain in treatment and to report their alliance with their therapist more highly if their therapists were a racial match, along with possessing other characteristics including empathy, genuineness, multicultural competence, and egalitarianism. Flicker et al. (2008) found that Latinx adolescents who abuse substances reduced their substance use more when working with Latinx therapists than did Latinx adolescents working with white therapists. Kim et al. (2009), in a study of 61 Asian American clients at a counseling center at a large university, found strong empirical support for their hypothesis that client perception of a shared worldview – which may or may not include a client-counselor racial/ethnic match - with their counselor is related to a strong working alliance and a positive session outcome.

Questions that remain about how racial and/or ethnic match or mismatch may influence the ability in clinical dyads to achieve common factors in treatment include: examining common factors beyond measures of therapeutic alliance, including engagement – commitment to goals, desire for collaboration with the therapist; therapist

factors – therapist commitment to and belief in a specific modality, therapist’s own biases and countertransference; and therapeutic setting and frame – consistency, a sense of safety, a comfortable holding environment, which could be potentially difficult to achieve in an under-resourced community health setting with garish lighting, uncomfortable seating, and inadequate facilities. There is a need for more explicit focus on how whiteness and its harmful norms manifest in the practice and application of common factors in treatment, particularly in the community mental health setting, which serves many clients with multiple intersecting marginalized identities.

Critical whiteness theory complicates the application of common factors, particularly to marginalized populations. Research on engagement defines it as the most important factor in treatment outcome (Miller et al., 2015; Laska et al., 2014). Engagement, however, can be defined by rigid rules regarding attendance and therapist assessment of a client’s “commitment” to treatment goals. This perspective can place the therapist in a position of power as the one who determines what this commitment looks like and if the client is meeting those standards. A therapist’s belief in and fidelity to a particular treatment model is also a common factor linked to better outcomes (Miller et al., 2015; Wampold, 2001). This approach can reflect the characteristic of white supremacy culture of only one right way – that there is an objective and specific approach to a problem that will maximize results. Additionally, the focus on measurable treatment goals resonates with the characteristic of quantity over quality, an emphasis on content or outcomes over process. The sense of urgency that Okun & Jones (2016) describes also relates to focusing on measurable treatment goals – that there are timelines that need to be met to mark progress.

The establishment of a safe and consistent therapeutic frame can be challenging to implement, given the obstacles inherent in working in community treatment settings. Within the context of CWT, safety may be defined very differently for clients and for clinicians. A BIPOC client may never feel “safe” with a white clinician (Owen et al., 2018; Pettyjohn et al., 2020) and may have more difficulty exhibiting behaviors that a clinician may think are essential to a functional therapeutic frame, like consistency, trust, and comfort (Pettyjohn et al. 2020). Furthermore, clients who experience psychosis may face different barriers to experiencing a sense of safety in a therapeutic relationship, because their symptoms can often make other people, and the world, feel threatening.

### **Contribution to Social Work Research, Education, and Practice**

Given the structural challenges enumerated above, and the tendency of mental health agencies and practitioners to pathologize certain normative responses to racism and poverty as psychosis (Nazroo et al., 2020; Sweeney et al., 2015), I propose a modified grounded theory study of clinicians in community mental health centers (CMHCs) in Philadelphia. This study will examine how clinicians approach treatment with this client population. In particular, this study will examine how clinicians navigate their beliefs in their own self-efficacy, relevance, and agency with this population, and how those beliefs impact their ability to provide trauma-informed care that aligns with the common factors of effective psychotherapeutic treatment. There is limited research on the clinical interaction with clients with psychosis more generally, and even less research on how issues of structural inequality impact therapist perception of client symptomology and approach to client treatment, particularly in CMHCs.



Self-efficacy theory has not been applied to the research on clinical care for clients with psychosis, which is a significant research gap. The research on psychosis and self-efficacy theory focuses on how to enhance self-efficacy in clients with psychosis, or on how client beliefs in their own self-efficacy impact their positive and negative symptoms. The research does not examine how clinicians' desire to have self-efficacy may in fact result in behaviors that are counter to their desire to be relational and trauma-informed in their care with psychotic clients. Finally, self-efficacy research tends to focus on counseling trainees, and less on the work of clinicians already working in the field. Rarely does this research examine clinician self-efficacy in community mental health settings. Therefore, this study addresses several crucial gaps.

There is some research on the impact of common factors on treatment outcomes for clients with severe mental illness, including psychotic symptoms, and research on common factors and treatment outcomes for clients in community mental health. What has not been examined, however, is the how the intersection of self-efficacy theory, trauma-informed care principles, the common factors in therapy, and issues of whiteness impact how therapists experience feelings of efficacy, relevance, and agency in their clinical work with clients with psychosis.

Social workers, since they provide most of the mental and behavioral health services in the U.S. - there are more social workers providing mental health services than psychologists, psychiatrists, and psychiatric nurses combined (National Association of Social Workers (NASW), 2020) – intentionally comprise the majority of the sample for this study. Advising social workers, social work educators, and social work agencies about the factors that impact social workers' capacity to experience self-efficacy in

challenging settings while also providing trauma-informed care, will improve social work education, agency and government policy, employee training, and staffing in CMHCs. The person-in-environment model (Kondrat, 2002; Wakefield, 1996), theorizing that a person's experience is nested in an ecosystem of social structures, is fundamental to social work education and practice. The person-in-environment perspective informs how both the environment of the care providers and of the clients impact the treatment that clients receive.

The National Association of Social Workers' Code of Ethics (2017) specifically names social justice as one of the profession's six guiding values and demands that social workers engage in social action to further the well-being of clients and of the larger society (NASW, 2017). Increasing awareness of the mechanisms that impact how social workers make decisions about the care that they provide to some of the most marginalized clients – BIPOC clients experiencing psychosis – and the potential consequences of those decisions can contribute substantially to how social workers are trained and supported throughout their careers. The perspective of social workers, who are ethically and professionally obligated to address structural and institutional forces and their impact on an individual's experience, is vital to the understanding of the experience of providing critically conscious treatment to those who experience psychosis.

### **Chapter 3: Methodology**

The objective of this modified grounded theory study is to provide insight into the clinical experiences of master's level clinicians in community mental health centers (CMHCs), specifically looking at their experiences working with clients with psychotic symptoms. This qualitative study utilized semi-structured interviews. I anticipated that structural factors, including racism, poverty, and the realities of COVID-19, would impact the work of these clinicians, although I attempted to leave space for the experiences of my interviewees to unfold. I chose modified grounded theory methodology because modified grounded theory is intended to illuminate a process and help to develop or generate a theory about a process that is not well-studied or well understood (Creswell & Poth, 2018; Thornberg & Charmaz, 2014). Research focusing on the clinical interaction between CMHC therapists and clients who experience psychosis, with an emphasis on the impacts of structural racism on this interaction, is extremely limited. Any research in this area will likely add insight into the unique processes that operate in the interaction between CMHC clinicians and clients with psychotic symptoms, with the hope that the study would result in substantive theory generation to inform best practices with this client population.

I attempted to follow Charmaz's (2006) constructivist approach to grounded theory research, which emphasizes the co-construction of theory through interactions with research participants. A grounded theory approach also emphasizes that data collection and analysis happen concurrently and iteratively (Creswell & Poth, 2018). As I moved through my study, I quickly adopted a modified grounded theory approach, which offers the researcher the flexibility to explore the data openly and inductively, with guidelines that ultimately allow the researcher to develop a theory that is grounded in

study data (Thornberg & Charmaz, 2014). This approach allowed me to modify my interview guides and approach in real time, based on my interactions with participants, as I moved towards theory generation.

I provide example of this modification here. As I was conducting my interviews, an unexpected theme began to emerge. I began to notice, both from the content of the interviews themselves and through my own ongoing clinical training, that many of the interviewees seemed to be discussing dissociative disorders, although they believed themselves to be talking about psychosis. I began to pursue this theme with more intention by adding additional follow-up questions or prompts when I started to notice certain topics emerge, such as when an interviewee would describe a client hearing voices, or when they would describe what sounded like an alter or distinct self-state of a client presenting in a session.

The sensitizing concepts of 1. self-efficacy theory, 2. the common factors literature, 3. the principles of trauma-informed care, and 4. whiteness from critical whiteness theory (CWT) have shaped the development of my approach to this study. Charmaz (2003) describes sensitizing concepts as “those background ideas that inform the overall research problem” (p. 259). The use of sensitizing concepts is a departure from pure modified grounded theory (Bowen, 2006; Glaser & Strauss, 1967), which is purely inductive and does not begin from any explicit theoretical orientation. Because I used these sensitizing concepts to inform my approach, this study may more accurately be described as a qualitative study that intends to generate theory about the practice of clinicians in community mental health with clients of color who experience psychosis. This theory generation may be influenced by the sensitizing concepts of self-efficacy

theory, trauma-informed care, common factors, and CWT. Glaser (1978) has acknowledged that the use of sensitizing concepts in modified grounded theory is a common starting point for qualitative research, and Blaikie (2000) argues that studies moving towards theory generation may contain sensitizing concepts, but no hypotheses.

### **Reflexivity Statement**

I worked in a CMHC in Philadelphia as an outpatient therapist for almost four years. During my time in this role, I worked with several clients with either a history of or who were currently experiencing psychotic symptoms. Throughout my time at this agency, I found that clinicians, myself included, generally felt unprepared to work with this population. In addition, many therapists felt that this population presented with a high level of need that was not fully acknowledged by the agency, and that clinicians were not provided with adequate support to meet these needs.

Generally, I am critical of the medical model of psychiatry as practiced in community mental health settings and I tend to view much symptomology as more reflective of living through complex trauma and in oppressive systems as opposed to being biologically based. These experiences and perspectives have the potential to influence my perceptions of my participants' experiences, and so I intended to be mindful of the potential influence of my own experiences when interviewing and when analyzing those interviews. My experience with this treatment setting, however, gave me additional insights into the experiences of my participants and may allow them to feel more comfortable sharing with me. Additionally, I am a white, cis-gendered, able-bodied female doctoral student at an elite educational institution. These positionalities endow me with significant societal privilege. I recognize that I bring many biases and lived

experiences that impact how I conceptualize, implement, and undertake this research, particularly given its grounding in critical and anti-racist theories.

### **Sampling**

Prior to data collection, I obtained study approval through the Bryn Mawr College Institutional Review Board (IRB). I interviewed 16 masters'-level clinicians – licensed social workers, licensed professional counselors, and licensed marriage and family therapists - working as outpatient therapists in CMHCs in the city of Philadelphia. Modified grounded theory utilizes theoretical sampling (Thornberg & Charmaz, 2014), which indicates that additional research subjects may be recruited as the data and analysis begin to indicate needed changes regarding who to interview or what questions to ask. My sampling strategy was initially purposive, and also utilized convenience sampling and snowball sampling, since clinicians who were interested in and/or participated in the project provided names of other clinicians who fit the inclusion criteria.

I recruited participants from different CMHCs across the city of Philadelphia. Inclusion criteria also included having worked with at least three clients of color with psychotic symptoms in long-term therapeutic relationships, which I operationalized as at least eight therapy sessions over at least a two-month period. The interviews took place between March 2022 and May 2023. My sample had the following characteristics:

**Agency:** My participants were employed at 11 different agencies at the time of being interviewed.

**Gender:** 13 participants identified as female or as a cis-woman; one participant identified as non-binary; two participants identified as male or as a cis-man.

**Race:** 11 participants identified as white, one participant identified as white/Jewish, three participants identified as Black, and one participant identified as Black/African American.

**Degree:** 11 participants had a master's in social work (MSW) or an MSW-equivalent, one participant was a licensed marriage and family therapist (LMFT), one participant had a master's in education in school psychology (M.Ed), and two participants were licensed professional counselors (LPC).

**Age:** the youngest participant was 27, the oldest was 61, and the mean age was 37.

**Years at current job:** shortest length of time nine months, longest length of time 11 years and four months. The mean length of time was four years and two months.

**Year of graduation from a master's program:** The earliest year of graduation was 1996, and the most recent was 2022.

**Role at agency:** Three of the 16 participants identified themselves as holding supervisory roles at their current agencies. All participants identified themselves on their demographic sheets as one of the following: outpatient therapist, outpatient trauma therapist, outpatient mental health therapist.

### **Recruitment**

I began my recruitment by consulting the Philadelphia Department of Behavioral Health and Intellectual Disability Services' (DBHIDS) website to locate email addresses and websites for CMHCs in Philadelphia. DBHIDS's website directed me to the Community Behavioral Health (CBH) website, [www.cbhphilly.org](http://www.cbhphilly.org). CBH of Philadelphia is a nonprofit 501 (c)(3) managed care organization that is contracted by the city of Philadelphia to provide behavioral health services to city residents. On CBH's website, I

located a provider directory, a 98-page document listing all of the providers of mental and behavioral health services in the city that provide services to Medicaid-eligible clients. Once I located this directory, I created a list that consisted of providers that offered outpatient mental health services and served adult clients in the city of Philadelphia. This list totaled 62 providing agencies.

Once I compiled this list, I sent a letter by email advertising the study to directors and CEOs of these agencies and gave details of participation in the study (see Appendix A). I did not connect with any potential participants exclusively through this method, however. I next posted a study announcement on the Philadelphia Society of Clinical Social Work (PSCSW) listserv, listing the study requirements and asking for participants. I re-posted this announcement several times over the course of 18 months, and I did successfully recruit several participants from this approach. I also posted the study, at a few different intervals, on several local social worker Facebook groups. This strategy also resulted in a few responses as well.

A complication that arose from Facebook recruitment was contact from individuals who did not meet the requirements of the study – but were apparently drawn in by the offer of a \$25 gift card. After meeting over Zoom for a few minutes with someone who had obviously not read the study announcement – or read it and disregarded it - I added a short weeding out questionnaire to my recruitment process. I asked all interested participants, before sending them the consent forms for the study, what year they graduated from their master’s program, what program they graduated from, the primary population served by their agency, and their clinical interests. These responses allowed me to judge if the person responding was likely to be eligible for



participation, in order to protect my own investment of time and that of the potential participant.

Also, at various points during recruitment, I reached out personally to professional contacts I had who might be able to connect me with other potential participants. I spoke with three different management-level community mental health clinicians to see if they might be able to assist in my recruitment efforts. They all were able to connect me with individuals who qualified for the study and several did end up participating.

### **Data Collection**

All interviews were conducted via Zoom. I worked with the participants to hold the interviews at times that were convenient for their work schedules and personal lives. Each interview lasted between 60-90 minutes. No interviewees chose to terminate participation during the interview.

Participants read and signed a consent form prior to beginning each interview (see Appendix B). Participants also completed a demographics form (see Appendix C) prior to the interview. The consent forms and demographics sheet were securely sent to the participants via Adobe Acrobat Sign. Adobe Acrobat Sign is an online, password-protected document storage service. Participants received a \$25 Amazon.com gift card upon completion of each interview. The interview guide (see Appendix D) focuses specifically on the experiences of social workers working with clients with psychosis. The interview guide was not adapted between interviews.

During the data collection process, I was initially only successfully recruiting white clinicians. Since one of the areas of focus of my interviews is racial dynamics that

operate in the clinical relationship, and since the majority of community mental health consumers in Philadelphia are non-white and a substantial percentage of clinicians in CMHCs in Philadelphia are non-white, it was not ethically appropriate nor demographically representative for my sample to contain exclusively white clinicians. To address this concern, I decided to reach out personally to personal contacts I had who had previously worked in outpatient community mental health agencies in Philadelphia in managerial roles to see if they could connect me with any non-white clinicians who might be willing to participate in my study. Through this process, I was able to recruit four Black clinicians for my study. I ended up with a sample of 16 clinicians, four of whom were Black and 12 of whom were white. The non-white clinician perspective and representation was crucial to the data that I was able to gather and was indispensable as I developed my theory and argument. My results would have been incomplete at best and full of glaring and ethically compromised omissions at worst, so this was an essential step in my process of data gathering.

During my interviews, I found myself the most anxious when I had to ask the questions on the interview guide that addressed race (see Appendix D). When I designed my interview guide, I intentionally left the questions on race towards the end of the guide, so that participants would ideally already be comfortable with the conversation and might feel more at ease discussing the complexities and nuance of racial dynamics in the clinical interaction. In addition, I experienced more anxiety about asking questions about race to the non-white clinicians I interviewed, since I was aware of the emotional labor that this question, asked by a white person, could impose upon my non-white participants. As the interview guide was written, the final two questions read as follows:

What kinds of challenges do you experience in engagement and alliance formation with clients with psychosis? How do organizational policies or practices help or hinder this process with clients with psychosis? How does race play a role?

What does creating safety in the therapeutic relationship look like for you in your work with clients who experience psychosis? How do organizational policies or practices help or hinder this process with clients with psychosis? How does race play a role?

I did ask every participant these questions in some form, and I received responses that were useful from all participants; still, the point remains that my own discomfort with these questions influenced how I asked them, depending on the participant, which likely impacted the responses I received. To illustrate these dynamics, I include a couple of examples of how I worded the question in different interviews. In my first interview, with a white male clinician, I said the following:

So just a couple more questions - what kinds of challenges, and I know a lot of this we've touched on before, but since it's on my interview guide, I have to ask everyone. What kind of challenges, you experienced in engagement and alliance formation with this client population and, within that kind of thinking about... Do you see organizational policies and practices being, you know, relevant to that and then, also, how do you think about race playing a role in that... that's a long question, so I will repeat that as needed but basically, challenges that you experienced in engagement and alliance formation.

I notice here – and I recall this conversation – how I struggled to simply ask the question without preamble and simply just allowing the participant to respond freely. In fact, the language I used “I know a lot of this we’ve touched on before... I have to ask everyone...” could have reduced the impact of the question and influenced the perception of the question by the participant.

My language seems to be an attempt to preemptively ease tension that I am assuming the participant might be experiencing; however, that assumption is not necessarily accurate and likely had some influence on how the participant chose to respond, whether or not he was aware of this consciously. In addition, I tack my question about race on at the end of a lengthy question. This could have sent a message that I either did not think the question was particularly important, or that I was anxious enough about asking the question that I could not give the question the space it deserves.

In an interview about midway through my interview process, with a white female clinician, I said the following:

When you’re thinking about engagement and alliance formation with clients with psychosis, what kinds of challenges do you find you experience in that process?...

I have been asking everyone, how do they feel, if they feel it does at all, race plays a role in engagement and alliance formation. If you feel like it plays a role... [and then again, after the participant spoke for a few minutes about engagement and alliance formation, I asked the question in relation to safety]

Again, this is sort of the same question, but, like, do you feel like... and I think you already answered this, but do you think that race can kind of, like, play a role

in creating safety. Like, are there people who expressed feeling unsafe, or, like, you sensed a lack of safety, like... body language, or behavior.

I see here that I have become more comfortable with asking the question without as much preamble. Still, however, I felt it necessary to say “I have been asking everyone” – an attempt to make the participant feel comfortable - and “If you feel like it plays a role,” which, again, could serve to downplay the importance of the question in the mind of the participant, even though it is one of the most significant questions I ask throughout the interview in relationship to my research questions and focus.

Finally, here is how I approached this question in an interview with a Black female clinician, whose interview occurred about 12 months into my 14-month data collection timeline:

So the last question it's about being... the safety and the engagement and alliance formation as well... and so... full disclosure. When I asked [friend who assisted me with study recruitment] to reach out to some people, it was partly because most of the clinicians I interviewed were white up until this point. And I just wanted much better representation from the ...so I sort of talked to him, and he's like, oh, you know a couple of people. And so how did you? How, if at all, do you feel that race play... I asked the white clinicians.... Like... I was wondering about how race played a role in like safety and engagement and alliance formation. Was that something that would come up? And I, I mean, I'm talking about clients with psychosis, but also more generally as well.

My excruciating self-consciousness regarding asking a Black person about racial dynamics comes through clearly here. First of all, I find it necessary, before I ask the

question about race, to tell the participant that I needed better representation in my sample, and that was why I recruited my friend, and the participant's former manager, to assist me. I say "full disclosure," as if I am sharing something with this participant which I did not mention to others interviewed – which is, in fact, true. I did not mention this to all of the participants. Perhaps my intent here was to make the participant feel that their contribution is seen as valuable to me, and perhaps also, unconsciously, I wanted to feel like a "good" white person by naming how I knew how essential it was for my sample to be more racially diverse. I also mentioned how I asked white clinicians the same question, as if to say, "don't worry, I'm not only expecting the Black participants to comment on race!"

### **Data Analysis**

Interviewees signed consent forms (see Appendix B) prior to beginning each interview. Interview transcripts and memos are stored securely in an online, password-protected data management program (dedoose.com). All interviews were held over Zoom and recorded. After completion of each interview, I spent approximately 30 minutes recording my initial impressions in a memo. Once I completed transcription of an interview, I destroyed the audio and video of the interviews.

I transcribed all interviews myself. I used the transcript provided by Zoom and then checked them by listening to the audio of the interviews and making changes as needed to the Zoom transcript. This process allowed me to begin to familiarize myself with my data. After each transcription session, I wrote a memo, reflecting emergent themes, reactions I was experiencing to the data, and commonalities I was beginning to notice among interviews.

I used dedoose.com to store, code, and analyze my data. My coding strategy consisted of two major phases, initial open coding and focused coding, in accordance with Charmaz's (2006) approach to coding in constructivist modified grounded theory. Open coding consists of staying close to the data, moving quickly but deliberately through the data, and keeping codes short and precise (Charmaz, 2006; Thornberg & Charmaz, 2014). Open coding involves moving through the data word-by-word, line-by-line, paragraph-by-paragraph – whatever type of close reading and analysis is most appropriate for the content units in the interviews. Focused coding involves looking over the initial codes created during the first cycle of coding and looking for the “most frequent and salient codes” (Saldaña, 2016, p. 240). These second-cycle codes moved me towards initial theory generation, using theoretical coding as I approached a “central/core category that identifies the primary theme or major conflict, obstacle, problem, issue, or concern to participants” (Saldaña, 2016, p. 298). Constant and iterative examination of the data, through coding and memoing, began as soon as I completed my first interviews, to allow for emergent codes and ideas to inform subsequent interviews, theory generation, and theoretical sampling, as dictated by a modified grounded theory approach. I continued to memo after each interview to process my responses to the data, improving confirmability and rigor (Guba, 1981; Krefting, 1991).

## **Chapter 4: Clinicians' Sense of Efficacy and Relevance in Treating Clients with Psychosis**

This chapter will focus on the theme of clinicians' sense of efficacy and relevance when treating psychosis. I begin this chapter by exploring othering, naming, and labeling as a response to clinician anxiety about their relevance to the treatment of psychosis. Next, I transition to discussing the role of antipsychotic medication in clinicians' sense of relevance. I also examine the tension between masters-level clinicians and doctoral-level clinicians, including psychiatrists and psychologists and how study participants experience professional hierarchies in community mental health agencies. Finally, I discuss clinician perspectives about how their race might impact their efficacy and relevance in the clinical dyad.

### **Othering, Naming, and Labeling as a Response to Clinician Anxiety**

In the interviews conducted for this study, clinicians often struggled with anxiety about their own competence in treating psychosis, and at times expressed feelings of hopelessness regarding their capacity to meet clients' needs and their ability to provide effective treatment. These responses often led to clinician othering of clients, which included clinicians viewing psychotic symptoms of their clients as something foreign and occasionally frightening. Participants also engaged in othering when portraying psychotic clients as too complex to treat effectively, as clients for whom traditional therapeutic treatment approaches were not applicable.

