

the Behavior Therapist

special issue

Violence

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Introduction to the Special Issue on Violence

Angela Moreland, Richard LeBeau,
and RaeAnn Anderson, *UCLA*

the Behavior Therapist has a long history of thought-provoking special issues that draw its members' attention to matters of the utmost importance in our field. Recently, the editorial team has focused on special issues that cover topics we feel have not received sufficient attention at our Annual Convention or in our publications. Recent examples include special issues on the role of psychologists as advocates for marginalized populations (October 2020), suicide prevention (December 2020), and Native American Issues in Behavior Therapy and Research (March and April 2021). We are grateful for the opportunity to highlight these issues of great clinical, scientific, and social importance and hope that these special issues generate meaningful discussion.

Our latest special issue is on the topic of violence. When we initially met to discuss this special issue many months ago, we concluded that it should explore topics related to violence that extend beyond those typically discussed in our field (e.g., developing and disseminating evidence-based treatments for posttraumatic stress disorder, understanding the sequelae of childhood abuse). Although these concerns are undoubtedly important and worthy of our continued attention, there are many other aspects of violence relevant to our roles as clinicians, researchers, and policymakers that should be explored.

To this end, we solicited broadly for this special issue. We reached out to numerous Special Interest Groups (SIGs) and posted on several list serves focused on topics related to violence. We were deeply impressed by the breadth,

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INSTRUCTIONS for AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.

- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.

- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.

- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a Copyright Transfer Form (which can be downloaded on our website: <http://www.abct.org/Journals/?m=mJournal&fa=TB>): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Richard LeBeau, Ph.D., at rlebeau@ucla.edu. Please include the phrase *tBT submission* and the author's last name (e.g., *tBT Submission - Smith et al.*) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

depth, and sheer quantity of the submissions we received. In fact, there were so many high-quality submissions that we could not fit them all in a single issue. (Several articles that were unable to be included in this special issue will appear in the fall issues of the journal.) Below, we briefly review the epidemic of interpersonal violence and provide a brief summary of the articles included in the special issue.

Why Focus on Violence?

Interpersonal violence is a pervasive public health concern that plagues clinicians, researchers, and policymakers. Approximately 3.3 million people in the United States report being victims of interpersonal violence annually, which includes physical assault, sexual assault, and witnessing community violence (Bureau of Justice Statistics, 2019). Importantly, several subpopulations report significantly higher prevalence of interpersonal violence, including women, people of color, and other marginalized populations. Victims of interpersonal violence are at increased risk for a range of behavioral, emotional, and physical health problems which have been shown to cause lifelong consequences if not addressed (Britt, 2001; Janssen et al., 2021). Further, interpersonal violence results in difficulties for the individual who experienced the interpersonal violence, but can also have tremendous impact on the entire family unit (Stanley & Humphries, 2017).

While decades of research have focused on the overall prevalence and impact of interpersonal violence, recent attention has examined the impact of interpersonal violence on specific populations, longer-term consequences, impact of comorbid mental health disorders, and treatments to address various forms of interpersonal violence. Given the state of the literature and field of interpersonal violence, this special issue aims to highlight the exceptional work that researchers and clinicians have conducted to understand and treat interpersonal violence more broadly, while also beginning to more carefully examine interpersonal violence impact and effective treatments among at-risk subpopulations.

An Overview of the Special Issue

The first three articles in this special issue focus on unique treatment approaches to address interpersonal violence. Boniface and Grasseti (2021) specifically describe a three-pronged treatment approach to address the impact of intimate

partner violence on the entire family by simultaneously targeting adult posttraumatic stress symptoms, child posttraumatic stress symptoms, and the parent-child relationship. Dauria and colleagues (2021) describe two efforts in their own community to address domestic violence-related homicide, which address the individual needs of survivors and a system-level approach to addressing the issue. The authors describe the goals of the initiatives, along with the accomplishments and lessons learned. Given the overwhelming need for effective mental health service delivery during the COVID-19 pandemic, coupled with increases in rates of interpersonal violence and difficulty accessing mental health treatment during this time, Salami and colleagues (2021) describe how the use of technology can aid access to mental health services for victims of interpersonal violence. The authors describe how the use of technology may have particular benefit to marginalized populations, who may experience greater consequences associated with the COVID-19 pandemic.