Racial dynamics also influenced clinicians' perspectives on their efficacy, which at times resulted in essentializing and othering clients. This othering can be seen as an unconscious defense on the part of the clinician in order to protect their own sense of efficacy and relevance in challenging clinical environments. How white therapists



manage their anxiety about how about how their racial privilege impacts their ability to be competent and effective clinicians at agencies that serve predominantly BIPOC populations. Feelings of frustration, incompetence, and irrelevance emerged from the as white clinicians in the study. I interweave the discussion of racialized othering throughout this section. Generally, othering, whether in terms of race or in terms of psychotic symptoms, is reflective of white supremacy culture and the norms of whiteness (Okun & Jones, 2016).

Alex, a nonbinary white clinician in their 30s, when asked to describe a client with psychosis with whom they had worked for some time, spoke at first about a Black female in her early 20s with whom Alex was still working at the time of the interview. Alex's therapeutic relationship with this client happened in the aftermath of what Alex called "a pretty specific...first psychotic break situation." Alex noted the complex trauma history of this client, naming in particular "a horrible family situation... incestual abuse... through the family... she was sexually abused as a child at... three different points in her childhood." Alex described this client's primary psychosis symptoms as voice-hearing, "mean, judgey voices," in addition to significant social anxiety. Alex's first comment about their work with this client, after describing the client's general symptom presentation and demographics, emphasized their own concern and anxiety about their level of experience:

I was working with her. I was... a fledgling therapist... I'm a very... strengths-based... empathy... loving, positive regard... you know, sometimes I... get stressed... I need more specific skills ... imposter syndrome is real.

Although Alex identifies relational components to their work with this client – being strengths-based, focused on alliance and safety, which are some of the most impactful common factors in therapeutic treatment (Kidd et al., 2017; Miller et al., 2015; Laska et al. 2014; Wampold, 2001), they feel “stressed” about their perceived lack of “specific skills,” and mention struggling with “imposter syndrome.”

Alex’s perception of how they were able to impact the treatment of this client potentially contributed to this imposter syndrome. The client’s “mean, judgey voices” that she perceived to be the voices of her neighbors, commenting that she was too loud in her apartment, were her primary and most troubling symptom. The client, after medication, was able to recognize that her neighbors’ voices, when she knows she is hearing them in reality, sounded different than the voices she was hearing in her head. This is an example of how antipsychotic medications, with their powerful effects, can significantly impact symptoms. Alex, however, found it a challenge at first to feel comfortable with this client’s desire to take medication, since that decision did not align with their therapeutic orientation:

I... came in with my vibe... let’s be friends with your voices, let’s try to be... nonjudgmental about it... maybe we can ask them questions... things that I had read and learned in school and I agreed with... but really, it was... her agency and her choice... she was really firm about wanting to do meds, and she [said]... I just hate [these symptoms], and I want meds ASAP. And so I was like, okay!... I’m going to support you.

Alex did ultimately support their client’s autonomy but did feel some tension with their own desire to engage with interventions that felt comfortable to them and aligned with

their preferred approaches and values. Perhaps, also, using interventions that aligned with their treatment philosophy and were within their area of competence allowed them to feel relevant and useful to this client's treatment. It is notable that Alex's support of their client's autonomy aligns with trauma-informed approaches to care (Bentall, 2021; SAMHSA, 2023; University of Buffalo, 2023) and with the common factors of effective therapy (Kidd et al., 2017; Laska et al. 2014; Miller et al., 2015; Wampold, 2001), even if they potentially did not feel as effective as they might have if they had used their preferred interventions.

Benjamin's anxiety about working with a client with psychotic symptoms, including paranoia, visual hallucinations, and auditory hallucinations, made it difficult for him to feel effective and to make decisions that his clinical instincts suggested were necessary. As Bandura (1977) theorizes, a belief in one's skills and abilities is a requirement to maintain the confidence to accomplish a goal, and therefore feel effective. Benjamin struggled to access this belief with this client. Benjamin's client John, (pseudonym chosen by participant) who was taking the first-generation antipsychotic Haldol, was experiencing noticeable side effects:

[It's] a pretty heavy medication... [The client] - I don't say this to seem... judgmental – drooled a lot...the... textbook picture of [side effects of an anti-psychotic medication] ... and that was disconcerting... I worried a lot... Do I need to check in with you about your medication more? Should this be happening? Do I bring any of this up?

Benjamin did not address these concerns with his client, and other comments in the interview elucidated why this might be the case. Benjamin stated also being concerned

about John's "flat affect", which he also thought might have been a side effect of antipsychotic medication:

I never had a good sense of whether [John's flat affect] was as a result of medication or not, I think. I was a pretty new therapist so maybe felt nervous trying to ask... does anyone ever tell you this, is this feedback you've gotten?

Benjamin referred to being a new clinician and to being inexperienced at several points throughout his interview, and often connected this newness to his own feelings of incompetence. In these excerpts, he appears to be indicating that his newness as a clinician made him hesitant to comment on symptoms or side effects that were troubling and that he interpreted could be potentially bothersome to the client.

John's termination of the therapeutic relationship with Benjamin was clinically significant, giving Benjamin increased insight into his client's experience. The termination also impacted Benjamin's feelings of anxiety about his clinical skills. After a lengthy period working therapeutically with Benjamin, John disclosed that he had recently been rejected by a woman in whom he had shown interest. He had written a long letter to her expressing his feelings for her and she told him she did not feel the same way. John was clearly devastated – in Benjamin's words: "He cried for the first time... it was very flat affect... crying but ... not... sobbing." Benjamin then chose that moment to interject a clinical intervention, which he felt went horribly flat:

I tried to...gently talk about social skills in that same session...What do you think it was like for that person to get a letter like that?... I... should have pressed on the brakes more... So he... missed... a couple of sessions which is out of the ordinary for him... Then unfortunately... I went out to have a drink with a friend

in the same neighborhood as where I worked, which is where he lived, and he walked into the bar. I don't know if he saw me ... But he was there... and he... never really responded to any outreach... He asked to be [transferred]... 'I want to see the other therapist who is here'.

Benjamin found out from the therapist to whom John was transferred that John had been put off by his response to the rejection. Benjamin described how the new therapist reported John responding to his intervention of challenging the letter to his crush as follows: "I'm not ... [John] started describing [to the other therapist]... I'm not here for therapy for that kind of feedback... that was... not what I wanted." Juxtaposing this experience with the incidents that Benjamin shared regarding his concern about medication side effects and his reticence to name them paints a picture that Benjamin, like many other new clinicians in settings with complex populations, often felt unsure about what to do. Either he feared he said too little, as the example about medication side effects illustrates, or he felt he said too much or intervened in a clumsy fashion, as the example of Benjamin's "gentl[e] talk about social skills" shows.

Benjamin, as a white clinician, also felt that his race at times could play a role in his feelings of efficacy with his Black clients with psychosis. He was discussing the relationship that he had with the mother and sister of a Black male adult client with psychosis. This client had significant symptoms, and so Benjamin often collaborated closely with his family. Benjamin felt that his race somehow made the client's family believe that he would be able to make progress with the client that they could not: "I had more of that feeling of... this young this nice young white kid will fix this or... do something... He's gonna be able to do something that we [the family members] can't."

Importantly, Benjamin pointed out that he tried to help the family of this client recognize their own expertise and experience when it came to working with the client:

I often tried to sort of flip the script in some ways by talking with [the client's sister] ... when she's like, what should I do when he's having... delusion[s]... [I'd say] well, what have you been doing? That's actually really smart and that's a good idea... trying to help her recognize... you have expertise.

Benjamin was trying to honor both the family's hope and trust that he could help, while also taking a strengths-based approach that acknowledged their own essential contribution to the client's well-being. Benjamin's use of the phrase "this nice young white kid... he's gonna be able to do something that we can't" highlighted the perspective that he interpreted this family had – that a white person could be more equipped to help them. If his assessment was correct, it would reflect internalization on the part of this family of one of the elements of critical whiteness theory (CWT): whiteness as a norm, in which all other races and ethnicities are seen as deficient to whiteness's own norms. His own uncertainty about his effectiveness also comes out, as he talked about himself as a "young white kid," someone whose clinical experience could not match the needs of his client. He was also quick to try to "flip the script" with this client's family and emphasize their own effectiveness with the client, influenced by his own lack of confidence in his ability to be of use, and potentially his discomfort with how his whiteness can be perceived.

At times, clinicians would express frustration with their clients with psychosis, which was likely another expression of their feelings of hopelessness. Therapist hopelessness was likely a mirror of the client's hopelessness. Not all therapists were able

to identify this dynamic, however. Miranda, a therapist in her 60s who had worked in several community settings for decades, before finally moving to a group private practice, exemplified this lack of awareness of how her frustration was likely a countertransference reaction to her client's own frustration with systemic barriers:

I'm thinking... more towards the end of our work together when I was starting to get a little bit frustrated with him about self-care... He had the ability to make a phone call, he had the ability to use public transportation- he wasn't somebody who was so mismanaged with symptoms that he couldn't do these things - it was a lack of follow through. And I think sometimes he felt that I was pushing him too much ... that was somewhat a bone of contention ... I would be tired about hearing all the complaints and all the excuses. Because it's not like he really had much else in his life that he had to do, he didn't have any children, he lived at home, he did not have a job, he didn't worry a lot about his older family members... He had plenty of free time... He didn't follow through and that would set him back.

Here, Miranda engages in othering – it is the client's fault, it is his lack of follow-through or his lack of motivation that is impeding his progress. She, the clinician, is choosing not to examine other potential causes of his difficulty with forward movement. In fact, she is dismissive of his struggles, expressing that she was “tired about hearing all the complaints and all the excuses.” She was putting emphasis on the failings of this client as an individual, as opposed to a trauma-informed perspective that looks across biopsychosocial stressors that impact client outcomes. The weight that Miranda gives to

individual responsibility is reflective of white supremacy culture (Okun & Jones, 2016), specifically, the focus on the individual over the community.

Myranda also comes across as judgmental, with her interpretation that the client did not have much else in his life to occupy him, and therefore there was no acceptable reason for him not to be prioritizing caring for himself and for him not to be progressing in the way that felt satisfactory to her. This is not to shame Myranda, however – she was likely engaging in an unconscious process of putting the responsibility on the client to “fix” their life so that she would not have to cope with the weight of her own feelings of hopelessness about his progress.

Cindy, a white female clinician in her 40s, who has over eight years of community mental health experience, actually named her awareness of the problem of othering psychotic clients, and of her attempts to intentionally counteract that inclination:

One of the ways in which I’ve... tried to remind myself to... not... separate myself too much from their experiences, to... tune into my own inner psychotic, right? I think we are all capable as people... it exists on a spectrum, right? It’s not one or the other... Have there been times when I’ve seen connections that really weren’t there? Or I thought that I’ve heard things that I really wasn’t hearing or seeing? You know what I mean? So... can I tune into that enough where I can join in their experience or be able to empathize?

Cindy makes an important point that was not named by any other clinician interviewed in the study – that psychosis is not a distinct, pathological experience that immediately signifies severe psychological illness. Psychosis is along the spectrum of human experience, and is an experience that many people have shared, even if they do not



acknowledge it. Clinicians can often connect with, and be open about, the experiences of depression, or anxiety, or even trauma. But psychosis, likely due to it being widely perceived as frightening and “other”, is something that clinicians rarely name as having experienced. Cindy’s willingness to acknowledge and “tune into [her] own inner psychotic” is a notable and laudable exception. In spite of clinician reluctance to align with having experienced psychosis, Van Os et al. (2001), in a nationally representative sample of over 7700 American adults, found that 17.5% of respondents reported psychotic experiences at some point during their lifetime, supporting Cindy’s belief that “we are all capable as people [of experiencing psychosis]”.

Clinicians were at times well aware of their own anxiety and their feelings of being unable to “fix” a client with psychosis, and potentially were also aware of feeling underskilled or unprepared for what faced them. For example, BC, a Black ciswoman in her 30s, was describing a session with a client who had a symptom presentation of disconnecting from the present:

I tried to get her attention, calling her name and nothing... Completely unresponsive, and at some point... I’m just looking at her. She’s not paying any attention to me, and I’d start to feel like, uh oh... what? How, how am I gonna bring this person back?... Where did we go?... The psychosis really seemed to arise when... she would get emotionally overwhelmed, and she would just kind of go somewhere... [so] I would just go back to grounding.

In this quote, BC is clearly feeling anxious – “like, uh oh... what?” She feels the pressure of re-connecting her client with the present, bringing her back into the room, and also is experiencing fear that she will not be able to do so: “how am I gonna bring this person

back”. In this situation, the clinician was able to remain calm enough to connect with a clinical intervention that felt comfortable and accessible to her – and was likely useful for the client as well – grounding.

BC also, however, seemed to exhibit a comfort and self-awareness regarding working with clients with psychosis. In fact, she reflected on how she has seen other clinicians respond to clients with a psychotic symptom presentation, and the anxiety that can be inherent in those relationships:

I think if the clinician is not very sure of who they are, it's going to make it infinitely more challenging to work with a person with psychosis, because... it can feel scary from the clinician side... You don't know where this is going to go, and you're just trying your best in that moment with that person. But I think if the clinician isn't very clear, then it's harder... Okay, what's my next step? ... Am I going to ask a question, am I going to do something? Is this going to trigger them?

BC did display self-assurance in her approach, and that often included using grounding skills and rapport building with clients. She was also aware that psychosis could trigger anxiety and fear in clinicians, because clinicians, in her opinion, interpreted clients with psychosis as less predictable. Her word choice, “if the clinician is not very sure of who they are,” speaks to that sense of anxiety, and also a lack of a coherent clinical identity, a common experience for new clinicians. BC’s insight also gives more of a window into her own clinical approach – “you’re just trying your best in your moment with that person”. This seems like the hallmark of a general relational approach that would work

with all clients, in fact, and also reflects BC's comfort with herself as a clinician and with treating clients experiencing psychotic symptoms.

Mary, a white ciswoman in her 30s who has worked as an outpatient community mental health therapist since 2016, shared an experience of feeling helpless in the face of challenging symptom presentation. Mary's client was a Black woman in her forties with a diagnosis of schizoaffective disorder. This client had experienced trauma at the hands of many larger systems, including having all of her seven children removed permanently from her custody over a decade ago by the child welfare system in Philadelphia. She lived in extreme poverty. This client claimed that living in poverty was the reason her children were taken from her, because she could not provide for them, and instead of being provided with supports, she lost her family. This client experienced delusions in which she believed that any representative of a system – the child welfare system, case managers, and, at times, her therapist – was actively attempting to harm her, and that the attempts at harm were personal. Mary stated,

She's convinced... these systems are out to get her... Everybody [she encounters in different systems] is actively communicating about... destroying her life... all her case managers... [It's] not just [that]... the system is designed to harm her, but... the people [working in these] system[s]... are actually intentionally harming her and manipulating her.

Mary found this dynamic very challenging to manage, because often these beliefs would be directed at her. Mary found herself walking on eggshells, fearful of saying the wrong thing that would harm her alliance with this client. She found their dynamic to be uniquely demanding:

It was a very stressful therapeutic relationship... For a long time... I just felt... angry and exhausted by the end of the session, because there was so much... criticism that I was always taking... Any intervention, anything that I said was... picked apart... I was very gentle... in my challenging, because... any time I challenged her, I would become an enemy.

Mary's frustration and feelings of incompetence and irrelevance emerge here, but also her clinical self-awareness. She can name her anger and exhaustion that she experienced in her interactions with this client. Still, she finds herself grasping at "any intervention," and then finding those attempts met with criticism and backlash. She was anxious about challenging client assertions that were likely inaccurate, because she did not want to become an "enemy." Mary, in her awareness of the fundamental structural and systemic issues at play, and it is hard to ignore the racialized element. It is probable that her client's diagnosis was impacted by her race, as Black people are significantly more likely to be diagnosed with psychotic disorders than people of other races (Metzl, 2011; Watkins et al., 2006). It is also likely that her race also contributed to her losing her children. Black women who are involved in the child welfare system are many times more likely to have their children removed from the home than women of any other race are (Harp & Bunting, 2020).

Naturally, Mary's client's experience with the child welfare system contributed to her distrust of government and health care systems. Mary found this distrust to be so pervasive that she named it as delusional. She was hesitant to use the word paranoia, because she recognized that the fear was grounded in her client's experience, but she did mention her consideration of naming this behavior as paranoid: "I'm even skeptical to call

it paranoia. But I think... It's paranoia that stems from a very real fear.” This assertion is an attempt to engage in less othering behavior – to recognize that symptoms which are very challenging to manage clinically are not just due to individual pathology but are grounded in systemic racism and structural oppression (Bresnahan et al., 2007; Combs et al., 2006; Halvorsrud et al., 2019; Nazroo et al., 2020).

Mary reflected on how her identity as a white therapist impacted clients of color with psychosis specifically. She noticed how the intersection of both marginalized identities could make engagement and effectiveness even more challenging:

I think psychosis... the main theme of paranoia just makes [a strong alliance] really hard, especially when there's a valid level of paranoia that you would expect in cross-racial... when you're a white therapist. So... finding that balance of how to... validate the paranoia that's real and challenge the paranoia that's a step too far... It's really hard... And maintaining the relationship... if you become a person that can't be trusted when they're in an active [psychosis] episode... If they don't trust anyone, then how can you... the things that you've built don't apply in those moments. It's... a different mindset entirely where the trust that you've built is... not accessible, so it feels very tenuous.

Mary noted that her Black clients who experience paranoia can find those symptoms exacerbated in the therapeutic relationship with a white clinician. Black people have likely all experienced racial trauma at the hands of a white person at some time in their lives, and Black clients with psychosis often have experienced trauma from white representatives of the mental health system, as Mary mentioned: “White therapists represent the system in a big way... represent that authority figure that will... hospitalize

you or take away your freedom if you say the wrong thing”. Coupling those experiences of discrimination with clinical paranoia, particularly when a client is experiencing a significant increase in symptoms, can result in severe damage to the trust built in the relationship. As Mary stated, when a client is in the midst of an active episode, “the trust you’ve built is... not accessible... it feels very tenuous”.

James, a white cisgender male in his 40s who has worked in community agencies since his graduation in 2019, also felt unmoored, helpless, and without guidance when he was confronted with clients who experienced psychosis. James, when discussing his experiences working in a dual diagnosis facility, stated that, even though he felt his supervisor was a skilled addictions clinician, they were not able to offer much in terms of working with psychotic clients beyond de-escalation skills for the therapist to employ if a client was activated:

We did get an hour of supervision with this person every week... This person was a skillful... drug and alcohol oriented... addictions-oriented clinician... so they... could be helpful with... ways to deal with psychosis, like, ways to stay regulated in the face of psychosis.

James felt that his primary source of support in working with these clients was the staff psychiatrist, and then the support was mostly focused on how to encourage medication compliance: “But there wasn't any real, specific support other than the psychiatric support... that I could perceive.”

Benjamin also expressed frustration at his lack of preparation for working with clients with psychosis: “The agency itself, I didn't feel... supported us in getting more training. And so... we never got any training about psychosis or working with

psychosis.” He also found it difficult that clients were assigned to clinicians based on how full a clinician’s caseload was, not based on specific expertise or interest: “Being able to say... this person's got a lot of expertise with psychosis... We should refer these clients to them. Instead it was like... your caseload isn't full or is full and it's got to be more full, so we're just going to assign you.”

Benjamin’s point also highlights the structural and agency constraints that impacted the treatment of clients and reinforced the powerlessness of clinicians – clinicians could not set their own limits about their caseloads and had very little capacity to refuse. Benjamin also noted that, even if he wanted to pursue clinical training on psychosis, with a caseload of over 60 individuals, he did not have the time or emotional energy to invest in it. Cindy also felt undertrained and poorly equipped to work with psychotic clients at her agency, finding that the standard approach to this population was to medicate them to reduce symptoms. In her own words, “[The agency’s message is] there is very little to nothing we can do to help people who have these symptoms, other than give them medication.”

Another clinician, MM, described herself as the “outpatient psychosis guru” at her agency. She explained that she enjoyed working with clients with psychosis, and therefore, at her agency – which appears to be different practice than at other agencies in which clinicians felt very little control over their caseload makeup – she would receive the majority of these referrals. She mentioned that she had invested in her own time in taking “a lot of trainings at this point” on working with psychosis. She took the initiative to develop this skillset – it was not something provided by her agency, or by her

masters'-level education. Even though this was driven by her personal interests, it was still an added burden that her agency did not support.

Sandy, a white ciswoman in her 30s with eight years of community mental health experience, who was, at the time of the interview, serving as the supervising social worker at her outpatient agency, similarly developed a personal clinical interest in working with psychotic clients. Like MM, this was because she was seeing so many psychotic clients on her caseload. She also received no training and took a proactive approach to educating herself:

There's no training, and I started and I was like what the fuck. I read. I asked... one of my friends here is a resident attending doctor, and he's doing the [university name] postdoc program, and... he'll give me some stuff.... I started going to these lectures too.

Sandy's tone and word choice made her frustration and disgust with the lack of training clear. Her intellectual curiosity and desire to provide high quality clinical care pushed her to educate herself further. This initiative was in spite of managing a caseload of 32 clients, four therapist supervisees, and two case manager supervisees, while also serving as the supervising social worker for the outpatient unit at her agency.

Mary also alluded to a concern that clinicians generally do not receive training in dissociative disorders<sup>1</sup> at the graduate level. This is problematic, for many reasons, but certainly one of those reasons is that most clinicians enter community agencies directly out of graduate school, working with some of the most traumatized clients. In Mary's own words:

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<sup>1</sup> Mary's comment is just one of many throughout the respondent data that spoke to the potential confusion in clinicians between diagnoses of psychosis and diagnosing dissociative disorders.



I didn't know about DID until I had a client with DID... my second client ever!  
And I had to be self-taught. I started reading books and I looked for a different supervisor... I thought, I guess I have to learn how to do this.

Mary believed that the onus was on her to learn these skills – that it was her responsibility to become skilled in treating this complex clinical presentation, and that it was not the duty of her graduate training or of her employer to provide the support she needed. While it is impossible for graduate schools or agencies to provide complete training in all of the clinical areas that new therapists might encounter, it also echoes the tenet of individualism over collectivism that is characteristic of white supremacy culture (Okun & Jones, 2016). Given the immense pressures on new clinicians in these challenging settings, it is a lot to ask that they also find the time and energy to become competent in the treatment of disorders like psychosis and dissociation completely on their own.

#### *Psychotic Clients and Evidence-Based Practices*

Another theme that emerged regarding othering psychotic clients was the opinion expressed by clinicians that clients with psychosis could not respond to evidence-based treatment models. Cait, a white cisgender female in her 30s, a clinical supervisor and therapist with over a decade of experience in community mental health, described this phenomenon:

Sometimes the psychosis... rules you out of some of ... the evidence-based treatment models ... It is really difficult to do prolonged exposure [PE] with someone who's got active psychosis. It's really difficult to do DBT [dialectical behavioral therapy] with someone who's got active psychosis.

“Active” psychosis seemed to mean, to Cait, that the client was currently exhibiting externally noticeable – or “positive” – psychotic symptoms: hallucinations, delusions, paranoia, disorganized speech. This perspective contributes to the theme of othering of people with psychosis: their behaviors are so far outside of the norm that they cannot even effectively participate in mental health treatment modalities – even in a setting, like Cait’s, that works with some of the most vulnerable members of society.

Cait’s agency is a trauma-focused treatment agency – in her own words, “we work in trauma”. There are two divisions of the agency – a “survivor services program and... a program that has adolescents and adults with problematic sexual behaviors or domestic violence issues”. Cait also named that psychosis is a common presentation among clients in the partial hospitalization program, which is the “problematic sexual behaviors or domestic violence issues” program: “Most of the people with psychosis, schizophrenia, things like that, end up in our partial hospitalization program”. The partial hospitalization program at her agency is the highest level of care, with dialectical behavioral therapy (DBT) as the primary modality. Therefore, the fact that many clinicians may view psychotic clients as being “ruled out” from the evidence-based treatments, like DBT and prolonged exposure (PE), that form the foundation of treatment at this agency, is perplexing.

Cait, as the interview progressed, continued to reflect on and verbally process these ideas, and was able to give some nuance to the discussion of the use of evidence-based practices with clients with psychosis:

I think there’s not been enough [research] to see how many evidence-based treatments can actually work with people with psychosis ... I know, with our

clinicians, if that presents... [they think] well, I can't do DBT, I can't do PE... I... wonder what it would look like.... It's probably not going to look the same as the manualized version I completed with somebody else in a different case... I also wonder if... there's been a disservice ... There's not been enough research, because, I think, unfortunately, society's been like... let's just make things go away, and that's our solution. And if you can make them go away, you can do PE. And I wonder what those things would look like if research... was done... to accommodate [psychotic clients and evidence-based practices].

When Cait mentions, "let's just make things go away," she is referring to prescribing antipsychotic medication. She also states that many clinicians in her agency do not feel that they can use the evidence-based practices that their agency primarily uses in their treatment approach until clients with psychosis are taking medication that reduces the presence of significant psychotic symptoms.

This is a form of othering – clients with psychosis are so far out of the realm of the normal human experience that they cannot possibly engage in these empirically tested approaches to managing mental illness. Of course, evidence-based practices should be modified to accommodate the range of neurodiverse clients who may need them, as Cait affirms: "I wonder what these things [evidence-based practices] would look like if research was done... to accommodate [these clients]". Still, her reflections make it clear that this perception of evidence-based practice being relevant to clients with psychosis is not reflected by the majority of clinicians in her agency, most likely because they feel fearful and anxious about how they might adapt the practices to suit these clients' needs. The perspective of EBPs as the necessary approach to treating clients is reflective of

elements of white supremacy culture, the first being one right way: “there is one right way to do things and when [a person does] not adapt or change to ‘fit’ the one right way, then those defining or upholding the one right way assume something is wrong with... the other” (Jones & Okun, 2001; p. 4). The privileging of EBPs also resonates with the white supremacy culture tenet of quantity over quality: “all resources of the organization are directed toward producing measurable goals... little or no value [is] attached to process; if it can't be measured, it has no value” (Okun & Jones, 2000; p. 3) Evidence-based practices rely on measurement and empirical validation, and when clinicians and agencies lose sight of the value of relational therapy that the common factors literature affirms is effective, quantity takes precedence.

### **Clinician Relevance and the Role of Antipsychotic Medication**

Another emergent theme related to clinicians’ experiences of helplessness when working with clients with psychosis was the fear that perhaps the only treatment agencies could offer to these clients was antipsychotic medication. This felt particularly disabling to clinicians because it made them question their own contribution to the client’s progress, given the psychotherapeutic treatment that they could offer. Clinicians also felt conflicted about the message that there was very little hope to offer these clients in terms of long-term improvements in outcomes, and also felt conflicted about how the agency sent this message.

Cindy shared about the difficulties that one of her clients had with antipsychotic medication adherence. This client’s primary psychotic symptom was auditory hallucinations, which Cindy described as:

Hearing voices. He's mentioned... hearing people laugh at him, or... a laughing in general... Sometimes he's like, yeah, sometimes I don't know if what I'm hearing is from the voices or if it's something that is actually going on outside... if it's something that he's hearing inside his head.

She also expressed the helplessness that she has felt at time when working with this client, a Black male in this 40s, who has expressed dissatisfaction and frustration with the need to take antipsychotic medication, even though they do dull his voices ("his medication seems to be working fine for him, at least well enough"). The frustration stemmed from Cindy not feeling that she had other treatment options for this client besides medication, particularly since clinicians in her setting did not receive adequate training, in her opinion, on working with psychosis:

I just don't feel like there's a whole lot of dialogue or training around this issue and I think that would be really helpful. Because I also think – and I admit, I may have embodied this on some level too, that... [the agency's message is] there is very little to nothing we can do to help people who have these symptoms, other than give them medication.

Cait echoed these same concerns. She also named something that was perhaps implicit in Cindy's statement above – that, for many in her treatment setting, and for society at large, the desired treatment outcome for psychosis would be some sort of "cure," and that successful treatment would mean that the psychosis would "go away":

Somebody's going to hear that there is a voice, and let's go put you on a medication, because unfortunately... a lot of people's goals is to cure the psychosis, let's make the psychosis go away, and that will... make you more

successful in... all of these other things in life... I guess if you go to a workplace and you're talking to yourself... people are going to react to that. Right? If you're on the bus and you're talking to yourself, people are going to react to that. If you get into legal trouble, people are going to react to that, right?... I think that there's... an overarching goal to medicate and to make those things go away, as opposed to.... Society as a whole... is uncomfortable with psychosis.

Cait seems to be emphasizing that the impulse to medicate psychosis “away” results from a combination of fear of psychosis by the general public and the availability of a medical solution to reduce the presence of those symptoms as soon as possible, even if the patient does not want to take medication. Society's discomfort with psychosis, Cait seems to assert, validates and informs psychiatry's impulse to treat it with antipsychotic medication.

Several clinicians struggled with the hierarchical tension at their agencies between master's level clinicians, which all of my participants were, and the psychiatrists. Psychiatrists were often seen as having the last word in all treatment decisions, in spite of the fact that therapists spent much more time with their clients than psychiatrists did in their five-minute appointments with clients every few months. These tensions reflected many of the elements of white supremacy culture in institutions, particularly paternalism, which dictates that those in power make significant decisions without involving the perspective of those who do not have as much power, including the master's level clinicians.

Mary brought up this tension when discussing a client with a diagnosis of psychosis whom she felt had been misdiagnosed. This client, a white male in his 30s, was

starting to display some increasing paranoia and delusional thinking, symptoms that Mary felt could set off alarm bells for other agency clinicians who might mandate hospitalization. Mary was concerned about the potential trauma of hospitalization on this client. She expressed her concerns as follows:

I feel like I've been avoiding accessing agency supports because I'm worried about how they're going to... I don't know if this makes sense... I feel like I'm doing my own thing with him in a way... I think that they would be like, you should 302 him, or... I don't know. I'm just worried about getting... getting people involved.

Mary felt protective of her client and felt that her client's presentation would be misunderstood and misinterpreted, and in a harmful way. This misinterpretation could lead to significant consequences – Mary feared hospitalization for her client. Because of these fears, Mary intentionally avoided connecting with other members of the treatment team at her agency. She also seemed to have some trepidation about how she was “doing [her] own thing with him,” as if other clinical staff at the agency, likely supervisors and psychiatrists, would not understand or support her treatment choices. Perhaps also, Mary was able to retain some of her sense of self-efficacy by choosing what information to share and what not to share with psychiatry.

Mary mentioned feeling fearful of communicating with psychiatry because she worried about how the psychiatrist might interpret client symptoms and could potentially want to hospitalize the client. She felt concerned about how this disruption could impact treatment: “Maybe he should... I should call this psychiatrist... Yeah, I think I'm very protective... I don't want our work to be disrupted.” She was reporting on work with a

current client when she was interviewed, which allowed her to share her concurrent reflections on the relationship, adding immediacy and urgency. She was experiencing in the moment of the interview the conflict she felt about involving the psychiatrist at her agency, and how her influence would be impacted by the involvement of psychiatry:

I would have... my power taken away from me somehow in terms of... decision making. The other thing is... he does have a psychiatrist who I don't really communicate with, but probably should... Yeah, [this client] has a psychiatrist at my agency, and he's... not a psychiatrist I particularly trust. I've worked with him a lot on evaluation.

Her hesitance is clear: she seems unsure that the psychiatrist would be supportive of her perspective and would override her belief about what would be best for her client. She felt conflicted about how hospitalization could impact the well-being of her client and their work together.

Sandy shared about a client with psychotic symptoms who was not being offered therapy initially, just medication, in spite of his specific request for therapy. This client was a Middle Eastern male in his 30s, presenting with symptoms of disorganization, paranoia, and with physical sensations of pressure in his genitals, which the client and the therapist were able to connect to his history of sexual abuse. Sandy and this client did eventually begin work together, and have continued their therapeutic relationship, but it took some time for the client to be connected to a therapist and not just be offered antipsychotic medication:

He needed to sort out this medication issue... He was... being slammed with medication instead of talk therapy when he was asking to talk... all his notes are



like I want someone to talk to. I want to talk... and it just wasn't... I don't know why it wasn't given to him.

Perhaps his symptom profile – which included calling the White House and identifying himself as a terrorist – felt frightening enough to clinicians working with him prior to Sandy that medication felt like a necessity. This client experienced several inpatient hospitalizations, both before working with Sandy and since they began their work together. Sandy described his reactions to the medication he was prescribed in the hospital as “pretty disturbing”:

He goes to the hospital, comes out, and he had been back on the medication in the hospital, and the medication really messed him up, and it was pretty disturbing to see someone who was... just... lively, funny, sweet, become like an old man...

Physically ... [he] went in on himself... fumbling around with stuff.

In spite of these troubling reactions, psychiatrists he encountered in the hospital and in outpatient settings were initially insistent on medicating him. Sandy, however, deserves a great deal of credit because she supported him in his self-advocacy to stop taking the medication.

This client has continued his therapeutic work with Sandy and currently they are working closely on connecting with different parts of himself that are more accessible when he is not medicated: “He's... split off versions of himself that he likes to talk about... these... personalities that he's created for himself, and how they help him operate in the world.” He has also made substantial progress in other areas of his life, including moving out of his parents' home, which, in addition to being a stifling environment for him, was also the place where his abuse as a child occurred. Not only

was he able to move out, but he was quickly able to find alternative housing, which both he and Sandy credit in part to their therapeutic work together:

I feel... [moving out of his parents' home] was pretty possible because of the therapy, and he didn't go to the hospital when he chose to do that... He was able to be...okay, like, I'm not going to go back home. I don't want to go back home... I'm gonna talk about it [in therapy].

Many clinicians interviewed named medication compliance as a persistent challenge for their clients experiencing psychosis. Cait summarized many of the issues impacting compliance:

I've tended to have less success with people with psychosis taking the antipsychotic medications. Antipsychotics tend to have a lot of side effects. And a lot of people don't like them, and a lot of people with psychosis have been on all of them before. And they usually are... in my experience, more resistant to taking them consistently. And as long as they're not doing harm...

When describing a Black female client who had active switching personality states, including a gruff male whom the client described as “the one who takes care of things”, a young child, and a teenage self, Cait mentioned that medication was the treatment prescribed for this client, but she declined to take it:

She was prescribed medication. She was not very consistent with medication, ever. So I also wonder how that contributed to the symptoms... would we have seen a different symptom level if she were taking medication?... we prescribed them to her, but she did not take them.

It is possible that taking antipsychotic medication would have reduced some of the more externalized symptoms of this client, as Cait indicates. Voice-hearing in particular can be distressing to clinicians, potentially because it feels so foreign and unknowable.

Some study participants mentioned the concern that clients sharing with therapists or psychiatrists that they heard the voices of deceased relatives or that they were conversing with ancestors could result in a diagnosis of a psychotic disorder. These types of experiences and reports clients are not unusual in certain communities and in fact are culturally sanctioned and protective. Whiteness as a norm that considers all other cultures as deficient can cause clinicians capacities to pathologize the context of how clients describe their experience. James shared his concerns about this particular issue:

When they're not actually hallucinating in the way... that it's characterized in the DSM... Indicative of schizophrenia or schizoaffective... they're talking about... having conversations with their ancestors... But they're not psychotic. It's not like they don't know... I had a number of clients [who expressed similar things]... I had my doubts as to whether the label... schizoaffective was really appropriate.

James's concerns in this area were particularly elevated because he did not feel that the psychiatrists at his agency would be able to understand this nuance. He also acknowledged the power differential between therapists and psychiatrists in agencies, and the challenges that emerge when clinicians attempt to question a psychiatrist's assessment of a client:

You know, you can't second guess psychiatry's... So... if someone reports that something that like... they talk to themselves a lot, or... yeah... I hear voices like... I talked to my grandma all the time. She died when I was 11...

James also expressed concern that a client was much more likely to be given a diagnosis of a psychotic disorder after mentioning interacting with their ancestors or with a beloved deceased family member if that client were also Black:

If somebody's given that diagnosis of a psychotic disorder, because they mentioned that way they talk to their dead grandma... you know they're more likely to get it if they're Black... maybe the psychiatry doesn't understand the cultural world... it's more acceptable to say you talk to your dead relatives.

James also expressed concern about the fact that diagnoses in community mental health tend to persist and “stick,” especially given the significant turnover of clinicians. If a client receives a diagnosis of schizoaffective disorder once after mentioning that they speak to a dead parent, that diagnosis is likely to follow them for as long as they are a client of that agency. And clients with psychotic disorders tend to be viewed as having a permanent, life-long, potentially debilitating condition, which makes it increasingly more likely that they will remain at an agency for years and receive the same medication and treatment:

Then... the next clinician comes along and sees a Black person that's got schizoaffective disorder... it just... carries on. This... thing of like... These people have chronic psychotic disorders right and they just stay [at the agency] forever and now they're on heavy meds and you [know] going off of those meds is not easy.

James names how these situations reinforce the erroneous and unfounded beliefs and stereotypes that Black people are, in his words, “chronic[ally] psychotic”. Additionally, a life in which a client is subjected to permanent dependence on extremely powerful anti-

psychotic medications should be taken seriously, particularly given the context, mentioned by several participants, that clients struggle with compliance with anti-psychotic medication. These clients may not feel empowered to push back on these diagnoses and do not necessarily have clinicians who feel empowered to advocate for them. Finally, James hints at the structural issue of therapist turnover: “and then...the next clinician comes along,” emphasizing how a severe diagnosis like a psychotic disorder gets handed from clinician to clinician without much question.

Cait shared some of the same concerns regarding her work with a female Black clinician of Caribbean descent:

I think, with her Caribbean background, she... spoke about spirituality in a way where I... as a therapist, maybe think about... Louisiana ... voodoo and spirituality ... I saw her twice. I saw her for a long time before the time she appeared with psychotic features, and she sort of fell out of therapy... stopped responding, disappeared... Then... popped up about a year later, clearly not in as great of shape... had all of the psychotic features present. But she did have... a more cultural religion to her island. She did... believe in ghosts and spirits and things like that, so... we have to consider that, because there's a lot of people where that religion... allows for... that kind of spirituality.

Cait's reactions to this client are complex. She does want to contextualize her client's symptoms and experiences and be culturally competent and sensitive. She does not want a client who “believed in ghosts and spirits and things like that” to be labeled immediately as psychotic, likely because the label of “psychotic” carries dangerous and consequential weight. This description of her client's symptoms, however, does other this

client – Cait sees the client’s symptom presentation as indicating that the client is “not in as great of shape.” She also distances herself from how the client presents - “ there’s a lot of people where that religion... allows for more of that kind of spirituality than I grew up with”. She is naming that she is unfamiliar with this manifestation of spirituality, and attempting to be self-aware regarding her own biases, but judgment is present. Her language indicates that she thinks of “that kind of spirituality” as falling far outside of the norm.

MM, the participant who called herself “the outpatient psychosis guru” at her agency, struggled with the tension between medication compliance and her role as a clinician in maintaining that compliance. MM shared the following anecdote when asked about what makes her feel successful when she is working with a client who experiences psychosis. Her response reveals both the general stress she experiences about helping them stay medication compliant, as well as her own internal insecurities about her role in treatment if a psychotic client does not take medication:

So... I had this participant with schizophrenia who was medication compliant, and actually started to get the inVega [an antipsychotic injectable offered either monthly or every three months], I believe, and he was able to get... a job as... a dishwasher part time... He was... very proud of himself. And I think that was... good to see, and also... I think it's good to see when they take medication, and they find that it helps... It's... doing something, because I think for so much of psychosis... there's not a lot of skills that you can... Coping skills are not really... relevant when you're... fully experiencing delusions or psychosis, and so... I think it's a big win when people are medication compliant.

MM implies that as a clinician, there is little significant contribution that she can make to her client's care unless her client is taking medication, since there is no possibility of tangible progress without the prescription of powerful antipsychotic. MM was asked when she feels successful with these clients, and she named specifically that helping clients maintain medication compliance helped with those feelings of success. Relational psychotherapy can be supportive in helping clients make decisions about medication that feel aligned with their values and goals, but MM was more focused in her anecdote on medication as the precursor to therapeutic work - "coping skills are not... relevant... when you're... experiencing psychosis" - and saw it as a "big win" once her client did become medication compliant. This was likely a "big win" because then MM would be able to resort to the skills that she felt that she could offer the client - the interventions and modalities that she tends to rely on in her clinical work were not available to her when a client was experiencing active symptoms of psychosis. She could use the skills she knew, and therefore believe in her capacity to help - she could then experience self-efficacy. This perspective could reflect an unconscious internalization of the hierarchical tension that is often present in these agencies between master's-level clinicians and psychiatric providers, who are frequently seen as occupying the top spot in the agency pecking order of prestige and authority.

Charlie, a Black female clinician in her 30s, expressed similar conflicts in her interview when discussing her clinical work with a client she described as African American, male, and in his 30s. She found it challenging to use the clinical tools that she believed would be most helpful when her client was not medication compliant. This

seemed especially frustrating to her because she and the client had identified skills that were productive when her client's symptoms were better managed:

Sometimes I had... a script [for a guided meditation] that I would use... And... he's... trying to cover his ears because... [his auditory hallucinations, the voices he would hear] were... basically challenging what we're trying to work on... [when] we do guided meditation... [The] difficulty working with him was he didn't want to take his medication... The medication would help him so well... when he would take it... [Then] everything was perfect, because we'd do a lot of CBT as well, and that was... helping him identify some of those thoughts were not rational.

Charlie expressed frustration at how the interventions that felt useful and productive to her, that allowed her to feel effective – guided meditations and CBT – were not accessible when her client was not medicated. Again, taking medication was a prerequisite for a productive therapeutic relationship: “When he would take it... everything was perfect.” Charlie did not say that she believed only in the value of medication when it came to supporting clients with psychosis, but she did say that therapy was almost not possible if her client was not taking medication. This statement again seems to be an unconscious defense against the clinician's own anxiety about their capacity to be helpful and useful. Being able to lean on tools like guided relaxation and challenging irrational thoughts was a comfort to Charlie, but when her client's noncompliance with medication did not allow her to resort to those strategies, she did not feel she could do her job.



Charlie did know why her client struggled with compliance – “[antipsychotic medication] made him extremely tired... His brain would be a little bit clearer, but then he would not have the motivation to do a lot of things.” When asked how this client responded to the agency psychiatrist, Charlie stated,

Let's see – [he was] not great. Sometimes... most times he'd miss his appointment. He'll be like, Well, I don't think I need that anymore.... We'd just talk back and forth about why it would be helpful... and sometimes he really needed the medication like if he had to work... Sometimes he [took on contracted work from others], but they had deadlines, and for him to get paid he had to meet the deadline... [I'd say to him], Listen, even if you take the meds between now and when you meet that deadline... that would be great.

Charlie felt responsible for helping her client maintain medication compliance and seemed to have internalized that part of her role as a clinician was to facilitate compliance. Her statement “we just talk back and forth about why it would be helpful” seems to indicate that she would devote significant therapeutic time to discussing the importance of medication and the positive impacts compliance would have on his life. The importance that Charlie's agency likely placed upon medication compliance meant that she did not have the opportunity to weigh client autonomy and choice, hallmarks of trauma-informed care and the common factors of relational therapy, when considering how to broach the issues surrounding medication with this client. The fact that her client would most often miss psychiatry appointments seems to indicate measurable reticence and hesitation about antipsychotic medication, but it does not seem that Charlie spent much time exploring why this client reacted so negatively to the thought of taking

medication. She seemed to feel the pressure to help him maintain compliance and felt that other therapeutic goals were necessarily secondary.

### **Tension between Masters-Level Clinicians and Doctoral-Level Clinicians and the Role of Hierarchy in Community Mental Health Agencies**

Hierarchical tension also exists between masters'-level clinicians and doctoral-level clinicians in these community agencies. Doctoral-level employees are given significant discretion and power in a treatment setting in which the masters-level clinicians are much more likely to have consistent and regular therapeutic contact with clients. Mary's interview highlighted the tension she experienced between herself, a master's-level clinician, and a doctoral-level clinician, a senior staff psychologist. Mary described how a client came to her agency for an initial assessment, identifying with a previous diagnosis of dissociative identity disorder (DID) that she received at age 16, and with the following symptoms:

She was telling me that she feels like she has... different personalities. One of them is a younger teenager... One of them is very angry... She experiences lapses of time ... switching between these parts of herself.

This client also found a great deal of meaning in the diagnosis of DID, because "it help[ed] her understand her experience." Mary's agency describes itself as a trauma treatment center specifically, which made the following sequence of events more bewildering. Mary consulted with a psychologist after making the diagnosis of DID, which was agency policy. Mary, as a master's level clinician, could perform the initial intake and assessment, but a staff psychologist had to sign off on the diagnosis. Mary was told by the psychologist, "I want to give PTSD with dissociative symptoms. I don't feel

comfortable with DID””. After Mary protested, the head psychologist at the agency weighed in and responded to Mary via email: “We need to change this diagnosis... Word for word in this email, she said, we don’t diagnose DID as a primary diagnosis.”

Mary found this troubling on several fronts: 1. The diagnosis had been given to this client previously and had a lot of meaning for the client; 2. The symptoms aligned exactly with the diagnostic criteria for DID, and not with the diagnostic criteria for PTSD with dissociative symptoms, and 3. Mary worked specifically for an agency that focuses on trauma treatment, and this agency was not comfortable with assigning DID as a diagnosis. Mary responded as follows to the email from the psychologist:

I wrote back and I was like, if this is what you need to do, that’s fine, but I’m not going to be the one to tell this client, you can handle that... For the record, I think that this is going to be damaging to her treatment engagement, and I think it’s going to be really important for her clinician to go with her experience... to join [with her]... and then I went on a whole diatribe about how can we say that we do not diagnose DID at an agency that specializes in trauma.

While Mary was not in this case distinguishing between psychotic symptoms and dissociative symptoms in the diagnosis of this client, this incident does highlight how reticent clinicians – even clinicians at agencies that focus specifically on trauma treatment – are to recognize and acknowledge the presence of significant dissociation.

Cait, who works at an agency that also defines itself as a trauma treatment center, openly acknowledged the reticence to diagnose DID. The client she described had distinct parts of self that the client would actively switch between in the course of a session: “It [DID] definitely came up [when they were trying to diagnose this client],

but... this is... out of our scope to make that diagnosis.” As Mary alluded to in her comments, it is hard to understand how diagnosing dissociative disorders could be “out of [the] scope” of a trauma-focused agency. Part of the reticence of clinicians at any level to diagnose DID could be because dissociative disorders are unfortunately still often not believed to be real by many clinicians and researchers (Paris, 2012; Pope et al., 2006; McHugh, 2013).