The remaining articles address an array of unique and thought-provoking issues related to interpersonal violence. Mii and colleagues (2021) focus on adolescent sexual reoffending within the family, which is a critical type of interpersonal violence that does not receive much attention in the literature. Given the need for clinicians to understand and assess for adolescent sexual reoffending, the article outlines challenges to assessment, prevention of recidivism, and family reunification. Yenne and colleagues (2021) define and describe maternal filicide, which is a type of interpersonal violence that is often misunderstood by clinicians and the general population. The authors describe maternal filicide, then outline a specific treatment approach and the lessons learned from implementing this approach. Finally, Rieger and Allen's (2021) commentary calls on all of us in the field to examine and challenge how we conceptualize and address the pervasive problem of gender-based violence. Their commentary concludes by providing concrete tools that can aid clinicians and researchers as they rethink gender-based violence.

We hope that these articles serve as an impetus for reflection and discussion, particularly with regard to our roles in preventing and treating issues related to interpersonal violence. We would like to express our deep gratitude to all of the individuals who contributed to this issue by authoring, reviewing, and editing these manuscripts.

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A 2Generation Approach for Traumatic Stress: An Optimized Therapeutic Service Delivery Model for Adult and Child Victims of Intimate Partner Violence

Rosa L. Boniface and Stevie N. Grasseti, *West Chester University of Pennsylvania*

NEARLY 20 AMERICANS per minute are physically abused by an intimate partner (Centers for Disease Control and Prevention; CDC, 2011). Intimate Partner Violence (IPV) is a highly prevalent form of violence that impacts 10 million people in the United States each year (Niolon et al., 2017). This number includes not only adult women, who comprise the majority of direct IPV victims (Truman & Morgan, 2014), but also the 3.2 million children who are exposed to IPV (Stiles, 2002), since 90% of families who experience IPV report that a child has witnessed the violence (Hamby et al., 2011). In the context of a global pandemic that is keeping families at home without typical external connections, the risk of IPV has increased and IPV rates for 2020–2021 are expected to exceed 10 million (SAMHSA, 2020). Women and children may be at a greater risk for IPV than ever before.

IPV can have serious mental health consequences, such as posttraumatic stress disorder (PTSD), both for adults who experience the violence directly and for children who witness or learn about it. While effective treatments for PTSD exist, these treatments are suboptimal in addressing the complex needs of families contending with IPV. Specifically, the most effective therapeutic services target either adult PTSD symptoms or child PTSD symptoms and the parent-child relationship (while referring adults out for their own treatment). Thus, needed comprehensive services may be underutilized by families who have experienced IPV because scheduling multiple appointments with different providers is a barrier to treatment, especially considering that some women who have experienced IPV may be single parents who do not have childcare available during their own therapy appointments. In fact, existing research suggests that logistic barriers have the greatest impact on whether or not

clients will begin cognitive behavioral therapy (Trusz et al., 2011). Current effective approaches can become more accessible to families that need them when they are optimized to provide comprehensive care for adult and child victims of IPV in one treatment.

The current paper draws from existing evidence-based models to introduce a new model, the Two Generation Approach to Trauma (2G4T) treatment, that may optimize care for families in which multiple members are experiencing posttraumatic stress (PTS) symptoms following IPV. While not all victims of IPV develop a full PTSD diagnosis, the 2G4T treatment seeks to be inclusive of all PTS symptoms and to be as accessible as possible given the pervasiveness, complexity, and breadth of IPV. The current article will further refer to posttraumatic and other trauma-related symptoms as PTS. A 2Generation (2Gen) approach targets individual and family needs simultaneously by providing simultaneously offered therapeutic service for children and adults where the whole family can thrive together. 2Gen is based on a clear theory of change but has yet to be tested in clinical settings. Given the strong theoretical rationale for 2Gen, it is critical to explore the model's clinical potential as an optimizing means of increasing treatment access for families struggling with IPV and its many negative outcomes.

Psychological Consequences for IPV Victims

IPV is a form of trauma that creates risk for a wide range of mental health concerns in both adult women who directly experience IPV (Lagdon et al., 2014) and in children who witness IPV (Carlson, 2000; Haj-Yahia et al., 2019; Wood & Sommers, 2011). PTSD is one of the many mental health concerns for victims of IPV. While the lifetime prevalence rates of PTSD diag-