### **Racialization of Clinician Relevance**

The dynamics of race and psychosis can impact the creation of a strong therapeutic alliance and, therefore, the clinician’s experience of their effectiveness and relevance in the relationship. In addition, these dynamics impact how the client experiences safety in the therapeutic relationship.

#### *Client racial preference for therapists*

Many respondents shared how their agencies navigate client racial preference of therapists, and their own reactions to client preference. Katie shared that her experience had been that when clients expressed a racial preference for their therapist, that preference would be honored to the extent that the agency was able to do so:

[My agency] never force[s] anyone that feels uncomfortable... I wouldn’t do it [work with a client who did not want a white therapist]. It’s just not fair... to the patient. They're not going to get the treatment that they need and... they're not going to feel safe.

Both stances – a client has to work with whoever is assigned to them, and a client can and should refuse treatment from a therapist who is not a good fit – draw attention to the reality that, even if all agencies intended to provide all clients with the best fit therapist

for them, clients have limited choices. Community mental health agencies are the only agencies providing mental health care for Medicaid clients in Philadelphia, so clients cannot choose to go elsewhere. Community mental health agencies have predominantly white clinician staff, so clients can agree to work with who is available or they can sit on a waitlist for a potentially extensive period of time for a Black therapist to have an opening.

Other interviews highlighted the challenges of matching Black clients with Black therapists. James, a white male therapist in his early 40s, named the critical racial mismatch inherent in the clinician population in community mental health agencies in Philadelphia: “Right off the bat... the vast majority of clinicians are white and the vast majority of the clients at a place like [agency name] and [in] Philadelphia are Black.” Because of this disparity, it is unlikely that a client will have much choice regarding the race of their therapist.

Benjamin, a white male clinician in his 30s, shared that, at his agency, a client’s preference for the race of their therapist was not acknowledged:

One of the things that I think... could make engagement challenging was, you got whoever you are assigned. There was not... a lot of room to... transfer clients, so if a client was like, I really want to meet with a black female therapist, [the agency would reply], we don't really transfer people and you're at this office... [but] we could easily transfer people... [so] why don't we?... especially during COVID.

When Benjamin referred to “this office,” he was alluding to the fact that his agency had multiple outpatient locations across the city, and he found it hard to understand why his

agency would not take the time to check its other locations to see if there could be a way to match a Black client with a Black therapist. When he stated, “especially during COVID,” Benjamin meant that, since sessions were being conducted virtually anyway, why was it so hard for the agency to do a bit of extra work to find a match for that client? The physical location of a client and how close they were to any of the agency’s offices were no longer major considerations. Benjamin believed that clients had the right to request a therapist with specific characteristics and felt frustrated that the agency did not try to accommodate that.

Several clinicians interviewed shared the experience of Black clients naming feeling more comfortable with a white therapist than a Black therapist. Katie shared that, while she has had many conversations with potential Black clients who expressed feeling uncomfortable with a white therapist, that she has also had the opposite experience:

One woman will only talk to me because... she's African American and doesn't like African American people ... I can't tell you how many people tell me that will sit with me and say ... we just we don't ever talk about mental health in my family... [many Black people] just don't believe in mental health... I can't tell you how many people tell me that.

Katie connected the client’s preference for a white therapist with the client’s explanation that her family is not comfortable talking about mental health concerns. Katie supports her one client’s assertion that her family does not discuss mental health by adding that she has been told by other Black clients that the [Black community] “do[es not] believe in mental health.” For this reason, Katie suggests, some Black clients feel more comfortable talking to a white mental health therapist than to a Black therapist.

Two other clinicians, James and Sandy, shared similar experiences. James stated, “I also had people tell me... I’ll never work with a Black therapist. I don’t trust other Black people.” Sandy, a white female therapist in her 30s, explained how the topic came up with one of her Black clients:

He was talking a lot about racial dynamics and like what it's like to be around white people and... then I was like, okay... So how do you feel that... you've been assigned to the only white therapist in the clinic? And he was like, I like it, feel good about it, feels like I can say whatever I need to say. So that was interesting.

This potentially resonates with what Katie noted, that perhaps talking about mental health concerns is stigmatized in Black culture and it can feel safer for a Black person to discuss their symptoms and experiences with a non-Black clinician. Sandy also added an additional perspective as to why some Black clients might prefer a clinician of a different race: “I think a lot of people have family of origin issues, and if I don't look like your family of origin, it might be easier.” Sandy presents the possibility that it might feel more comfortable to talk about traumatic experiences with someone who does not bear a physical resemblance to or feel culturally connected to people who have traumatized them.

Sandy also wondered if her effectiveness with clients was impacted by other elements of her identity, beyond race. Sandy, whose agency served a large population of immigrants, believed that cross-cultural and sociopolitical dynamics often impacted her work more than racial dynamics:

I don't want to say beyond race. But... added to race is culture and working with people from all over the planet... Like what the fuck... you are a child bride... I hate this ... You were... forced to marry your cousin. And now you're psychotic... Your country was bombed... I've thought a lot about... what it means to work with people from countries that we've... colonized, and then they're... here in the same country... at this... weird community clinic. It's like, I'm your therapist... Hi! Bizarre.

When Sandy said “beyond race,” she was implying that race was not the only identity element that impacted the relationships she has with her clients. She struggled with understanding problematic elements of her clients’ native cultures, including seemingly oppressive marital practices like forced and arranged marriages. She also seemed to make a connection between some of the oppressive structures, including colonization, that her clients had experienced and the development of psychosis. Sandy also names the challenges of being a therapist to a client from a war-torn, colonized nation, a client who then immigrates to the colonizing nation, when Sandy herself represents the colonizer to the client. Beyond Sandy’s concerns about her effectiveness with clients due to their psychotic symptoms, she also grappled with how her ethnic and cultural identity could impact her client work.

*Cross-racial clinical dyads, white therapist imposter syndrome, and “naming” race*

At times, white clinicians found that their race increased their imposter syndrome in the clinical relationship. Alex acknowledged how challenging it felt, as a white person, to navigate the dynamics of race with their primarily Black client population. Alex shared a belief of their own role in the therapeutic relationship that did not align with the



perspective of some of their clients of color: that it is the responsibility of the therapist to name race as a factor in the relationship:

The “I don’t see color” response is... a response I’ve gotten a few times... ‘it doesn’t matter because I don’t even see color’... one response I did get recently was... the person was saying that they value other perspectives. And she was saying that her last therapist was a white man and she learned a lot from him... she’s a Black woman... and we did talk about race at the very beginning... she told me she didn’t care at all... She doesn’t think about it, [doesn’t] worry about it; she likes everyone.

Alex expressed their discomfort with these responses and that they did not know how to reply. They directly named that it felt inappropriate as a white person to challenge the “I don’t see color” perspective when shared by a Black person: “it’s different when you’re on the side of the oppressor, than when you’re being oppressed.” They felt that it was not their place to challenge a Black person’s perception. It is possible that Alex’s client was responding in this way in an attempt to appease Alex or to be liked by them, or perhaps simply because they wanted to focus on something else. Still, the inherent power differential in the therapeutic relationship can elicit appeasement behaviors from clients. The power differential is even more pronounced when a therapist has an additional element of power and privilege – their whiteness.

Alex also shared that clients at times actively did not want to address race when they named it in session:

When it comes to race, I try to bring it up. I struggle sometimes. Especially because, sometimes, when I do bring it up, it so often gets brushed off. So I think

to myself, you know, you want to do it first, because it's here in the room, so you have to name it, but you haven't built any trust, then why would that person want to talk to me about race?

Alex believes that they have an obligation to bring up race in sessions with clients, and to be the first one to do so – so, likely early in the relationship - even if the topic “gets brushed off”. They also acknowledge that it could be difficult for a client to engage with them about race, particularly early on in the therapeutic work, if the safety of the alliance is in its early stages of development.

Cindy also named the importance of making sure clients are aware that race is a topic she is open to discussing:

I make it clear that I am not averse to talking about this issue...I might sometimes preface things with... I want to recognize that I'm coming at this as someone who has this particular background as a white person... in this position.

Cindy, when she mentions race with clients, at times will also name her whiteness and the inherent power in her position as a therapist and how that influences her perspective and what she might share. Her belief that it is her responsibility as the therapist to make race a “safe” topic for clients reflects the experience that Alex shared. Perhaps engaging in a behavior that Cindy internalized as part of her role as a therapist – naming race and the power of her position – helped her feel effective and relevant, especially in a cross-racial therapeutic dyad.

#### *Black therapist perspectives on the impact of race on their effectiveness*

BC's insights about how her racial identity informed her clinical work showed less of a tendency to essentialize BIPOC clients: “I do feel like, at least for the

engagement and alliance formation, when folks would come in and see clinicians of color, that it was helpful.” She expanded upon this as she reflected on specific ways in which her race positively impacted the client relationship:

I think there were certain times that my race was a benefit, particularly when COVID hit, and... spring 2020 through... fall, 2020, with so many murders and killings of African Americans in quick succession... I think it was at one point almost two people a week, and it got really untenable. Then I would hear race being brought up in session, or I would bring it up in session, just as a possibility, and sometimes clients will say, well, this was this was my reality before this happened. So it's sad, but it doesn't make any difference. And then there were others that would say that they couldn't look at their phone, and then it would lead the session in a different direction... Just me asking a question or bringing race into the session, that somehow gave them permission to... unpack, unload some of whatever they were carrying. I think, because also the way I decorated my office, again with the safety component in session, I tend to use some like Afro-centric... sort of themes. My office was decorated as such as much as I could ... bright colors, and things like that. It's also very organized in my office... Clients have told me... it helped them feel safe because it was predictable, and when I ended up sharing an office for certain points in time, they knew. They would come in and say, Hmm, somebody moved your stuff.

BC touched on a variety of different ways in which her shared race with her clients impacted the safety of the therapeutic relationship. She was able to provide safety for her Black clients during a tumultuous and painful period, when the murder of Black men at

the hands of police was a frighteningly common occurrence. Her race allowed her to hold space for the variety of responses that Black clients were having to the events of 2020, whether they did not feel that the events were particularly impactful – “it’s sad, but it doesn’t make any difference” – or they were overwhelmed and traumatized by the enormity of them – “others would say that they couldn’t look at their phone”. BC also named the importance of the therapist “bringing race into the session”, that it “gave [the clients] permission to... unpack, unload some of whatever they were carrying”. BC’s willingness to meet the client where they were at in terms of their response to the racial violence of 2020 showed less of an inclination to label, to assume that all Black clients would respond in the same way.

Finally, BC’s race created safety for clients even in how she decorated her office. BC expressed her intentionality in her use of Afro-centric themes in her office and her attention to bright colors. Keeping her office clean, organized, and consistent also created safety, and likely helped clients feel valued and respected – that the space in which they spoke about some of their most intimate and vulnerable concerns was designed with their comfort in mind. Clients’ reactions to BC’s items being moved when she shared an office are evidence of the importance of this safety, and of the care that clients felt for her. In contrast to the way in which they felt respected by the space she created for them, her clients were uncomfortable with how her items were not necessarily respected – “somebody moved your stuff” – by others who were sharing the space. BC’s shared racial identity with clients allowed her to feel more connected to their needs and therefore, more effective and relevant, in spite of their difficult symptoms and presenting problems.

Blue, a Black female clinician in her 20s, also reflected on how the events of the spring and summer of 2020 impacted her client work, and how her identity as a Black person contributed to the creation of a safe space for clients to address these events. At first, Blue shared that she was not sure how much her race played a factor in creating safety with clients. Then, she did reflect on how the events of the pandemic and the highly publicized murders of several Black men by police during her time working in community mental health impacted her clients' experiences. Blue worked in a partial hospitalization program that incorporated both group and individual therapy: At first, Blue was dismissive of race in the relationships she has with her clients, but as the interview unfolded and she continued to reflect, she explored how the historic events of the spring and summer of 2020 impacted the dynamics of the groups she led:

[Race] come[s]... up when something big happens... [like] the George Floyd...situation ... You have participants who feel really strongly against it. And then you have other people who [say]... Well, it wasn't that big of a deal and that's when you kind of see [the racial tensions emerge in groups]... I will say that the Black clients will bring it up more in my group or the other therapist's group that is Black, just... judging by... [treatment] notes... So I would say, it comes up more with our groups.

This reflection led Blue to contemplate how the treatment notes of the different group therapists indicated that discussions about the explosive racial tensions crossing the United States in 2020 occurred more frequently in groups led by Black therapists. In her experience, Black clients were more likely to broach these topics when Black therapists were facilitating groups.

Charlie, a Black female therapist in her 30s, believed that her race was impactful for her clients. Most of her clients were Black, partly due to the demographics of her agency, but also, she believed, because those clients had wanted a Black therapist:

Most of them were actually Black on my caseload, period. They all wanted Black therapists... They've expressed some level of discrimination in a system that is supposed to help and protect them. [Clients shared that]... I want to connect with the therapist that looks like me.

Charlie recognized that Black clients, when engaging with the mental health system, had likely experienced racism in the past. She connected clients' desire for a Black therapist with a need to feel safe in a system that had traumatized them before – that they believed that a Black therapist could protect them against being harmed. Charlie did also acknowledge that this safety was not always something she could guarantee: “at the end of the day they still have like some resistance [to participation in treatment], because [clients say to me], you are still part of the system... [and] that's what makes me [Charlie] sad sometimes.” Charlie wrestled with the knowledge that she could also be causing harm to her Black clients, by virtue of her participation in a harmful system. Even though Charlie could recognize that her shared racial identity with clients could be a way in which she could create safety for them, she also recognized that, by participating in an oppressive system, she could act in ways that would be counter to the principles of trauma-informed treatment and the common factors of effective treatment.

Joanne shared about a relationship with a Black female client in which their first interactions created safety and comfort for that client, safety that continued for the length of the relationship:

I had one client, she she's one of my favorites, I'm not gonna lie. I called her... to make her [initial] appointment... I was saying [to the client on the phone]... I was assigned to you as a therapist. I was calling to make an appointment. And she said... I just want to let you know that I want to my next therapist to be Black... [And then]... code switching has to happen, and it kind of did happen in that moment for me, and I think that's something that does happen to Black therapists working in different agencies, like the code switch is definitely real, and... I was like, yeah. So you want to schedule your appointment now?

Joanne found that their shared Blackness – which her client was able to recognize immediately over the phone by Joanne's code-switching – created an instantaneous connection for this new client. The client made it clear on the phone that she had been through at least a therapist or two – “my next therapist” – a common occurrence at community agencies with frequent staff turnover. Although Joanne did not say this, she implied that this client had never had a Black therapist before. This client said almost immediately after Joanne called that she wanted a Black therapist. Their relationship, in Joanne's eyes, was extremely positive – “she's one of my favorites, I'm not gonna lie” – and it is likely that their shared racial identity played an important role in the strength and safety of their therapeutic alliance.

## **Conclusion**

Clinicians in this study openly shared about the treatment challenges presented by clients with psychotic symptoms. For many clinicians interviewed, working with a client who experiences psychosis presented unique difficulties and often caused the clinicians to doubt their own effectiveness and relevance. These doubts could lead to clinician

othering of these clients as a way to manage their own anxieties about their capacity to be of service to individuals experiencing psychosis and making treatment decisions that were not in alignment with the research-informed common factors of treatment and the tenets of trauma-informed practice. Clinicians mentioned the belief that evidence based treatments that they knew and practiced were not possible to implement with clients who experience psychosis, at least not until the clients' psychotic symptoms were controlled by medication.

The role of psychotherapy in the treatment of psychosis often felt fraught for these clinicians, who noted the primacy of psychiatry in their agencies and often felt that their first treatment goal had to be medication compliance, no matter what the cost was to the therapeutic alliance. Clinicians struggled with feeling valued and relevant in agency systems in which psychiatrists and psychologists maintain authority and often have the last word about treatment decisions, even though masters-level clinicians provide consistent and regular therapeutic treatment to these clients and arguably know their individual needs best. Finally, clinician perspectives about how their race might impact their relevance and efficacy with clients also emerged in interviews. Critical whiteness theory provides a lens through which to examine how the racialized dynamics of these treatment relationships can play a role in the treatment decisions clinicians make as they try to maintain their belief in their own efficacy.



## **Chapter 5: Relational Dynamics in Hospitalization of Psychotic Clients**

The therapeutic relationship with clients who experience psychosis profoundly impacted how therapists navigated the decision of hospitalizing a client. All of the therapists interviewed had experience with hospitalizing clients with psychosis. Many therapists were involved in involuntary hospitalization, and all therapists were involved in some way with clients voluntarily hospitalizing themselves. The therapeutic relationship between therapist and client impacted the hospitalization experience in many ways and at times was a determining factor in how treatment proceeded after hospitalization. The major subthemes about hospitalization of clients with psychotic symptoms included: therapists feeling like they are the only ones responsible for client safety; how the strength of the alliance prior to hospitalization impacted the alliance post-hospitalization; how therapists and clients at times had differing perspectives on the traumatizing impact of hospitalization; and finally, the racialized dynamics of the hospitalization process. The significant role that clinicians play in the hospitalization process could lead them to make decisions in service of feeling effective, while at the expense of their commitment to relationally-based treatment.

### **Therapist feelings of responsibility for client safety**

Many therapists interviewed expressed feeling like they were the only ones in the web of systems involved in hospitalization who were responsible for client safety. This weighty responsibility often resulted in therapists taking on a burdensome level of extra work to ensure client safety, which is an additional stressor in the community mental health work environment in which clinicians are already significantly overworked, with large client loads and oppressive amounts of paperwork. BC, a Black female therapist,

spoke to some of these concerns when she described the experience of considering hospitalization for a Black female teenage client. This client had a diagnosis of severe depression and had some psychotic symptoms at times, including, in BC's words, "[when we were] talking about really sensitive topics, or some triggers for her... sometimes she would just kind of go to a place that was not in my office, and would have to do some more grounding work to bring her back." BC described the systemic challenges and time-consuming burdens of the decision making regarding choosing whether or not to hospitalize this client:

She really didn't want to go. She didn't want to... physically leave the office, and... it was close to when we were closing, which would have been around 8 o'clock ... That process... involved me, it involved this family member, the client, and my supervisor to really work together to create a plan, and also establish what the next steps were in the event that she did not go to the hospital because we needed to know that she was going to be safe. So that was... a really time-consuming experience, and I think we ended up calling mobile crisis, and so we were there until mobile crisis arrived, and then I stayed in the office while they did... all of their questioning with that adolescent and their... guardian.

BC was concerned for the safety of this client but was also in a position in which the client did not want to be hospitalized. Also, since the client was a minor, BC had to involve the client's guardian, her uncle. BC mentioned that all of this occurred at the very end of the work day, at eight p.m., which meant that BC had to stay at the office likely for a couple of hours after closing, waiting for the mobile crisis team to arrive and evaluate the client. BC clearly felt that it was her responsibility to help facilitate the

conversation with the mobile crisis team as well, and so she stayed with the client and her guardian as the client was interviewed by the crisis team.

Clinicians have a responsibility to keep clients safe, to the extent that they are able, and it is also true that this level of involvement and effort beyond the clinical hour is burdensome, given their high caseloads and demanding paperwork requirements. It can be argued that this is an unreasonable expectation; however, it is a testament to the commitment that these clinicians have to their clients and to the relationship with their clients that they have this level of engagement in the process. BC's desire and willingness to communicate with mobile crisis about the level of need her client had is evidence of the value that BC placed on this relationship.

An additional point of significance in this incident was that, ultimately, the client calmed down when the mobile crisis team arrived and did not need to be hospitalized. BC continued to work with the client and her family to provide ongoing support since hospitalization was, for the time being, ruled out. BC did not ultimately make the decision that the client did not need to be hospitalized; the mobile crisis team, when they arrived at the agency to evaluate the client, assessed that the client's level of risk was not high enough to mandate hospitalization. In consultation with mobile crisis and with BC's supervisor, BC and the client decided that they would now meet twice a week to provide additional support for this client, now that the immediate crisis had passed. BC also provided support for the client's family, educating them on how to respond if the client showed increased symptoms at home:

There is a conversation we had... my supervisor, myself, and her caregiver...if this is what happens at home – and [the client] was present for the whole

conversation... this is what is going to happen... [I] impressed this upon the caregiver... You have to do this. It's going to be hard. You can always give us a call.

Again, the clinician shows an impressive commitment to supporting this client, even though it means adding an additional weekly session and, consequently, an additional burden to her workload. The clinician also creates a collaborative safety plan with the client's support system, providing even more scaffolding for the client. BC prioritizes her relationship with her client, creating safety and providing consistency, even when these accommodations have the potential to increase her workload.

Charlie, a Black female therapist, shared a similar experience of feeling a heavy responsibility for a vulnerable client's welfare. This client was a Black male in his mid-thirties, and he had long-term, significant psychotic symptoms, including auditory and visual hallucinations, including seeing non-human forms in his peripheral vision; disorganized speech; and significant dissociation. He was hospitalized frequently. He had experienced chronic complex trauma throughout his childhood and early adulthood, including parental abandonment, exposure to community violence, and traumatic loss. Charlie stated that usually this client would agree to hospitalization, but she described the experience of trying to hospitalize him, potentially without his consent, after a substantial increase in symptoms.

In her description of her interactions with this client, Charlie mentions a 302, an administrative petition to mandate a psychiatric hospitalization, commonly referred to by the clinicians with the administrative code "302". This incident was during the height of

the lockdown period of the COVID pandemic, so Charlie was seeing this client virtually. The client was not physically present in Charlie's office.

There was only one time I [said]... these are the options. Either I 302 you, or... I call the police... We gotta figure something [out] ... Most times he'd be like all right. I will go by myself, and I would spend like 2 hours [convincing him to go to the hospital] ... because of the way he presented with his symptoms.

Unfortunately, [this time] I couldn't trust him enough [to promise to go to the hospital when I said]... You're gonna go to the hospital and call me when you get there... He also didn't trust .... the mobile crisis team to come get him... [so I'd say]... I'll stay with you on the phone. You call an Uber. Honestly, sometimes I... wish I could call you an Uber. I wish I could come get you and take you ...

When... we would have to take him to the hospital, the beds would be so full that they would not admit him immediately, and he has to sit there in the waiting room for hours ... He'[d] say... I don't want to sit there for hours, ... I'll [say]...if you if you need me to stay on the phone for hours... You really need to be somewhere where they could at least give you medication ... Please do not leave.

Charlie's commitment to this client and concern for this client and her investment in the relationship, are evident in this account. She also seems to feel that the relationship she has with this client means that she does not trust anyone else to manage his hospitalization appropriately – including the mobile crisis team and the staff at the hospital. The client himself claims not to trust the mobile crisis team to do their job, which Charlie then takes on as additional responsibility for her – she tells the client that she will stay with him on the phone “for hours” if needed, and states that she wishes she

could call him an Uber to ensure he arrives. Charlie was speaking with the client on the phone during this session, due to COVID restrictions.

Certainly, Charlie has reason to be concerned about whether or not her client will receive the care he needs, because of his own reticence to go to the hospital and the severity of his symptoms, but she cannot force him to take an Uber, nor can she force the hospital to admit him once he is there. She could call the police, but she recognizes the potential for additional trauma if the police were to come. She cannot control the outcome, but her feelings of responsibility for this client, and her perception that she is the only person who is standing in the way of whether he lives or dies, pervade the account that she gives here.

There are significant structural issues to manage with hospitalization, which Charlie names – no available beds, which meant a long wait time. Also, the systemic failure of the mobile crisis team – not having the availability, the staffing, or some other constraint, to arrive when needed. These system-wide challenges could mean that the client would not stay at the hospital upon arrival, which is Charlie’s concern. At this point, however, Charlie has done her due diligence and the client had gone to the hospital. She does not need to continue her involvement beyond this point, not until the client returns to her clinical care after he goes to the hospital. In this particular case – in fact, on two occasions – this client did not stay at the hospital for very long, not beyond the initial 72-hour hold that a 302 involuntary hospitalization requires in Pennsylvania:

Twice he was there, but they released him... after I think it was 72 hours... A bunch of times he left. He was like, I'm not staying. I'm better... Then we [would]

talk about... If you claim you're better. You either go to your mom's house, or you go somewhere where I know that you're safe... you're not going back home.

Her continued concern and fear that she is the only one standing between her client and something terrible happening emerges again here. She doesn't seem to believe that he is well enough to leave the hospital – “If you claim you're better,” she says, implying that she does not agree that he is. She also tries to tell him where she thinks he should go, now that he has left the hospital, that will be the safest place for him. Again, in actuality, her influence is limited, but she appears uncomfortable with allowing her client to act independently. The hospital bears responsibility for his welfare here also. If he was allowed to leave, the hospital has chosen to claim that he is safe enough to go. Charlie's role as his therapist is to advise him and to be concerned for his welfare, but she also has to reconcile herself with the fact that she may, in fact, have no control over his safety.

In an anecdote about a different client who went voluntarily to the hospital, Charlie noted that the complications of COVID made accessing needed services challenging. The mobile crisis team was understaffed and had to adhere to safety protocols, all of which led to inadequate service provision: “Another issue that we faced during that time was the mobile crisis team only go... according to their availability. So if they're working with someone [else], you kind of have to wait till they're done with that person.” This put an additional burden on all of the therapists I interviewed – all were interviewed between March 2021 and May 2022, so the impact on services during the most severe and dangerous parts of the COVID pandemic were fresh in the participants' minds. Therapists were put in the position of having to advocate extensively for clients and over-involve themselves in crisis management to be sure that clients were safe, to the

best of the therapists' ability. This is part of the explanation for the caretaking behaviors exhibited by the therapists, while also being even more of a reason why the therapists could not hold themselves responsible for systems meeting their clients' needs – the systems were even more inadequate than usual.

Throughout the interviews, therapists navigating the complex decision-making regarding hospitalization of clients with psychosis often took on responsibility beyond their professional role on behalf of clients, taking on responsibilities for the needs of others that are not essential, but that the individual sees as necessary. Charlie and BC both engaged in this responsibility beyond the professional role on behalf of their clients. They both feel some discomfort with letting their clients take sole responsibility for their welfare beyond what they as clinicians are required to do in crisis management situations. For BC, that meant staying at work very late, liaising with the mobile crisis team, safety planning with the client's family, and making room in her schedule for extra sessions for this client. For Charlie, this sense of responsibility meant staying on the phone with a client as they traveled to the hospital, wishing she could call an Uber for a client to ensure they arrived safely at the hospital, and staying on the phone with the client to be sure that the client stayed in the waiting room.

It is worth considering how Charlie and BC's caretaking behaviors of their clients in these therapeutic relationships manifest here. Do these behaviors result from their own personality traits and personal history, or are they a result of being part of system in which clients and direct care workers like therapists are continually disempowered? Is their sense of responsibility an attempt to assert their own agency in a system in which the perspective and impact of direct service clinicians are not often valued? This



responsibility beyond the professional role aligns with the need for self-efficacy in these broken systems. Bandura (1977) claims that the environment plays a key role in self-efficacy. Some of the clinicians in this study choose to accommodate for the failings in the institutions that are supposed to protect their clients and protect their own needs for agency and relevance by engaging in responsibility beyond their role. It is likely that there are many factors influencing their actions, but an argument can be made that they are taking on significant responsibility not required of them in their roles in these anecdotes.

Regarding structural and systemic issues, Rebecca, a white female therapist in her 20s, also shared an experience of the mobile crisis team not fulfilling its obligations and potentially endangering a client. Rebecca worked at an agency that served primarily adolescents and young adults in the years just following the development of psychotic symptoms. When clients receive treatment for psychosis early in the timeline of disease development, the prognosis is often better (Fusar-Poli et al., 2020; Marshall et al., 2005). Rebecca's agency often received referrals from local hospitals of young clients who had been repeatedly hospitalized over several months or a couple of years. Because of the younger ages of her client population, Rebecca often worked closely with family members of her clients. Rebecca shared this account of the failure of the mobile crisis team, and also of how she and her client's mother worked together to keep the client safe:

One of my participants' mom called [the agency 24-hour emergency number] and I had seen [the client]... two days before, and she was definitely more symptomatic ... [She] has a history of... making decisions that... put her at risk and can be pretty unsafe... Her mom called ...after she... returned home after

being out all night... and she'd gotten... physically assaulted... And her mom had called mobile crisis ... [Mobile crisis]... never came and so I called back, and... gave them... collateral, and they ... used my... observations of her in our session... From that hospitalization she was hospitalized for... two months, which... felt really hard. I... visited her quite a few times.

Rebecca, in collaboration with the client's mother, was able to successfully hospitalize her client. Rebecca's client was vulnerable and was obviously displaying significant symptoms, if her hospitalization lasted for two months. Rebecca was invested in getting her client the care she needed. When the mobile crisis team did not fulfill its obligations by failing to respond to her client's mother's call, Rebecca called crisis herself and provided additional information to corroborate the mother's concerns about her daughter's symptoms. Rebecca's call appears to have made the difference, and the client was hospitalized.

Like many of the other accounts in this section, Rebecca both managed the structural weaknesses of the hospitalization and crisis response system in Philadelphia and also took on an additional level of responsibility for her client's welfare. Making a follow-up call to the crisis team to facilitate the needed hospitalization of her client was definitely excellent clinical care, but Rebecca should not have had to go above and beyond in this way. The mobile crisis team should have done their job and responded appropriately. Again, a clinician is filling in the systemic gaps to provide the best care for a client. Unlike some of the other accounts, however, Rebecca does not express the same level of anxiety – that she is somehow the only person keeping her client from falling through the cracks – that was expressed by the other clinicians in the study. She made an

additional call to support the mother's account and then let mobile crisis take over at that point. BC and Charlie, in the previous accounts, spoke at length about all of the additional steps they took, the significant investment of time they gave to their clients' safety. Both BC and Charlie's accounts had an emotional weight and charge that was not present to the same degree in Rebecca's anecdote.

At another point in the interview, Rebecca reflected on the relational dynamics of being a white woman working with Black clients with psychosis. She was aware of how her role in the therapeutic relationship could be one of surveillance, not of safety and trust, particularly when she looked like people from other treatment settings, including hospitalization, who had traumatized the client. She shared an interaction from her work with a teen client that reflected these tensions:

[Race has] explicitly come up with one person I work with... a 16-year-old Black teenager, and he'll... appease me and be like... Miss [Rebecca]... What do you need... when do you want to see me, or like things like that... Each time I'm like, wait a minute. What do you want? ... This [relationship] is for you... I don't need anything... This is your time... Our relationship is pretty... restrained and... he is pretty hesitant to... be in therapy... Whenever I... reflect that... or name it, he'll... agree, but... not engage.

Rebecca connected this anecdote to a previous reflection she had shared, that many of her Black clients had been hospitalized or in other treatment settings and had had many negative experiences with white female clinicians in particular. This Black teenage client showed some of the behaviors that one might expect after having traumatic experiences with white clinicians. He was very guarded and tried to "appease" her, as Rebecca said.

He did not want to direct his sessions with her, and she recognized his hesitancy to be in therapy, in spite of her efforts to create space for his thoughts and feelings. He was compliant but not “engage[d]”.

As I reflected on the varying responses to crisis situations that I am writing about in this section, I noticed how most of the clinicians who went what could be perceived as “above and beyond” for the care of their clients were Black clinicians, often attempting to hospitalize Black clients. When Black individuals display psychotic symptoms, they are more likely to be arrested, treated as criminals, or potentially even harmed or injured by law enforcement as opposed to white people with psychotic symptoms (Denzel, 2016; Ford, 2015; Misra et al., 2022; Tegnerowicz, 2018). The Black clinicians in my study all were aware of the potential harm that could come to a Black client who is displaying symptoms that are confusing or difficult for a non-clinician to understand: symptoms that could be interpreted as dangerous or criminal behavior (Ramsay et al., 2011). This could account for some of the extreme concern and potential over-involvement in client well-being that I have described from BC, Charlie, and Blue, all Black female clinicians.

### **The impact of the pre-hospitalization alliance on the therapeutic relationship**

The therapeutic relationship and the strength of the alliance were impactful as the therapeutic dyad navigated decision-making regarding hospitalization and its aftermath. Many therapists interviewed leveraged the relationship they had with a client when making decisions about hospitalization, and a stronger therapeutic alliance often meant that clients were more willing to agree to a voluntary hospitalization. A strong therapeutic alliance also often meant that the relationship did not suffer significantly as a result of hospitalization. This aligns with the literature on the common factors, indicating that a

strong therapeutic alliance is one of the greatest predictors of positive treatment outcomes (Laska et al., 2014; Miller et al., 2015; Wampold, 2001).

BC, when sharing about the teen who she almost had to hospitalize in the anecdote in the previous section, stated that, although her client was not happy with the situation, she could respect how BC was transparent with her boundaries about hospitalization and safety from the beginning of their relationship. Not only was BC transparent, but she also actively held those boundaries, which actually increased the trust that the client had in their relationship:

She didn't like [that they had had to strongly consider hospitalization, and that BC was supportive of potential hospitalization]... One of [my strengths] as [an] outpatient therapist was [that]... my boundaries were very clear with all of my clients ... It was part of my job, that there are certain things by law I had to do. And then there are other things that I do because I care... The next time we met ... [we were] unpacking the last session [when BC had almost had to decide on an involuntary hospitalization for the client], and then also [I was] sharing [with the client the idea that]... [you may] have an argument with someone [referring to the previous session and the strong feelings the client had about BC's urging hospitalization], but you're able to talk through it ... You often come out better ... I can actually trust this person because they were consistent, and they actually did exactly what they said they were going to do. And so that that was helpful [for this relationship].

BC's client, in this situation, was a female Black teenager who had experienced substantial attachment wounding and traumatic loss. In BC's own words,

[she] was living under the care of her grandmother and uncle... I don't remember where her parents were, but I know they were not in a state that they could take care of her... She was removed from her parents' care as a young child... and she was, as she described it, a product of rape.

For a client with this kind of complex trauma history –a common feature of the vast majority of community mental health clients – safety, trust, and reliable, consistent boundary-setting and boundary-holding are seen as essential features of treatment. Research on the common factors in therapy show that these features are also likely some of the most potentially impactful and healing elements of treatment (Laska et al., 2014; Miller et al., 2015; Wampold, 2001), since complex trauma is defined by extended and pervasive developmental attachment wounding (Karatzias et al., 2022; Spinazzola et al., 2021). Clients with these histories likely never experienced a sense of safety in their primary early attachment relationships, and so the reparative and reliable container of the ethical and appropriately bounded therapeutic relationship is novel, essential, and restorative, even if it is likely also challenging.

BC directly addresses how she establishes clear boundaries with clients and then maintains them, even in difficult relational moments with a client. In this example, she conceptualizes boundary-setting as providing clients with clear expectations about how she as the clinician will respond in a crisis. Most importantly, she follows through on these expectations, even when, as in this example, the client does not initially like that she is holding that boundary. Because BC effectively held this important limit, her client continued to experience her therapist as safe and reliable. This allowed the therapist and

the client to resume their relationship after this difficult interaction and effectively process what happened and how to move forward productively.

Katie, a white female therapist in her 50s, described a few different clients with ongoing chronic psychotic symptoms who had been repeatedly hospitalized. In her experience, those clients were often very willing to go to the hospital, and even recognized it as an important option in their toolkit of illness management and self-care. She also discussed their willingness to go to the hospital within the context of the therapeutic relationship, and how that relationship allowed them to continue their work after the client returned from the hospital. In the following example, Katie mentions a few different clients who tend to recognize the need for hospitalization when their symptoms are significantly impacting their sleep:

I have another client... [with] psychosis and...I've never had to [involuntarily hospitalize her]... She voluntarily goes and ...she's able to recognize... if she doesn't ... sleep, the voices come. I have... another female and male and they're the same way ... With their diagnosis, they have a hard time [with] sleep issues... [The first client mentioned] will recognize that if she hasn't slept well in... a week or two she starts to unravel... and... decompensate[s]... It's a conversation [between us] and she's like, I have to go to the hospital and she will go to the crisis center... I've never had to 302 her. She will voluntarily go.

Katie and her client have worked to help the client identify signs of symptom recurrence – not sleeping for several days. Whether it is she or Katie who initiates the conversation, it appears that a conversation happens in therapy and the client is willing to hospitalize herself voluntarily. Katie's collaborative approach with these clients is in alignment with

elements of trauma-informed care, which include safety, choice, collaboration, trustworthiness, and empowerment (SAMHSA, 2023; University of Buffalo, 2023). The way that Katie talks about this pattern also indicates that this has happened with some regularity. And since it happens with regularity, the clients return to their work with Katie after hospitalization and the relationship is not adversely impacted, which is likely due to the strength of the relationship prior to the need to hospitalize.

It also appears that Katie does not move immediately to a state of activation herself, when discussing safety concerns and the potential for hospitalization with clients. In the interview, she spoke calmly and confidently about her clinical decision-making. She cares very much for her clients, but her many years of experience with community mental health clients – over 20 years at the time of her interview – seem to have given her a sense of assuredness about how she navigates challenging decisions with her clients. This level of confidence did seem to be a departure from some of the responses of the less-experienced clinicians interviewed. She also did not display the same intensity of feelings of responsibility for the safety of clients that some of the newer clinicians described in the earlier section of this chapter. Her approach felt collaborative and warm, but she also seemed to recognize how far her influence over clinical outcomes could reasonably extend.

Cindy spoke at length about some different experiences with hospitalization that reflected how the therapeutic alliance impacted the hospitalization process and its aftermath. With a client with whom she had a strong rapport, she described the following experience:



He was reporting suicidality and said ‘I just want to let you know, I’m taking myself to the hospital. I’m hearing the voices and I want to kill myself so I’m just going to go.’ And I was like, ‘Hey, great! I’m glad you’re doing that’... I worked with him for... a good two years... He was just ... sweet as pie... very talkative, ... very bubbly, he’d come in... He’d usually only stay for about a half hour, though, cause he was like, ‘oh, I’ve done talked off your ear enough so I’m going to go.’ [laughs] He was really sweet. And he... seemed to really enjoy our time together.

This client was aware of an increase in symptoms and their relationship to his suicidality. He agreed with Cindy’s assessment that the appropriate step to care for himself was to go to the hospital to be evaluated and possibly admitted. He called Cindy to let her know, suggestive of the strength of the relationship. Their work continued after he was discharged from the hospital. Cindy’s tone when speaking of him is somewhat infantilizing and dehumanizing – calling him “sweet as pie” and “bubbly”. This is important to note, because clients with psychosis often are othered and dehumanized, not only by the world at large, but also by clinicians. Still, Cindy’s care for this client is evident. Perhaps her sense of care hinged on seeing him as childlike, which is reminiscent of paternalism, one of the traits of white supremacy culture in institutions (Okun & Jones, 2016).

Cindy was not the only interviewee who viewed psychotic clients as childlike. James, a white male clinician in his 40s, described a client with psychosis as follows:

There were there were times when I felt like, am I being overly condescending?  
But then... this person [had] a very childlike aspect to them that often seemed

like... they were having trouble keeping their thoughts organized enough to recognize what they should do.

James was uncomfortable with labeling this client as childlike – “am I being overly condescending?”, but still did classify them in this way. It is notable that James named a symptom of psychotic disorders, no matter the age of the client – disorganized thought patterns – as childlike. This paternalism can compromise a client’s choice and autonomy, elements of trauma-informed practice (SAMHSA, 2023; University of Buffalo, 2023).

Cindy also shared about a relationship with a client that was less successful. The challenging nature of this relationship was apparent when Cindy initiated a conversation about a possible need to be hospitalized. Cindy described the conversation with this Latinx, non-binary (with pronouns she/her and they/them) client in her mid-20s:

It wasn't so much... [that] without question, you need to go to the hospital. [She/they were]... experiencing some suicidal ideation, but that was actually relatively normal for them on some level... Their baseline was maybe... five out of 10 for suicidality. It was slightly elevated, but she was also reporting some psychotic symptoms... I said... ‘I think this would be a good idea for you but I’m still going to leave it up to you’... There was another instance where we had thought that there maybe needed to be another hospitalization because of suicidality, and we decided to contract for safety... I had to call my director at the time to discuss it to get another opinion, because... ugh, there’s so much ... liability, which... I hate it, but I understand why it’s there, so it was just like ... let me ... cover myself... She really didn’t want to go, because she said it was just a miserable experience the first time around, which I understand... So, there may

have been some issues with trust there, but it's really hard to say... It's hard to tell because there were some trust issues in general. Even though I really liked her a lot, I don't know how much she really liked me.

When Cindy involved her supervisor to help her make the decision and navigate the process, it appears that her client was upset. Cindy also felt some discomfort with this decision and recognized that her concerns and the agency's concerns about liability were potentially driving her choice to involve her agency director. Cindy stated, "let me... cover myself," indicating that her reasonable concerns about liability did influence her, but she also recognized how this decision may have impacted her relationship with her client. Her client expressed not wanting to go to the hospital because of prior negative experiences, and since they contracted for safety, Cindy did not pursue hospitalization further. Still, it appears that this negatively impacted the relationship. Cindy alluded to "trust issues in general" with this client, implying that these relationship challenges existed prior to the hospitalization conversations. Cindy felt that this client did not really like her, perhaps at any time during the relationship, and also implied – "there may have been some issues with trust there, but it's really hard to say" – that the challenges with trust were exacerbated by the hospitalization.

Rebecca, in her description above of her client whose mother enlisted Rebecca's support to hospitalize her daughter, explained how that hospitalization impacted their relationship:

It was... a relief that she was... somewhat safe... in the hospital, but at the same time it... felt really hard, and I know that she felt ... imprisoned... stuck. And I have such mixed feelings about it... She was discharged in September, and... we

had been seeing each other pretty regularly until... mid-December, and since then it's been... very hard to get in touch with her, and I haven't seen her for a session in a while. I've definitely tried to talk to her about... the 302 and the hospitalization, but she hasn't wanted to process it. And I've... respected that.

This client, a 24-year-old Black female, had been hospitalized four times in a year, the most recent being the two-month hospitalization that Rebecca initiated with the client's mother. Rebecca's conflicted feelings about being involved in the 302 are evident. She felt "relief" that the client was safe, but also knew that the client found the two months of hospitalization to be extremely difficult – she felt "imprisoned" and "stuck." And while the client did come back to work with Rebecca for a few months post-hospitalization, she never wanted to talk about the experience. Ultimately, the client stopped showing up for sessions. It is hard to know if Rebecca's involvement in the 302 petition created a rupture in the relationship, or if difficult life circumstances of the client prevented her from continuing treatment. Still, Rebecca clearly felt some concern that her decision-making and her collaboration with her client's mother were factors in the therapeutic relationship ending abruptly and without closure.

Joanne, a Black female therapist in her late 20s, shared an example of a client with whom she had an established alliance initially, but their relationship suffered after the hospitalization. This client had a diagnosis of schizophrenia and was suffering from severe suicidal ideation when the hospitalization occurred. The client, a Black male in his 30s, felt somewhat tricked by Joanne and that Joanne and his mother had colluded in hospitalizing him:

His mom got the papers for a 302 and he did go. He wanted to come to my office to see me first before he went to the hospital because he felt it was unfair that he had to go. But when he got to my office it became very... hostile and assaulting, saying like, oh, you're only a therapist, because ... you weren't smart enough to be a psychiatrist. I don't even know why I came here to see you. This is dumb. I thought you were going to talk her out of the 201. But you're agreeing with her.

The way Joanne described the therapeutic alliance prior to the hospitalization gives insight into the relationship:

He didn't really want to come to therapy, but we started out with rapport building, playing games... With [this client], I learned that I can't do more work than the client. He was the one that taught me that... Working with him was definitely interesting. [There was] some flirtatiousness happening... Strict boundaries had to be reinforced multiple times with him.

Joanne describes some challenges with boundaries and erotic transference in this therapeutic relationship, but there is also a strong attachment. In fact, the client's hope that Joanne would have talked his mother out of the hospitalization also speaks to the connection he feels to her and to the relationship. Although he was very angry – “you're only a therapist...you weren't smart enough to be a psychiatrist” – eventually he and Joanne were able to repair their relationship. Joanne's tone when discussing this client was compassionate without being patronizing or lenient, and her discussion of boundaries is reminiscent of how BC managed the relationship with her teen client who was expressing suicidal ideation. Possibly, again, the feelings of responsibility for client safety and the loving and consistent comfort with holding boundaries with these clients

could be related to the level of commitment these Black clinicians have to protecting Black clients – clients whose vulnerability and life experiences are accessible to the Black clinicians in ways that they cannot be to white clinicians.

### **Therapists wanting to avoid hospitalization and fearing trauma of hospitalization**

Another common theme was the theme that clinicians saw hospitalization as a negative or perhaps a sign of failure on their part as a therapist, and that hospitalization was to be avoided at all costs. Many therapists spoke of how their agency considered hospitalization as a last resort, and also named how traumatizing hospitalization could be for clients. At times, however, clients themselves named that hospitalization was useful, and that it was not a uniquely traumatizing experience.

Cait, a supervisor at an agency that provides both treatment for trauma survivors and a long-term partial hospitalization program to provide court-mandated treatment for perpetrators of domestic violence or sexual assault, spoke about her agency's philosophy on hospitalization:

I think our agency probably 302's less than what I would expect the average trauma agency should probably 302.... Given that most of the diagnoses are significant depression, significant PTSD... the large majority of our clients have, at all times, some passive suicidal ideation. Or self-harm... So I think our goal is always... is this person capable of contracting for safety? Do they have some supports in their life that are... willing to step up in this moment and help them through what we know could just be a moment. And if so, we will definitely try to go that route.

Even though Cait indicates that a large number of clients at her agency could, at any point, meet the criteria that might indicate the need for hospitalization, her agency chooses to proceed with caution. Perhaps even because so many clients could potentially qualify for hospitalization at any point, Cait's agency chooses to proceed cautiously. She appears to believe that her agency is even more cautious about hospitalization than other agencies might be: "Our agency probably 302's less than I would expect the average trauma agency should probably 302." The "should" in her statement indicates that Cait might even think that maybe the agency's caution keeps clients out of the hospital who could potentially qualify, or who might be safer in the hospital. Cait and other study participants are well aware of the potential trauma of the hospitalization process and they seek to do whatever they can to help clients avoid it. Cait notes that feelings of suicidality can be "just a moment" and that community supports can make a difference between the need for hospitalization and a person's ability to tolerate suicidal ideation without entering an inpatient setting.

Rebecca described her agency's perspective on hospitalization similarly to how Cait described hers:

It's definitely... a last resort? We try to prevent it, and... provide more care when people are not doing well in order to prevent it. But then... when things escalate... we try to get... people... in a higher level of care. Once in a while, that's... a transition to a... day program, but I think our... program is... conservative... in terms of recommendations. But we're not... usually involved in petitions.

Even though her agency works with younger clients who are potentially at greater risk, and who benefit significantly from intensive intervention, Rebecca sees hospitalization as a “last resort.” It is a course of action that is to be “prevent[ed],” and the agency, which Rebecca terms “conservative,” exhausts all other options first. Not only does Rebecca know that the inpatient experience can be traumatizing for clients, as when she described her 24-year-old client’s treatment history, but she also feels uncomfortable with how a mandatory hospitalization, a “302,” takes place: “I’ve... been a co-signer on a petition... it’s felt awful... I think everyone I see has experienced involuntary hospitalization ... That’s... such a traumatic experience [for a young person]... Getting handcuffed... It’s just... awful.” A 302 technically involves getting arrested, since the client is unwilling to comply and can be resistant.

MM also named how traumatizing the 302 experience can be for clients. MM works at an agency like Cait’s that serves court-mandated offenders and perpetrators of violent crime. Her participants have likely all experienced arrest at least once, if not multiple times. She describes the fear that her clients have of police involvement:

It actually happens pretty often with the people we work with, because there's a lot of fear that they will go to jail [because they are offenders], even though it's a 302... What sucks is that they handcuff you for a 302, and that's really... upsetting... [Getting] criminal justice involved.

The criminal justice system is actually involved in the 302 process, beyond arrest.

Individuals at times have to appear in court when they are under a 302 mandate. MM describes how her clients experience anxiety and confusion about the 302 process, believing that they may actually be headed to jail when they are handcuffed to be taken to



a psychiatric hospital. Sandy, a white female participant in her 30s, named the 302 process as one of the reasons she left her community mental health job of seven years:

They refuse to engage in a different way of hospitalizing people. They [said]... it has to be that we go in a cop car... and we felt... really bad. Yeah. And then I was like fuck this. I'm gonna go.

Sandy recognized the distress that the 302 process caused for clients, and it was so unsettling to her that it was the final straw for her to leave a job she had been committed to for many years.

Blue also described how difficult it can be to have to hospitalize a client, because of the inevitable law enforcement involvement. Blue, who also works at a treatment center for perpetrators of violent crimes, described a Black male client with a repeated pattern of hospitalization, returning to the program after: "He doesn't really get mad at the program as much as he gets mad at the people who cuff and take him. So... he'll come back... [and] be like, hey, how you doing?" This client clearly has a pattern of involvement with law enforcement in these situations, and undoubtedly, these interactions have been difficult and likely traumatic. The program where Blue works is a safe space that he does not hold responsible for his experience, but his anger at the police who "cuff and take him" is obvious to Blue. And of course, as a Black man who is even more vulnerable because of his mental health symptoms and his criminal history, he has likely experienced previous trauma at the hands of the police.

MM shared another experience that illustrates the close connection between the process of involuntary hospitalization and police arrest:

He proceeds to show up to our office clearly having a psychotic episode... Speaking in a baby voice... A man with a very deep male voice, so he's... in a baby voice yelling... and... he... grabs the candy dish off the front desk and starts throwing it at everyone.... And... saying a lot of... things that weren't making sense. And we were gonna 302 him. But then he... ran out of our office... and actually then got rearrested about an hour later, because he had gone to [a nearby shopping mall], and in the midst of all this had like started stealing food, or... stuff from... the stores, but then was... lying ... on... the... floor somewhere non-responsive after all this. And so he actually got arrested, and they took him to jail, which was very upsetting for everyone, because we were like he needs to be in a hospital. He gets out. He then gets... rearrested and 302'd, twice right after this... it just keeps happening... He can't go more than a couple of days without that.

The experience with this client suggests how intertwined the criminal justice system is with the involuntary hospitalization process. This client experienced arrests and hospitalizations almost interchangeably over several days. He was in the midst of a mental health crisis, but the police can mistake severe psychotic symptoms for someone who is at risk of engaging in criminal behavior, particularly among Black people (Bhui et al., 2015). Society at large is quick to assume that unusual behavior of individuals with psychosis is dangerous (Walsh et al., 2002). This poses particular dangers for clients at MM's agency, who are already under the scrutiny of the criminal justice system because of their criminal history and sentencing requirements. The clients MM works with are all mandated to treatment, and any divergence from their court-determined treatment plans can have serious consequences. Significantly, MM's client is a Black male and

vulnerable to police violence. Black men are at heightened risk of police violence (Smith Lee, 2019; Edwards et al., 2019). Edwards et al.(2019) estimate that 1 in 1000 Black men will be killed by police. This risk is even greater for Black men in the midst of a mental health crisis (Denzel; Ford, 2015; Misra et al., 2022; Tegnerowicz, 2018). After the client ran out of the office, MM did not take any follow-up steps to try to ensure his safety, such as calling his support network or alerting his parole officer. MM was not obligated to do more than she did, but she also did not seem to feel obligated. The client left and was out of her direct control, and she accepted that and waited for the outcome.

Cindy had another experience with a 302 in which she reflected on her own anxiety about the process and her perspective on hospitalization as a last resort.

I encouraged her strongly, because of her level of suicidality, ‘You need to go to a hospital, this is the one that is nearest to you, and you need to call me to let me know you’ve been admitted, or at least have someone call me to confirm that you have been admitted. And if you don’t – and this is not like a threat or anything, just safety precautions – and if you don’t, I will have to petition for a 302, which is an involuntary hospitalization. And I really don’t want to have to do that.’ I gave her 24 hours, and she never called me, and I called the hospital she was supposed to go to, and they said she had never been admitted, and I was like, shoot. So I called and petitioned for a 302; thankfully, if I’m remembering correctly, it was just that she had delayed going by a couple of days... My understanding is that even if she had gone I still would have had to put in the 302... That probably would have been traumatic, you know, because it often involves police, you know, and getting arrested, technically.

Because of the severity of the client's suicidality, Cindy felt that she did not have a choice but to urge her client to go to the hospital and then let her know that she had been admitted. The language Cindy chose in her description of the incident – “this is not like a threat or anything” and “I really don't want to have to do that” shows the conflict she was experiencing about petitioning for a 302. She does not want to see herself as engaging in coercion, but she is. While Cindy may not be actively threatening her client, she is at least making it clear that there are consequences to the client's actions.

Cindy names that a substantial reason why she did not want to have to petition for a 302 was the police involvement and arrest of the client. It is notable that Cindy did not take some of the above and beyond steps that other clinicians took, discussed earlier in the chapter. Cindy left the responsibility to the client at first to go to the hospital and then contact her. She did not stay on the phone with the client or call the mobile crisis team. She did want the client to check in with her to confirm that she had made it to the hospital, but she did not stay in constant contact with the client to ensure as much as possible that the client would in fact go, as described by Charlie, BC, and Blue, three of the four Black therapists interviewed for the study.

It is important to note, however, the instances in which clients did share that hospitalization was a good choice. Hospitalization was not universally traumatizing, in spite of the extreme caution that some clinicians expressed about the experience. Cindy shared about a conversation she had with a client after he returned:

The one guy... who called me and told me he was going... [said] the staff were... really great [and he]... really felt supported... they wanted to make sure that [he] was okay ... He was... very positive about [his experience].

Katie expressed similar feelings about hospitalization being at times beneficial for clients: “With me it’s definitely positive. Sometimes, inpatient psych is nothing positive but with me [at times] definitely.” In particular, Katie has seen that clients who need medication adjustment can find hospitalization to be especially beneficial:

If they need to be stabilized on medications... to change the meds... We need to... titrate something up or down... I mean sometimes you don't sleep much [at the hospital] and... yeah... Usually it's just for the medications... to get stabilized and then to come out and start the treatment again.

She certainly recognizes that inpatient hospitalization isn’t necessarily a pleasant experience – “I mean sometimes you don’t sleep much and... yeah” – but she sees its usefulness. She also mentioned that in most cases for her, hospitalization was voluntary, so she and her client agreed that they should go. So, although many therapists express reservations about hospitalization and are very committed to working through other alternatives before mandating hospitalization, there are times in which both clients and clinicians feel comfortable about the decision.

### **Racial relational dynamics in hospitalization**

A final theme for this chapter is how racial dynamics, both in the therapeutic dyad and in the interactions between clients and other system-involved staff – can influence the experience of clients as they navigate the experience of hospitalization and its aftermath. One of these themes has already been explored in some depth in previous sections: how several of the Black clinicians interviewed in this study seemed to feel more of a sense of responsibility for the safety of the clients, often Black, who were in the process of hospitalization. The Black clinicians I interviewed – BC, Charlie, Blue,

and Joanne - were often the clinicians who took impactful additional steps when a client was in crisis – calling the mobile crisis team, attempting to contact their client by phone, staying on the phone with them for several hours, if needed, to be sure they received the help that they needed. The previous section also illustrated how some of the white clinicians interviewed did not necessarily take on the same amount of responsibility for the hospitalization of clients. These white clinicians did take the steps legally required of them to ensure the safety of clients - but their actions did not tend to go beyond legal mandates.

Several clinicians specifically named the racialized trauma that hospitalization caused their Black clients in particular. Katie, a white therapist, shared that several clients she had worked with over the years had had a variety of negative experiences with white clinicians and the hospitalization process:

They've had experiences... that have been traumatic with someone... who's white... Or they've had traumatic experiences with some other therapist in the past, like someone has 302'd them and forced them to go into the hospital... Another therapist that they've seen or [they've had a traumatic experience with]... the person at [hospital] intake... I... find ... if a traumatic experience has been something with a white police officer [or]... a therapist that 302'd them [then we need to] acknowledg[e] it.

Katie described this pattern of client experiences in response to a question asking about how racial dynamics in the therapeutic relationship impacted clients' feelings of safety. Her naming of the hospitalization process in particular underlines the very real possibility of Black clients experiencing racial trauma in the mental health system. She also

recognizes how this history will influence her therapeutic work with her clients and wants to process these traumas, not avoid them.

Many of the situations already discussed in the chapter address the potential trauma of police involvement inherent in the hospitalization process. Sandy, Blue, MM, Cindy, and Rebecca all specifically named this possibility. Mary, however, shared an extensive experience about the hospitalization of a Black teenage boy that has not yet been fully described in this chapter, which illustrates powerfully and painfully how many elements of this hospitalization process can cause psychological, emotional, and physical harm. Mary, a white female clinician in her 30s, wrestles with her role in this process and the emotional toll that may have taken on her client.

This account is a heart-wrenching and vivid account of the potential for harm that hospitalization can cause when Black clients are victimized by the system, Mary's client was a 16-year-old Black male who was experiencing psychotic symptoms that required hospitalization. Mary described the circumstances that necessitated the hospitalization as follows:

He would get really overwhelmed by his emotions, and then start to... devolve into psychosis... He would think that... someone was following him and...see... shapes moving, like a tapestry that I had on the wall... When I had to 302 him, I believe he was having some kind of, if not hallucinations, he was having... paranoid thinking, and he was expressing... wanting to kill himself, and that he would... go start a fight with somebody, or... try to get shot, I think was what he said.... He was... telling me that he didn't trust himself to not hurt himself or someone else when he left my office.

The client's symptoms were severe and indicated to Mary a need for hospitalization.

Mary also noted transference from the client that she interpreted as potentially influencing his presentation:

He had some... care-seeking behaviors... It seemed like he had very big emotional reactions to... get me to care take for him. So that was part of it. So what I did was... I told him that I had to, because... he just disclosed that [he could not promise to stay safe] to me in the context of me walking him through... This is what will happen if you tell me that you're not safe. So he... knew that if he said... I don't feel safe. I can't keep myself safe... that he would have to go to the hospital, and we were talking through... Do you think that this would be helpful for you? It sounds like you're really feeling like you can't keep yourself safe. That's really scary.

Mary is already expressing the internal conflict she was experiencing about her decision to 302 this client. She felt that she had done her due diligence and provided informed consent by describing what would happen if he expressed not feeling safe. She made it clear that this would result in hospitalization. He did tell her specifically, in response to this explanation, that he did not in fact feel safe. Still, her perspective on his care-seeking behaviors created some uncertainty about his motivations for saying he did not feel safe when she asked him. Of course, she still had to take him at his word, when he agreed that he did not, especially given the seriousness of his suicidal and homicidal ideation. He clearly expressed that he did not trust himself.



After the client stated that he could not keep himself safe, Mary reviewed with him how hospitalization could be potentially beneficial to him and what his concerns might be. He then did agree to go, but once he agreed, he started to have misgivings:

The benefits and the things that you're worried about ... Helping him try to make the decision to go, and he had made the decision to go, and said he would go on his own, and he was aware of... what would happen if he didn't go on his own, that he would have to be 302'd... Then we were... trying to get ready to go, and he started... refusing to go.

Mary's detailed account of the decision-making process for the client continues to highlight her own agonizing internal debate. She tried to be as clear as possible about the potential outcomes and consequences, trying to give this teenager as much opportunity to agree or disagree of his own volition. She was also trying to continue to emphasize her care for him and her desire to provide a trauma-informed level of support – honoring his process and his autonomy, while also maintaining her ethical commitment to providing sufficient care that protects her client's safety to the extent that she is able. Once he did begin to waver, and started to refuse, after Mary had made it clear that a 302 would be her only option, Mary's ethical dilemma begins to deepen, as she explains:

We had... come to this kind of agreement. And then, during the time we were waiting for... all the calls... approvals and stuff, he... started getting nervous about going, and... started feeling like he wasn't going to be able to make himself go. And there was this... loss of control... he's like I can't... I want to go, but I can't do it... If I try to go by myself, I'm just gonna run or something... He really

put me in a position where... I had to call the police, which obviously is not what I wanted to do for a young Black man... It was really horrible.

Mary explicitly names how the client's race makes her decision-making more complex and potentially dangerous. Mary felt she had no good options, and that her only option was a terrible one – to mandate hospitalization or call the police if he tried to leave. She was very aware of the danger of police involvement for a young Black male who is in the midst of a mental health crisis.

The prospect of hospitalization is frightening for this client, as it can be for anyone in his position. This client is a teenager, not an adult, which makes his uncertainty and anxiety even more understandable. Her client likely has directly or indirectly experienced discrimination or even aggression from the police by this point in his life, so the potential for police involvement adds an additional layer of danger. The stress of the situation and the anticipatory anxiety of the police arriving brought out understandable defensive reactions from the client, which then impacted how he interacted with the police when they did arrive:

I... tried to walk him through what was going to happen when they came... Had [he] ever been to the hospital... before? And... we talked about... the cops... that was a part of our conversation, and trying to get him to go by himself... [I said to him, it] seems like that would not be... an interaction you'd want to have... And he... started getting... antagonistic in preparation, knowing that they were coming... preparing to defend himself. So first of all... he had... his hood up and a sweatshirt and his hands in his pockets, which is for police... a danger image. So the first thing that they did was... start patting him down... They just walked

up to him and started touching him... I was... too optimistic about how unnecessarily forceful they were going to be.... But he went with them. He didn't... resist... which was good... He definitely... had a reaction to the patting down. But then he was able to keep going.

Mary was very aware of how her client's experience could be significantly more dangerous because he was a Black teenage boy. She was also struggling with her own role in the situation and her responsibility for the outcomes. Her guilt and fear about her client's experience come through in her choice of language. She felt the need to prepare him – “tried to walk him through” – and she was concerned about how the police were perceiving him – “which is for police... a danger image.” She sees that he is treated differently, likely because of his race when referring to “how unnecessarily forceful” the police were. She felt responsible for not preparing him adequately – “I was too optimistic.”

Mary does not name how her position as a white ciswoman gives her privilege or creates significant distance for her from her client's experience, but it weighs on her. The responsibility of being a white woman who is making the choice to involve the police in the mandatory hospitalization of a young Black male is not a decision she makes lightly, as the extended and detailed account of this experience makes clear. Even if inpatient hospitalization was the only option that Mary had, given the context of her client's symptoms and the realities of the agency policies that mandated her decision, she still was painfully conflicted by the course of events.

When her client returned from the hospital, he and Mary had the opportunity to process the experience. She felt that their relationship did survive the hospitalization –

she continued to work with him for another year – but that the relationship was certainly changed:

It's hard because I feel.... from a textbook perspective..., everything that happened would led me to have to do the same thing again... [it] just felt like a test... of our relationship in some way.... And... afterwards it was definitely different... I think he did feel like he trusted me less... I remember... having a direct conversation with him about how much... our relationship was impacted, how the experience was for him, and if he had resentment or frustration with me, and ... he seemed to be... ambivalent... Kind of like, I get why that had to happen, but also... it wasn't... really helpful... And I think he definitely expressed... losing some trust in me, but also knowing that..., it seemed like he was feeling both [anger at me and an understanding of why I had to do what I did] at once.

Mary and the client underwent a parallel process, an experience in which both parties in a clinical relationship experience similar difficulties (Hakeem, 2010): both felt ambivalent about their choices, but also recognized that the options were limited. They both left the episode less trusting of one another, although they could consciously understand why the experience resulted in hospitalization.

Mary recognized that her client had lost trust in her, and she understood that, but also didn't think that she would have been able to make different choices if the situation presented itself again. Her choice of words “textbook perspective” does indicate uncertainty. She recognizes that, in accordance with policies and procedures and with professional codes of ethics, she could not have made another choice. Not hospitalizing

her client was conceivably putting him in danger. However, that “textbook perspective” does not account for the fact that a Black male teenager is in danger when law enforcement and carceral systems – which can include mandated hospitalization – get involved. The experience of hospitalization, with police involvement, for a white person is much less dangerous than it is for a Black person. Any involvement of the police is even more dangerous for a Black male. Mary’s agonizing process of decision-making makes it evident that she is wrestling with that reality, and recognizing that her options are terrible, no matter what choice she makes.

### **Conclusion**

The experience of hospitalizing a client with psychosis was shared by all clinicians interviewed in this study. Clinicians described their own multifaceted decision-making processes about hospitalization, touching on structural restrictions, challenges of engagement and relationship-building with clients who experience psychosis, therapists’ own perspectives on the utility and ethics of hospitalization, and how racial dynamics in the therapeutic relationship impact the alliance. The themes of this chapter included therapists feeling like they are the only ones responsible for client safety; how the strength of the alliance prior to hospitalization impacted the alliance post-hospitalization; how therapists and clients at times had differing perspectives on the traumatizing impact of hospitalization; and finally, the racialized dynamics of the hospitalization process. This chapter explores how different aspects of the therapeutic alliance and relationship impact the decision to hospitalize, the conversations with clients about hospitalization, how clients navigate the experience of hospitalization itself, and how the therapeutic relationship is impacted in the aftermath of hospitalization.

## **Chapter 6: Discussion, Limitations, and Implications for Research and Practice**

### **Introduction**

Through multi-phased analyses of my interviews, in accordance with Charmaz's (2006) approach to coding in constructivist modified grounded theory, I used line-by-line coding and then focused coding, to move towards theory generation. My findings and analysis attempt to answer this research question: How do clinicians in community mental health agencies preserve their feelings of efficacy, agency, and relevance in the treatment relationship with clients who experience psychosis? The theory I propose that emerged from my findings answers the research question thus: When clinicians do not believe that they have the skills or ability to provide care to clients with psychosis, they may sacrifice the core elements of a safe therapeutic relationship and devalue empathic connection with clients in service of actions that give the therapists a sense of agency. Clinicians engage in behaviors that may be counter to trauma-informed care principles to achieve a sense of efficacy in their work with psychotic clients, because the environment in which they work, and its multiple and conflicting pressures, hamper their ability to provide the care their clients need. I will discuss this overall process first, then I will talk about major findings contributing to the process in terms of contributions to the current literature and recommendations for practice.

### **Clinician self-efficacy in CMHCs**

Social cognitive theory informs Bandura's self-efficacy theory (Bandura, 1977, 1997, 2001). He believes that self-efficacy is due to the interaction of three variables – environment, behavior, and personal factors. The environmental realities of clinicians in CMHCs - their limited training, settings with poor resources, inadequate supervision,

high caseloads, clients with high levels of need and complex symptoms – can impact their belief in their own efficacy, and then their behaviors and clinical decision-making as a result. Clinicians in this study do voice their belief in relationally based work that aligns with the common factors literature and with trauma-informed principles, but many of the decisions they make are in service of feeling effective so that they can have some sense of impact when working in a system that often undermines their role.

These decisions often align more with elements of white supremacy culture in institutions, as identified by Okun & Jones (2016). These elements include a sense of urgency, action over process, the “one right way” of evidence-based practice, privileging a medical model, prioritizing individualism – putting the emphasis on the client as the problem, not the system, and therefore othering clients. Finally, the elements of white supremacy culture manifest when clinicians in the study take on a role that can be controlling and coercive – enforcing medication compliance and engaging in involuntary hospitalization, for example - as opposed to relational, in the service of feeling effective.

A final important element informing clinician self-efficacy in this study is the role of race. Study findings showed that white clinicians can feel less effective generally in their cross-racial clinical relationships with psychotic clients. This can contribute to more othering of these clients by clinicians and to treatment decisions that can end up being oppressive, to support the clinicians’ own needs for self-efficacy. Black clinicians in the study, when working with psychotic Black clients, examine the variety of ways in which their shared racial identity can be impactful to the course of treatment.

### **Overview of study findings**

Clinicians in outpatient community mental health settings struggle with systemic, institutional, and individual barriers to providing competent, values-aligned care to psychotic clients. This struggle creates clinician anxiety, leading them to doubt their efficacy and relevance. Feeling ineffective can be a disabling deterrent to their work, so clinicians must find ways to manage those feelings to continue.

Clinicians preserve their feelings of efficacy and relevance in the treatment relationship with clients who experience psychosis by othering, naming, and labeling their clients with psychosis, making meaning of their role in treatment of psychosis when medication seems to be the predominant treatment approach, and learning how to navigate the clinical hierarchies in CMHC settings. The active role that masters'-level clinicians in these settings can have in hospitalizing clients is another means through which they experience a sense of agency, efficacy, and relevance.

However, hospitalization is a fraught process for the clinicians in this study. Therapists struggle with making the decision to hospitalize clients, which is complicated by therapists often feeling like they are the only ones responsible for client safety. The belief that they are indispensable to this process both increases clinicians' confidence in their relevance to treatment while simultaneously putting pressure on the clinician to make the right decisions. The strength of the therapeutic alliance also contributed to how therapists navigated the hospitalization process, with a stronger alliance giving therapists the sense that they could exert more influence. Therapists also grappled with the potential for traumatization from hospitalization and discussed how that impacted their choices. The racialized dynamics of hospitalization, with attention to the race of clients, clinicians,



law enforcement, and other service providers involved in the process, also played a role in how effective therapists believed they could be.

Finally, racial identity more generally contributes to clinician sense of relevance. White therapists in this study experience anxiety about how their racial privilege impacts their ability to be competent clinicians at agencies that serve predominantly BIPOC populations. Black therapists interviewed in this study grapple with how a shared racial identity can be advantageous in their clinical work, but that this shared identity can also complicate clinical decision-making and can potentially cause some clinicians to take on responsibilities for the needs of clients that are not essential, but that the individual may see as necessary in their role.

### **Othering, labeling, and naming**

As clinicians faced the realities of working within systems that compromised their sense of agency, they often engaged in othering, labeling, and naming psychotic clients to manage their anxieties about their role in effective treatment of these clients.

The theme of othering, labeling, and naming of psychotic clients as a way to preserve feelings of self-efficacy is important because the current literature on self-efficacy and psychosis focuses on self-efficacy in the client experiencing psychosis, not on how clinicians experience self-efficacy in their work with this population (Godoy Izquierdo et al., 2021; Pratt et al., 2005; Cardenas et al., 2013; Kurtz et al., 2013; Ventura et al., 2014; Vaskinn et al., 2015; Chang et al., 2017). Moving the focus to how clinicians find ways to experience self-efficacy with these clients can draw attention to ways in which graduate schools, training programs, and agencies can support these clinicians. The field of social work should devote resources to developing ways to help clinicians

experience self-efficacy with these clients, while continuing to practice relationally without engaging in othering behavior influenced by the traits of white supremacy culture.

The othering, labeling, and naming of psychotic clients is crucial to my overall theory as a way in which clinicians manage the opposing tensions of wanting to practice in accordance with the common factors of treatment and trauma-informed principles while also maintaining belief in their own relevance to treatment. Othering, labeling and naming emphasize the conflict experienced by study participants when they try to balance the relational elements of care that the common factors literature emphasizes – alliance formation, engagement, creating safety (Laska et al., 2014; Miller et al., 2015; Wampold, 2001) - while working in a setting that does not allow them to do so.

This othering, labeling, and naming took a variety of forms in the study findings. One way in which this emerged in the interviews was clinicians feeling ill-equipped – and therefore ineffective - to work with clients with psychosis, as if to indicate that psychosis was such a specialized area of practice that traditional rules of practice did not apply. Some interviews connected this feeling of ineffectiveness to inexperience. In particular, study respondents found themselves lacking the specific skills they believed they needed to work with clients with psychosis, particularly study respondents who were relatively new to the field. Clinicians identified experiencing imposter syndrome working with psychotic clients in particular, with some respondents fearing that they did not have much to offer psychotic clients.

Some clinicians worried that their newness to the field played a role in feeling incompetent and made them hesitant to intervene actively on their clients' behalf. Some

respondents worried that they were not intervening enough with these clients, or not intervening appropriately, indicating perhaps a belief that psychotic clients needed more scrutiny or attention than clients with other diagnoses. This mirrors the literature that suggests that the high level of client need in agency settings, with particular reference to clients with severe mental illness, can impact clinicians' sense of control and increase burnout risk (Rupert & Morgan, 2005; Chen et al., 2019). Psychotic clients were othered by clinicians in the study, as they were seen as somehow fragile and more vulnerable to harm from a new and incompetent clinician.

Clinicians were at times well aware of their own anxiety and their feelings of being unable to “fix” a client with psychosis – a lack of efficacy - and also experienced feeling unskilled or unprepared for working with these clients. This finding resonates with the literature that argues that clinicians tend to see individuals with psychosis are somehow unknowable, or, in the words of Kamens (2019), “un-understandable” (p. 209), and therefore unable to respond to relational treatment (Sass, 2019).

A common finding was the lack of training provided for working with psychotic individuals. Clinicians came into the field from graduate school without much experience with psychosis, but then were expected to manage a caseload that included many psychotic clients. Clinicians were aware of the need for training in this area but were frustrated by agency response to this need. Since clinician sense of efficacy is dependent on the therapist's ability to access and execute the skills needed to produce outcomes, this lack of training negatively impacted clinician belief in their expertise. Lack of graduate training in psychosis has been identified as a concern in the literature (Combs, Penn, Spaulding, et al., 2006), with particular emphasis on the fact that early-career clinicians

are likely to encounter clients with psychosis, and therefore should be receiving more training and education. Training at the post-graduate level is also a concern – many clinicians in the field do not pursue advanced training to improve their skills working with psychotic clients (Waller et al., 2018; Berry & Haddock, 2008; Pilling & Price, 2006; Prytys et al., 2011). This finding aligns with the findings of this study.

As a means to manage their anxiety about their lack of skills, and to access a sense of agency, some clinicians in the study chose to pursue training on their own. Some clinicians expressed particular interest in psychosis and attended trainings and sought out readings and lectures to support their work. What could compromise this decision to seek training to assert their own agency, however, was a heavy workload that often involved a high number of clients. Training and research require unpaid time outside of face-to-face work with clients, but therapists were still compelled to seek out these opportunities to enhance their client work and to connect them with a sense of efficacy. Some clinicians expressed that it was the responsibility of their agencies to provide this training; other clinicians simply sought this training out on their own, not expecting that their agencies would furnish this support for them. Findings also showed that therapists often saw staff psychiatrists as their only workplace resource for help with treatment of psychosis. The help that psychiatrists could provide, however, was in the form of antipsychotic medications, not in training on therapeutic interventions for psychosis. Psychiatrists were not generally named by clinicians as a source of support to reduce their own feelings of incompetence.

This fear of incompetence was not present in all interviews, but othering could emerge through other means. Hopelessness was often underneath the tendency to other

psychotic clients, and this clinician hopelessness likely mirrored that of the client. The shared experience of clinician and client hopelessness is a theme reflected in the literature on psychotherapy for psychosis (Nabors et al., 2014; Ridenour et al., 2023). Not all clinicians could name how this influenced their perspective and practice, however. Findings included holding clients responsible for their therapeutic progress, or lack thereof, instead of clinicians questioning their own role in the relationship. This is the flip side of clinicians' concerns about their own efficacy – putting the responsibility for client progress on the client as an attempt to avoid feelings of impotence. This focus on individual factors impeding treatment as opposed to a focus on systemic and institutional challenges echoes the feature of individualism in white supremacy culture. In institutions, individualism can emerge with the assertion that individual accountability is privileged, and collective accountability and responsibility are not recognized (Okun & Jones, 2016).

When the clinician emphasizes individual client accountability, the clinician creates a perspective on clinical work in which the client's effort has more of an impact on treatment outcomes than the contributions of the therapist. Not only does this perspective undermine the therapist's sense of relevance to the treatment relationship, it also places undue responsibility on the client. Some therapists displayed a lack of awareness that their desire to put all of the impetus on the client to make change was likely a countertransference reaction to a client's own frustration. This resonates with literature that shows that when therapists are unaware of countertransference, they can engage in behaviors that pathologize and blame clients (Hayes et al., 2015; Hayes et al., 2011). Again, this is an example of othering: the client is responsible for poor outcomes due to their lack of follow-through or motivation. The clinician does not need to examine

their own role in poor outcomes. What is new about this study, again, is the emphasis on how self-efficacy is impacted by these experiences, and the clinical choices the study participants made to manage their anxieties about their own effectiveness.

Another theme that emerged regarding othering psychotic clients was the opinion expressed by clinicians that clients with psychosis could not respond to evidence-based treatment models. This is a finding that other researchers have identified in studies examining implementation of evidence-based practices (EBPs) with clients with psychosis (Waller et al., 2015; Mueser & Berenbaum, 1990). Study findings showed that some clinicians believed that EBPs could not be used with psychotic clients. Client symptoms, particularly if clients were unmedicated, were seen as too severe to allow clinicians to follow the treatment models to fidelity. Participants named the need for additional research on EBPs with clients with psychosis to allow clinicians to use these modalities effectively. It was notable that agencies in which certain EBPs – prolonged exposure (PE) and dialectical behavioral therapy (DBT) in particular – were practiced also had a large number of psychotic clients. In spite of this reality, study findings reflected clinician concerns that EBPs could not be used with this client population.

Othering, labeling, and naming also emerged when clinicians discussed the racial dynamics present in their client relationships. White clinicians often grappled with their sense of relevance to the work, when working with a predominantly BIPOC client population. This anxiety about relevance was present in several interviews with white clinicians who stated that it was their responsibility to “name” race first in their conversations with clients. While clinician intentions were likely benevolent, as the naming of race seemed to be a way to perform “good” whiteness. This desire to name

race, and the belief that it is the responsibility of the clinician to do so, aligns with the current research literature on *broaching* (Day-Vines et al., 2007) – the therapist’s belief that it is their responsibility “to have explicit discussions about the extent to which racial, ethnic, and cultural factors impact the client’s presenting concerns” (Day-Vines et al., 2018). This study provides a more nuanced set of findings – that clients may not always want to focus on the racial element of the relationship and may ignore or resist therapist attempts to name it.

Many clients stated that the race of their therapist was not of particular importance to them, or even that they preferred a therapist of a different race. This was a hard reality for some white clinicians to accept, and some felt the urge to pursue the conversation even when clients tried to move on. Some Black clinicians in the study were less inclined to expect a certain reaction from BIPOC clients on the topic of race and did not assume that all BIPOC clients would respond in the same way. These clinicians normalized that some BIPOC clients didn’t necessarily want to address race explicitly at all and resisted the urge to essentialize those clients. Finally, it is important to name that working with a client with psychosis who is also BIPOC, as many of the clients discussed in the study are, creates many intersecting layers of marginalization, and so the tendency to other these clients can be even more pronounced.

### **Medication, psychiatry, and agency hierarches**

Another emergent theme related to clinicians’ experiences of helplessness, and therefore their doubts in their own self-efficacy, when working with clients with psychosis was the fear that perhaps the only treatment agencies could offer to these clients was antipsychotic medication. This felt particularly disabling to clinicians because

it made them question their own contribution to the client's progress, since prescribing medication is the role of psychiatry. Clinicians also felt conflicted about the message that there was little hope to offer these clients in terms of long-term improvements in outcomes and reflected on how their agencies conveyed this belief. Tensions between master's level clinicians and psychiatrists were not the only hierarchical tensions in participant agencies – other doctoral-level staff also pulled rank with the study participants, even though participants were the individuals who spent the most face-to-face time with clients. These tensions are not addressed frequently in the research literature, so this study raises another question that is worth investigating further.

Some participants saw conflict between the agency stance on medicating psychotic clients, the common factors of relational psychotherapy, and a trauma-informed model of practice. The findings consistently showed clinician and client concerns with the side effects of medication and client struggles with antipsychotic medication adherence, concerns that other researchers have noted (Farrelly & Lester, 2014; Seale et al., 2006). Several clinicians shared that their clients were hesitant to take antipsychotic medication as prescribed, even when medication adherence was a requirement. Some clinicians interviewed worked with court-mandated sexual and domestic violence offenders, many of whom displayed psychotic symptoms. Not keeping to their treatment plan could put some of these clients at risk with the criminal justice system, and still some of these clients did not want to abide by their medication regimen due to the disabling side effects. Many clinicians described observing the troubling side effects of these medications on their clients, and also named that clients often struggled to adhere to the medications because of the side effects. Some participants named the agency



perspective that antipsychotic medication was the only useful treatment option for psychotic symptoms. This impacted clinician sense of relevance – if medication is the only worthwhile treatment for psychosis, what role does the therapeutic relationship have? The therapeutic alliance, the strongest predictor of positive treatment outcomes as indicated by the research on common factors (Kidd et al., 2017; Laska et al. 2014; Miller et al., 2015; Wampold, 2001), can be damaged by clinicians feeling that they have to agree to the stance that antipsychotic medication is the only effective treatment for clients with psychosis. If a client is intentionally refusing antipsychotic medication, the common factors literature would indicate that the therapist would explore this stance compassionately, while ultimately supporting the client’s autonomy.

The trauma-informed approach to clinical care overlaps with the common factors of therapeutic treatment, emphasizing safety, choice, collaboration, trustworthiness, and empowerment (SAMHSA, 2023; University of Buffalo, 2023). Clients who were actively discouraged from, even forbidden to, stop taking medication even if they found the side effects to be disabling were being denied the essential elements of trauma-informed treatment. Trauma-informed care asserts that clients are the experts on their own experience, not clinicians. The common factors of therapeutic treatment also emphasize autonomy, collaboration, and safety. When clients are unable to feel empowered to make decisions about treatment, this is in conflict with both the principles of trauma-informed care and the identified common factors that result in effective treatment.

Trauma-informed medication prescription and medication has been a focus of recent research, and recommendations include psychodynamic prescribing – recognizing the transference that arises from medication prescriptions; the situational briefing model,

which is intended to improve communication with patients about medications; and the deprescribing model – supervised dose reduction and stopping medications that aren't necessarily serving a purpose anymore (Kieran, 2022; Mintz & Belknap, 2011; Gupta & Cahill, 2016; Leonard et al., 2004). These recommendations would be useful in the agency settings in this study. The recommendations could also empower clinicians to recognize their own vital role in the treatment of their clients, since the clinicians could leverage the strength of their therapeutic relationship with clients to help them make an informed medication decision. The strength of the therapeutic alliance has been found to be associated with greater medication adherence (Tessier et al., 2017).

Not all participants expressed negative perspectives on the use of antipsychotic medication. In fact, some clinicians believed that antipsychotic medication was a necessary precursor to relational therapy. These therapists also saw their role as supporting psychiatry – that the therapeutic relationship could be a vehicle to facilitate client medication compliance. This role could also engender a sense of self-efficacy in these clinicians. They felt that the clinical skills and tools they were equipped to use were not accessible if clients were not taking medication to reduce their active psychotic symptoms. Relational psychotherapy can be supportive in helping clients make decisions about medication that feel aligned with their values and goals, but these participants focused more on medication as the precursor to therapeutic work.

Tensions between psychiatrists and the master's-level clinicians interviewed for this study also showed how participants wrestled with their own relevance to treatment. Participants also shared ways in which they showed agency in the face of these treatment hierarchies. At times, clinicians expressed feeling protective of their clients, and worried

about communicating with psychiatry about their clients' treatment, for fear that their clients would be misunderstood and perhaps mistreated. Therapists even shared that they actively avoided these communications, in the hopes of sparing their client from hospitalization. This intentional avoidance by therapists was a way to preserve their own sense of agency, and in these cases, could actually be in accordance with the common factors of treatment as well as trauma-informed care principles: therapists wanted to protect their clients from the harm that they could face from a hospitalization that the therapists may have felt was unwarranted, given the context that the therapeutic relationship provided. The therapist who did not want to consult with the psychiatrist for fear of hospitalization knew enough more about the client and the client's wishes, due to the strength of their therapeutic alliance, to be concerned that a hospitalization could do more harm than good.

Also, some clinicians shared about their experiences with their diagnostic impressions of clients being discarded by doctoral-level clinical staff. Doctoral-level employees are given significant discretion and power in a treatment setting in which the masters-level clinicians are much more likely to have consistent and regular therapeutic contact with clients. Two participants shared experiences in which a diagnosis of dissociative identity disorder (DID) was discarded by other clinicians because their agencies were not comfortable with that diagnosis. One of the participants completed the initial assessment of a client who had been diagnosed with DID previously, had symptoms that aligned with the diagnostic criteria, and identified strongly with the diagnosis. For these reasons, the participant gave this diagnosis after completing the initial assessment. This diagnosis was discarded by a doctoral-level staff psychologist, in

spite of the participant's insistence that the DID diagnosis was clinically appropriate. These examples of psychiatrists and psychologists pulling rank when master's-level clinicians try to provide clinical input impacted participants' sense of relevance and agency in their treatment settings.

### **Hospitalization and efficacy, relevance, and agency**

#### *Taking on responsibilities beyond the professional role and therapist agency*

The active role that masters'-level clinicians in these settings can have in hospitalizing clients is another means through which they experience a sense of agency, efficacy, and relevance. Clinicians are able to make the call about whether or not to mandate involuntary hospitalization – to “302” a client, as it is referred to throughout the interviews by the clinicians. This is a fraught process for clinicians for many reasons, not the least of which is the fact that a 302 is actually a legal action, which involves being arrested. A 302 is technically a warrant for arrest. Although there were times when clients were willing to be hospitalized – a voluntary hospitalization, or 201, which does not involve arrest - participants still felt conflicted about the hospitalization process. However, there is evidence in their responses that hospitalization at times felt like an opportunity to display agency. One way in particular that some clinicians seemed to experience a sense of agency was through taking on responsibilities beyond their professional role on behalf of clients during the hospitalization process in an attempt to ensure client safety.

Some of the Black participants in the study spoke extensively about measures they took to be sure that clients in crisis were safe. Some of those measures included staying very late at their agency to be sure the crisis assessment of a client was complete

with a comprehensive safety plan, calling the mobile crisis team repeatedly to ensure they were going to arrive, staying on the phone with a client for hours until they made it to the hospital, staying in touch with a client by phone to see if they were admitted to the hospital, adding additional sessions into their schedule to accommodate a client who was not hospitalized but needed more attention than a single therapy session a week, and checking in with a client immediately after they were discharged to weigh in on where they should be going to be safe. These accounts left the impression that the relationship these therapists had with their clients meant that they did not trust anyone else to manage their hospitalizations appropriately.

It is possible that the shared racial identities of these clinicians and the clients they were deciding whether or not to hospitalize made the therapists more concerned about client safety, particularly since severe mental health symptoms in Black people are more likely to be interpreted as criminal behavior (Tegnerowicz, 2018; Denzel et al., 2016). Unfortunately, the reality is, no matter what measures a clinician takes to protect a client's safety, a clinician cannot ensure hospitalization. The sense of agency that an active role in hospitalization could impart to a clinician was one way to manage the hopelessness and powerlessness that they could feel in the face of a capricious and unpredictable mental health system. The overburdened inpatient hospital facilities in the Philadelphia area put therapists in the position of needing to advocate extensively for clients and over-involve themselves in crisis management to be sure that clients were safe. This was even more of an issue during the COVID pandemic, because crisis services in the city were chronically understaffed. Crisis responders had to take the time

to adhere to strict health and safety protocols due to the COVID-19 crisis, all of which led to inadequate service provision.

The accounts of hospitalization from some white clinicians in the study did not show them displaying the same level of additional responsibilities beyond the requirements of their professional role. While some accounts did show therapists making efforts to fill gaps left by an overburdened crisis system, these accounts did not show the same level of anxiety about client safety and did not express fears that no one else could adequately care for their clients. Some white clinicians also did not involve themselves in hospitalization of a client beyond telling them to go to the hospital. These therapists were not in constant contact with the client throughout the process but gave the client the responsibility to get themselves safely to the hospital.

In one case, a white clinician did not act to be sure a vulnerable client with a history of arrests and hospitalizations made it safely to the hospital after the client ran out of the agency. Later, that client was arrested shortly after leaving the office and ended up hospitalized. The difference in behavior between the Black and white clinicians and their sense of relevance and importance to the provision of safety of clients were notable in the accounts of hospitalization that they shared.

### **Therapeutic alliance and efficacy**

Study findings pointed to a relationship between the strength of the therapeutic alliance and the likelihood that clients would agree to a voluntary hospitalization. Study findings also pointed to a relationship between a stronger therapeutic relationship prior to hospitalization and a greater chance that clients would process the experience of hospitalization with their therapists, and therefore strengthen the relationship, after

returning from the hospital. The literature on inpatient hospitalization and the therapeutic alliance primarily focuses on the therapeutic alliance that clients have with inpatient therapists and doctors, not on the therapeutic alliance with their outpatient clinicians (Blais et al., 2010; Dinger et al., 2017). A few studies, however, have observed the link between a strong therapeutic relationship with a therapist and a reduced risk of rehospitalization for individuals with psychosis (Frank & Gunderson, 1990; Shattock et al., 2017; Smerud & Rosenfarb, 2011). Clinicians experienced a sense of efficacy and relevance when clients did return after hospitalization, and they felt relevant when clients wanted to process the experience of hospitalization. They struggled with feeling less effective and relevant if those conversations did not happen, even if it was because the client was actively uninterested in talking about their time in the hospital.

Participants recognized that the alliance they had with their clients facilitated conversations about hospitalization. Clinicians in the study reported that having transparent boundaries, strong communication, and consistency in the therapeutic relationship helped clients make decisions about hospitalization and also helped the relationship rebound after hospitalization. This all emphasized clinician relevance to client treatment outcomes. Other therapists in the study named how their strong clinical alliance with psychotic clients allowed them to converse openly with clients about their increasing levels of concerning symptoms. The clients took the recommendations of these therapists to consider voluntary hospitalization more seriously because of the strength of their relationship.

Study findings also indicated that, when clinicians were involved with involuntary hospitalization of clients, the therapeutic relationship, and therefore the efficacy of the

therapeutic treatment, could be impacted in the aftermath. When clinicians had to assist family members in facilitating an involuntary hospitalization, clients were often very angry with therapists after they were discharged. Some clients terminated the therapeutic relationship as a result, but some therapists were able to process the experience with clients and continue their therapeutic work if their therapeutic alliance was strong enough prior to the hospitalization.

### **The trauma of hospitalization and the impact on clinician sense of efficacy and relevance**

Several participants shared their concern about how hospitalization could be a traumatic experience for their clients, which impacted their beliefs in their efficacy and relevance. Participants at times were fearful that hospitalization might be harmful to clients, which was not in alignment with the principles of trauma-informed care. How would it impact therapist sense of effectiveness and relevance if they were colluding with a system that they believed could hurt clients?

One way in which clinicians grappled with this tension was their belief that their agencies were less likely to hospitalize clients involuntarily than other agencies. Several respondents shared some version of the thought that their agencies were more cautious about involuntary hospitalization, viewing it as a “last resort”. The potential trauma of involuntary hospitalization was named by a number of participants who felt discomfort at their involvement. Several of the clinicians in the study named that many of their clients with psychosis, if not all, had experienced an involuntary hospitalization at some point. Additionally, some interviewees named that involuntary hospitalization for clients was particularly traumatizing because it was technically an arrest. At times, individuals have



to appear in court when they are under a 302 mandate and may also fear that they will go to jail when they are being handcuffed during the involuntary process. Because some therapists in the study worked in settings with individuals who were mandated to treatment as part of criminal sentencing, they felt even more conflicted about hospitalization because of the potential for law enforcement involvement. One participant described a client who had been repeatedly hospitalized involuntarily, but always returned to her agency feeling angrier at the police for their treatment of him than he did at the therapist's agency.

Hospitalization was not universally traumatizing for clients, however. Some respondents shared accounts of clients who found hospitalization to be beneficial. These respondents did not claim that it was pleasant for clients but noted that hospitalization was at times productive and could help clients, keeping them safe and stabilizing them on medication. As mentioned previously, there were clients of the therapists interviewed in the study who would choose to go to the hospital, because they knew their symptoms were worsening, and hospitalization felt like a safe enough choice for them to opt for it.

### **Racialization of the hospitalization process**

The Black clinicians I interviewed, as I have emphasized earlier in this discussion, were often the participants who took additional steps when clients were in crisis. It is possible that some of the Black clinicians in the study either felt more of a responsibility to take an active role, perhaps because they were more acutely aware of the danger of the hospitalization process going wrong for a client, and of what the outcomes could be. Or perhaps they felt that their shared racial identity with clients meant that they could have more influence on, and therefore efficacy and relevance to, the process. Their agency in

the process – staying as involved as possible, even if it went far beyond what they were required to do in terms of policy and professional ethics – may have been a way to manage their anxieties about the dangers that hospitalization could pose to their clients.

Several white clinicians mentioned that their relationships with BIPOC clients, whether during the process of hospitalization or not, could be negatively impacted by previous hospitalization experiences. The findings included accounts of clinicians that they had working with clients who had had a variety of negative interactions with white clinicians throughout the hospitalization process. These harmful interactions had the potential to cause detriment to clinicians' working relationship with clients – an example of the racialized dynamics of hospitalization harming clinician effectiveness.

Interviewees specifically named working with clients who had experienced being 302'd by a white therapist, who had had a traumatic experience with an intake coordinator, or who had been cuffed and taken away to be hospitalized by a white police officer.

One account of a Black teenage male being hospitalized by a white officer challenged a respondent's own sense of agency and efficacy throughout the process, as the participant felt torn about what it really meant to keep a client "safe". The client was unable to contract for safety, and so the clinician felt compelled to involve her clinical supervisor and then call the police because her client was refusing to go to the hospital voluntarily. This respondent struggled poignantly with her feelings of self-efficacy as a trauma-informed clinician as she tried to balance her client's desire for choice, empowerment, and safety with her ethical and policy-mandated obligations to keep her client physically safe. Even if her client was hospitalized and did not kill himself or harm another, he was still likely to be harmed by the experience of being arrested, brought to

the hospital, and mandated to stay in an inpatient treatment setting. The literature does show that Black individuals are more likely to be hospitalized (Oluwoye et al., 2021; Snowden et al., 2009) and more likely to be involuntarily restrained in inpatient settings (Payne-Gill et al., 2021; Schnitzer et al., 2020; Smith et al., 2022), and so clinician concern for the traumatization of their clients is supported by the current research.

One white respondent shared that her relationship was restrained and stiff with a Black teenage client who had a history of psychosis. She believed that the relationship had been harmed from the outset because of his traumatic experiences at the hands of white female clinicians in inpatient hospital settings. It was difficult to engage this client and the clinician felt that he often tried to defuse tension and appease her, by trying to meet her needs and not assert his own. He would do this by asking her what she needed him to do, and when she wanted to schedule their next session, without feeling that he could name his own preference. He was unwilling to risk vulnerability in session with her, because of his fear of hospitalization and retraumatization.

### **Race and efficacy, relevance, and agency**

How white therapists manage their anxiety about how about how their racial privilege impacts their ability to be competent and effective clinicians at agencies that serve predominantly BIPOC populations. Feelings of frustration, incompetence, and irrelevance emerged from the as white clinicians in the study. Several of the white clinicians noted the high likelihood of a white therapist – Black client dyad in the Philadelphia CMHC system, and that this often meant that clients would not be able to have a therapist of their preferred race. The common factors indicate that safety is an essential feature of the therapeutic alliance, and it may not be possible for a Black client

to feel truly safe with a white therapist (Goode-Cross & Grim, 2016; Hook et al., 2016; Sue et al., 2019; Ward, 2005).

Some participants shared that their agencies did try match clients with a BIPOC therapist if that is the client's preference, but that this is difficult to accomplish due to the small numbers of BIPOC clinicians in the community mental health system in Philadelphia. Other participants stated that their agencies did not prioritize matching clients with a therapist of the client's preferred race. Even if all agencies intended to provide all clients with the best fit therapist for them, in reality, clients have limited choices. White clinicians recognized that their race could impact the treatment they could provide, which compromised their belief that they could be effective and relevant – able to carry out the tasks necessary to provide the client with what they need and confident that they could add something useful to the treatment process. In fact, some white clinicians believed that their race in itself could in fact make them less qualified to work with BIPOC clients.

Respondents were aware of how pervasive the distrust that BIPOC clients with psychosis had in white clinicians could be. BIPOC clients with psychosis often have experienced trauma from white representatives of the mental health system. Respondents noted that Black clients who experience paranoia can find those symptoms exacerbated in the therapeutic relationship with a white clinician. Clinicians in the study want to engage in less othering behavior – they want to recognize that symptoms that look like paranoia can be grounded in systemic racism and structural oppression. In spite of that, they recognize that these symptoms create severe problems for psychotic clients and can impact their ability to function.

The Black therapists interviewed in this project grapple with how a shared racial identity can be advantageous in their clinical work, but that this shared identity can also complicate clinical decision-making and can potentially cause clinicians to over-function. All of the Black participants in the study shared experiences that showed how their race both could make them feel relevant and effective but could also lead them to take on layers of responsibility for clients that did not impact the white clinicians in the same way.

Some respondents found that their shared racial identity helped with client engagement and with strengthening the therapeutic alliance. Some of the Black respondents spoke of ways in which their shared race with Black clients, particularly naming how they could hold space for a variety of Black clients' feelings and experiences during the summer of 2020, when the murder of Black people at the hands of the police was happening with disturbing frequency. One Black respondent, who led group therapy in her role, in addition to working with individual clients, noticed that discussions of the racial tensions were much more frequent in groups that she led than in those led by white therapists, indicating that the therapist's presence made those discussions safe enough for Black clients.

Two other Black respondents specifically named how they believed they had predominantly Black caseloads because those clients had specifically wanted a Black therapist. Some of these clients believed that they would feel safer with a Black therapist in a health system that had harmed them in the past. Even just the initial contact between a Black therapist and a Black client revealed the level of comfort and security that having a Black therapist could provide. In this account, the client immediately relaxed when

realizing that her next therapist would be Black, and the participant shared that she believed that some of the strength of their relationship was due to their shared racial identity.

### **Limitations**

This qualitative study does have a number of limitations. Qualitative studies are not generalizable, due to their small sample size. It is possible that my study findings would be different if I interviewed clinicians at different agencies in Philadelphia, in another city, or in a rural area, since the demographics of the client population and of the clinicians would be different in any of these settings. Agency policies and procedures which impact the standard of care also vary from agency to agency, so greater agency representation in Philadelphia could have provided richer data.

My sample is comprised of 16 interviews. 13 of the participants identified as female, two identified as male, and one identified as non-binary. Additional male-identified, transgender, non-binary or otherwise gender nonconforming participants would add richness to the findings. Since a major focus of the study was on how racial dynamics in the therapeutic relationship impacted the care of psychotic clients, it would have been ideal to have more BIPOC participants. My study had only four Black-identified participants and no participants identifying with any other race or ethnicity.

I was the only one coding my data, which could introduce subjectivity bias. My interpretations and readings of the data are the only ones considered as I wrote up my findings. It would have been ideal to have another colleague code my data and compare their coding to my own. In addition, I could have asked some study participants to review my coding, a process known as member checking. Also, as a white heterosexual

American ciswoman, my perspectives, experiences, and beliefs differed from those of many study participants. Despite differences between myself and some of my participants related to race, ethnicity, and gender identity, I attempted to manage subjectivity bias through “bracketing,” which refers to a “conscientious effort to suspend assumptions, beliefs, and feelings in order to better understand the experience of respondents” (Padgett, 2008, p. 75)

As I wrote up the findings of my study, I found places where I could have asked additional questions to get increased clarity on participant answers. In particular, some participant accounts of the hospitalization process were unclear in places. I could have reached out to those participants with follow-up questions to gain more insight into their responses. I also could have asked more specifically about how racial dynamics in the clinical relationship operated with psychotic clients in particular, because some participants spoke more generally about race in the relationship with a variety of clients, and not just with clients with psychotic symptoms.

Finally, my interviews were conducted via Zoom, for a few reasons. One, my interviews were conducted during the COVID-19 pandemic, so many participants were working remotely. It was easier to meet over Zoom. Plus, meeting over Zoom protected me and the participants from exposing each other to COVID-19. In addition, meeting over Zoom allowed participants to conduct interviews in places that were comfortable to them, and not necessarily at their workplaces, where they may have felt less able to speak freely about their experiences at their agencies. Finally, meeting over Zoom was convenient for me and allowed me to conduct the interviews from home. However, meeting over Zoom did mean that I was less able to attune to participants’ body language

and facial expressions in response to my questions, so I may have missed subtle cues. I was not able to see the environment in which participants worked, which could have informed my interpretation and analysis. In addition, observing the work environment of participants could have prompted me to ask more questions, particularly about the tensions that agency policies and procedures can produce in clinicians as they attempt to provide trauma-informed care.

### **Implications for practice and research**

#### *Practice implications*

Findings from this study pointed to several implications for policy and practice. In general, the lack of agency that clinicians in a challenging treatment setting experienced created decision-making in the service of self-efficacy that could clash with the common factors of treatment and the principles of trauma-informed care. These clinical decisions could reinforce the harmful characteristics of institutional white supremacy culture. The implications for practice and policy suggested here all originate from the need for clinicians to feel more effective and relevant in their treatment of clients with psychotic symptoms, while also practicing in accordance with their clinical values and with best practices in antiracist, trauma-informed treatment.

Many clinicians in the study expressed frustration at the lack of training they received on the treatment of psychosis, both at the graduate level and in their agency settings. Since clients with psychosis commonly receive treatment at community agencies (Cusack et al., 2006), and clinicians at these settings are very likely to work with these clients, it is imperative that training to improve the clinical care of psychotic clients is implemented in these settings. In addition, graduate education could devote more



attention to the needs of this client population. Many clinicians, in the interest of offering good care to clients with psychosis, spent their own time and resources on additional training. It should not be the sole responsibility of clinicians to equip themselves with the skills they need to serve this complex population. Ideally, post-graduate training can be provided to clinicians at their agencies, at no additional cost, since the workload at CMHCs tends to be burdensome and the low rates of pay can make accessing additional training difficult.

In addition to formal training, community agencies should employ clinical supervisors who are equipped to offer supervision and support to clinicians on the treatment of psychotic clients. Study findings indicated that clinical supervisors at times could offer insight on de-escalation techniques of clients with psychosis but were not prepared to support clinicians with recommendations for treatment. In general, study findings indicated that clinical supervision was inconsistent and insufficient for the therapists. They were more likely to receive administrative or task supervision. Clinicians also connected with supervisors during crisis management, but clinical supervisors did not necessarily offer proactive and educational support on how to build clinical skills to help their psychotic clients.

Supervision and training at agencies could also focus on improving the competence of white clinicians in their work with BIPOC individuals. Many white clinicians in the study recognized that their white privilege could create barriers to providing the care their clients deserve. Agencies would do well to create opportunities for clinicians to engage in reflective practice on how issues of race and racism impact their work. Ideally, agencies would build these opportunities into the structure of the

work week, and clinicians would be compensated for the time they spend in mandated trainings and supervision.

Tensions between master's-level clinicians and doctoral-level clinicians and psychiatrists should be addressed proactively in agencies. Clinicians should be respected as integral members of the treatment team. Potential ways in which communication could be improved between clinical staff could include regularly scheduled case consultations or staff meetings, with required attendance from both agency therapists and psychiatrists. This increased communication and collaboration could also lead to more creative and trauma-informed ways to approach the treatment of psychosis. Study findings repeatedly pointed to agency practice for treating psychosis as prioritizing antipsychotic medication, even if clients did not want to be medicated. Trauma-informed practice emphasizes client-clinician collaboration and client autonomy. If medication was no longer viewed as the only effective treatment approach, clinicians and psychiatrists might be more open to alternative approaches that could align more closely with client wishes.

Clear and consistent agency policies on the procedures for hospitalization could reduce some of the variance in how hospitalization is used as an intervention by different clinicians. Findings showed that clinicians often varied in how they responded to client crises, potentially because they did not have clear guidance on protocols. All clinicians should be trained on these policies, and potentially training should be annual, to ensure as much consistency as possible in the decision-making regarding hospitalization. Finally, increased funding for crisis response services could potentially provide more options for clients in crisis, perhaps even reducing the necessity of hospitalization for some individuals. In addition, more resources for mid-level options for care, like intensive

outpatient programs or partial hospitalization programs could also give clinicians and clients more options that are less restrictive and potentially less traumatizing than inpatient hospitalization.

### **Research implications**

Findings from this study give some possible directions for future research. Some of the relationships suggested in the data could be tested by quantitative studies. For example, does a stronger therapeutic alliance, perhaps measured by the Working Alliance Inventory (WAI), predict more voluntary vs involuntary hospitalizations, or predict fewer hospitalizations? Does a racial match in the therapeutic dyad predict greater feelings of therapist efficacy and relevance? Does a racial match with a client predict less hopelessness or powerlessness in the therapist, and greater feelings of agency?

Several clinicians voiced their uncertainty about how to apply the evidence-based practices they learned and that their agencies used as their preferred modalities to their work with clients experiencing psychosis. These clinicians named the need for research that tests the applicability of and suggests modifications for these evidence-based modalities, particularly cognitive-behavioral therapies, motivational interviewing, dialectical behavioral therapy, and exposure therapies, when they are used with psychotic clients.

Continued examination of how self-efficacy theory is relevant to the clinical relationship is indicated, since much of the literature on therapist self-efficacy comes from the field of counseling and psychology, and not social work. Many studies on self-efficacy draw their sample from graduate students who are often working in university settings. The research on clinician self-efficacy is not inclusive of clinicians in

community mental health settings, nor does it include exploration of the work of clinicians with psychotic clients. The literature on counseling self-efficacy rarely addresses the dynamics of race in the clinical dyad, and how those dynamics impact clinicians' feelings of self-efficacy.

## **Conclusion**

This dissertation was a modified grounded theory study that, through multi-phased coding and analysis of 16 semi-structured interviews, attempted to answer the research question: How do clinicians in community mental health agencies preserve their feelings of efficacy, agency, and relevance in the treatment relationship with clients who experience psychosis? This project brought together critical whiteness theory, the research literature on common factors in therapy, perspectives on trauma-informed care, and self-efficacy theory (McIntosh, 2003; Miller et al., 2015; Okun & Jones, 2016; Wampold, 2001; SAMHSA, 2023; University of Buffalo, 2023; Bendall et al., 2021; Bandura, 2001; Bandura, 1997) to examine the treatment of psychosis in community mental health centers.

This study's findings led to the generation of this grounded theory: Clinicians in CMHCs preserve their feelings of efficacy, relevance, and agency when treating clients with psychosis by engaging in behaviors that reduce their anxiety about their efficacy while also allowing them to feel impactful in client treatment. These behaviors and clinical decisions, however, create tensions within clinicians, for they can conflict with the principles of trauma-informed care. Clinicians preserve their feelings of efficacy and relevance in the treatment relationship with clients who experience psychosis by othering, naming, and labeling their clients with psychosis, making meaning of their role in

treatment of psychosis when medication seems to be the predominant treatment approach, and learning how to navigate the clinical hierarchies in CMHC settings. The active role that masters'-level clinicians in these settings can have in hospitalizing clients is another means through which they experience a sense of agency, efficacy, and relevance. The decision-making regarding hospitalization was fraught for study participants, as they struggled with the need to keep clients safe and their fears about the potential harm that hospitalization can cause. Themes related to hospitalization included therapists often feeling like they are the only ones responsible for client safety, how the strength of the therapeutic alliance contributed to therapist navigation of the hospitalization process, and the racialized dynamics of hospitalization. Finally, therapists discussed the ways in which their race impacted their perception of their relevance to the clinical relationship with psychotic clients.

Implications for practice, policy, and research include the need for more training for clinicians, at both the graduate level and the post-graduate level, in best practices for the treatment of psychosis. The provision of consistent and high-quality supervision with clinical supervisors who are able to advise clinicians on treatment modalities for psychotic clients should be readily available. Clinical supervision should also provide a safe environment for clinicians to explore how their racial identities impact the work they do with clients. Collaborative and inclusive case consultations and staff meetings could bring doctoral-level psychologists and psychiatrists together with master's-level clinicians, ideally easing some of the hierarchical tensions that can be present at these agencies and leading to more creative and client-centered approaches to the treatment of psychosis. Regarding hospitalization, agencies across regions could aim become more

aligned in their hospitalization procedures, making the steps in the process clear and providing thorough training for employees. These policies should be created in alignment with trauma-informed models of practice. Increased funding for crisis response services could potentially provide more options for clients in crisis. Finally, funding for initiatives to recruit and retain a more diverse clinician population in agencies would provide clients with more options in their choice of clinician.

Further studies could examine the application of evidence-based practices to clients with psychosis, with particular focus on their use in community agency settings. Also, quantitative studies could be conducted to test the relationships that were suggested in the study findings, including how the working alliance might predict hospitalization outcomes and the relationship post-hospitalization, and the influence of a racial match in the therapeutic dyad on the therapist feelings of efficacy, relevance, and agency. Continued examination how self-efficacy theory is relevant to the clinical relationship is indicated, since much of the literature of therapist self-efficacy comes from the field of counseling and psychology, and not social work. The research on counselor self-efficacy does not include community mental health clinicians who work with psychotic clients or address the dynamics of race. Attention to these gaps in the research literature could provide important insights into how to improve the clinical care of psychotic clients in community agencies, clients whose needs are often not prioritized but who still deserve the highest quality treatment.

## Appendices

### Appendix A: Study Announcement

**Study Title:** Examining the Therapeutic Relationship between Community Mental Health Clinicians and Clients with Psychosis: A Qualitative Study

Dear Community Mental Health Colleagues,

I am writing to tell you and your colleagues about a study I am conducting about social workers in community-based mental health agencies in Philadelphia working with clients who experience psychosis. I am a PhD candidate in Social Work at Bryn Mawr College Graduate School of Social Work and Social Research. The data I collect in this study will be analyzed for my doctoral dissertation and will only be collected after approval of the ethics review committee for research involving people.

The purpose of the study is to learn about the challenges and successes that social workers experience in working with this population. Through this study, I hope to identify ways to support social workers as they work with this often marginalized and high-needs population.

For this study, I am inviting social workers to participate who:

1. have earned a Master's degree or higher in social work.
2. work as outpatient therapists at a community-based mental health agency – a public or private clinic or agency aiming to provide mental health treatment primarily to people who are socially marginalized, living in poverty, and/or living with significant mental health problems.
3. Have worked with at least three clients of color with psychosis at their agency, for at least eight sessions over the course of at least two months.

If social workers from your agency decide to participate, I will ask them to participate in up to two 60-90-minute interviews over the course of six months with the researcher. With time for paperwork, participation requires up to five hours of time.

Participation in this study is voluntary and participants can withdraw from the study at any point. My hope is that participation will be an interesting opportunity for social workers to reflect on this area of work. All participants receive a \$20 gift card after completion of each interview.

This study is being conducted by a PhD candidate researcher at the Graduate School of Social Work and Social Research at Bryn Mawr College after approval of the ethics review committee for research involving people.

I plan to hold interviews over Zoom. Please feel free to distribute this invitation widely to social workers at your agency.

If you have any questions about participation at this stage, or if you meet the criteria and would like to participate, please contact me at the following email address [cshank@brynmawr.edu](mailto:cshank@brynmawr.edu).

Please also feel welcome to share this letter of invitation with colleagues.

Thank you very much.

Sincerely,

Carolyn Solo, MSS, LCSW

Doctoral candidate

Bryn Mawr College Graduate School of Social Work and Social Research



## **Appendix B: Consent Form**

**Title of Study:** Examining the Therapeutic Relationship between Community Mental Health Clinicians and Clients with Psychosis: A Qualitative Study

### **Introduction and Purpose of Study**

I am a Ph.D. candidate at the Graduate School of Social Work and Social Research (GSSWSR) at Bryn Mawr College. I am seeking to interview social workers who work as outpatient therapists at community mental health agencies in Philadelphia. I will ask you questions about your experience as a social worker working with clients who experience psychosis. This interview will contribute to my dissertation research.

I am inviting you to participate in this interview.

### **What is involved?**

The interview will last between 60 to 90 minutes. I will conduct the interviews over Zoom and will record the interviews. I will also collect demographic data. I may also take written notes.

I may ask you to conduct a follow-up interview if I have additional questions.

### **Confidentiality:**

While no study can fully assure confidentiality of participants, the following steps will be taken: You will choose a pseudonym and I will avoid sharing information that identifies you. Participant names will only be attached to the consent form and not the transcripts of the interviews. Nothing with your name or other identifying information (names and places mentioned in the interview) will be used publicly. In addition to me, the only other person who will view the video of our Zoom interview is a hired transcriptionist, who will assist me in transcribing the audio of the interview. My research adviser, Dr. David Byers, may review portions of de-identified interview transcripts to support my analysis.

Audio and video data will be temporarily stored on my password-protected OneDrive until it is completely transcribed, and then destroyed. Transcripts will be stored on my password-protected OneDrive. I will then use the data from the transcripts to write my dissertation, which will be published.

### **Risks of participating:**

The risks of participating are minimal. The ways that confidentiality will be protected have already been described. In the unlikely event that you find that what you discussed in the interview is upsetting to you after the interview is over, please be in touch with me. I will provide you with some names and numbers of individuals or agencies that can provide further assistance, should you feel that might be helpful.

You are free to terminate participation at any time.

**Benefits of participating:**

Although being interviewed will not help you directly, it is also possible that having a chance to share your experiences of working with this population will inform and assist other clinicians who do the same work. Your experiences could also inform administration and management of community mental health agencies about the experiences of clinicians like you. I hope that participating in this project will be an interesting and possibly a rewarding experience for you. In addition, your participation will help to educate me how to engage in strong qualitative interview research in the future, and to consider an area of potential future research.

**Compensation:**

Participation is completely voluntary. You can terminate your participation at any time. You will receive a \$20 gift card for each interview that you complete.

**Deception:**

There is no deception involved in this study.

**Voluntary Participation:**

You do not have to participate in this project. There will be no negative consequences if you decide not to participate. No one, other than me, will know whether you have participated in this project.

If you do decide to be interviewed, you can stop the interview at any time. You can also refuse to answer any questions that you don't want to answer.

**10) Questions about the research and rights of research participants:**

If you should have any questions about the research, please feel free to e-mail Carolyn Solo, principal investigator, [cshank@brynmawr.edu](mailto:cshank@brynmawr.edu). If you have questions about your right as a research participant, please be in touch with Gary McDonogh, IRB chair, [gmedonog@brynmwr.edu](mailto:gmedonog@brynmwr.edu) or [irb@brynmawr.edu](mailto:irb@brynmawr.edu), or with the Graduate School of Social Work and Social Research (GSSWSR), Bryn Mawr College, IRB departmental reviewer, Carolina Hausmann-Stabile, [chausmanns@brynmawr.edu](mailto:chausmanns@brynmawr.edu).

**By completing this survey, you consent to participate in this study.**

**\*Please print or save a copy of this form for your records\***

I am 18 or older: Yes \_\_\_\_\_ No \_\_\_\_\_

I have read this consent form, or it has been read to me: Yes \_\_\_\_\_ No \_\_\_\_\_

I have had all of my questions about the study answered to my satisfaction. Yes \_\_\_ No

I have been given a copy of this consent form. Yes \_\_\_\_\_ No \_\_\_\_\_

I agree to participate in this research. Yes \_\_\_\_\_ No \_\_\_\_\_

*If applicable*, I give permission to audiotape my interview. Yes \_\_\_ No \_\_\_

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewer Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix C: Demographic Information

**Pseudonym:**

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**Demographic information:**

Age (years): \_\_\_\_\_

Gender identity: \_\_\_\_\_

*Potential responses include but are not limited to cis-woman, cis-man, transwoman, transman, non-binary, or other (please specify)*

Race/ethnicity: \_\_\_\_\_

MSS/MSW graduation year: \_\_\_\_\_

Months/years at agency: \_\_\_\_\_

Please describe your role at your agency:

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## Appendix D: Interview Guide

1. After reading the consent form, do you have any other questions for me about the study?

2. Tell me about a client who experiences psychosis, with whom you have worked for some length of time – a current or past client.

Probes: demographics, course of the treatment, their symptoms, your reactions to the client, the therapeutic alliance you have developed and how you have developed it, interventions you feel are most effective, how agency supports the work you do with this client

3. Have you ever hospitalized a client with psychosis? Would you be willing to walk me through that experience?

Probes: demographics, agency regulations, choice points, what started the process, how did you feel about it afterwards, did you continue the relationship with the client, what was the relationship like after the hospitalization

4. What does a successful session with a client with psychosis look like for you? When do you feel successful?

5. What kinds of challenges do you experience in engagement and alliance formation with clients with psychosis? How do organizational policies or practices help or hinder this process with clients with psychosis? How does race play a role?

6. What does creating safety in the therapeutic relationship look like for you in your work with clients who experience psychosis? How do organizational policies or practices help or hinder this process with clients with psychosis? How does race play a role?

7. Is there anything I have not asked you about that you would like to share with me?

Thank you so much for your time.

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