nosis in the United States general population is around 7% (Kessler et al., 2005), prevalence has been estimated to be as high as 64%–84% among abused adult women (Pico-Alfonso, 2005). Limited research exists around the prevalence of PTSD in children who have experienced IPV. From the studies completed results are similar; approximately 5%–10% of children in violent homes develop a full PTSD diagnosis (Graham-Bermann & Levendosky, 1998; Lehmann, 1997). Authors make an important distinction that nearly 75% of children demonstrate functionally significant intrusive memories and symptoms of hyperarousal, core features of PTSD, without meeting full diagnostic criteria (Levendosky et al., 2002). These findings support 2G4T's efforts to be inclusive of individuals who meet full criteria for PTSD as well as those demonstrating PTS. Further, recent research shows similarities in PTS across parent-child dyads in families who have experienced IPV (Galano et al., 2020). The data are clear—IPV is harmful and parents and children's functioning is intertwined in families that experience IPV. Furthermore, there is evidence that these experiences in childhood are impactful to later functioning; children who witness IPV are more likely to become victims or perpetrators of violence including later in life with their own intimate partners (Ehrensaft et al., 2003). It is important to understand the intergenerational transmission of IPV and to optimize strategies for effectively intervening.

Theoretical Mechanisms Describing Risk Transmission

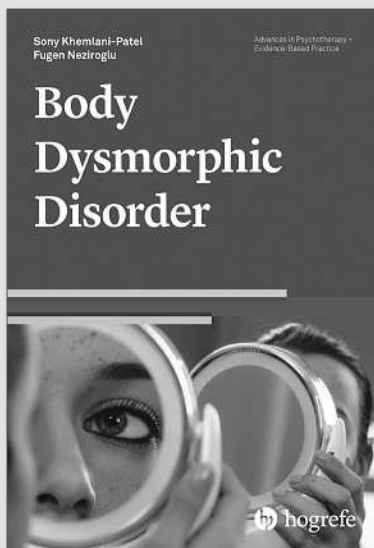
Social Learning Theory

For decades, Social Learning Theory (SLT; Bandura, 1973) and the Intergenerational Transmission of Violence Theory (IGT; Hamby et al., 2011; Powers et al., 2017; Straus et al., 1980) have helped to explain why children who witness violent behaviors at home are more likely to demonstrate behavioral problems in childhood (Cox et al., 2003; English et al., 2009; Ybarra et al., 2007) and to become victims or perpetrators of violence later in life, including with their own partners (Ehrensaft et al., 2003). Through observational learning, children understand violent behavior as a strategy for navigating conflict and they repeat this behavior when faced with their own conflicts.

IPV also affects children indirectly through its impact on parenting behaviors. IPV has been found to be associated with

A compact guide to assessing and treating body dysmorphic disorder

Coming
August
2021



Sony Khemlani-Patel / Fugen Neziroglu **Body Dysmorphic Disorder**

Advances in Psychotherapy –
Evidence-Based Practice, vol. 44
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This volume provides a user-friendly evidence-based guide to the diagnosis, phenomenology, etiology, and treatment of body dysmorphic disorder (BDD). New and seasoned clinicians can learn about the foundations of CBT for BDD as well as the rationale and instructions for modifying the approach to meet the differences in symptoms found in this client group. The book explores techniques for treatment engagement, including adjusting therapeutic style, appropriate utilization of behavior and cognitive therapy, family involvement, and motivational interviewing techniques. Other issues associated with BDD are also highlighted: poor insight, comorbidity, concerning rates of suicidality, and ambivalence regarding treatment.

The authors outline step-by-step instructions for numerous novel and advanced treatment strategies including perceptual re-training, attentional training, acceptance and commitment approaches, and ways to manage ongoing desire for cosmetic surgery. Detailed case examples are presented with corresponding treatment guidelines to highlight the variety in clinical presentation and corresponding treatment approaches.

The materials for this book can be downloaded from the Hogrefe website after registration

the victimized parent's aggressive and neglectful parenting practices (Ogbonnaya et al., 2019). Graham-Bermann and colleagues (2009) found that parenting behaviors matter; parenting behaviors predicted resilience in children who were exposed to IPV such that victimized mothers who reported better parenting skills were more likely to have resilient children.

Cognitive Theory

In addition to providing salient models of violence as a behavior strategy for navigating conflict and impacting parenting behavior, IPV may contribute to risk for later IPV through cognitive mechanisms (Powers et al., 2017). Adults who have experienced IPV report shame, self-defeating thoughts, and a belief that they are powerless to change the situation (Flynn & Graham, 2010; Liang et al., 2005). Experiencing IPV also impacts adults' beliefs about themselves as parents—when a parent is traumatized, they are no longer able to see themselves as a loving and able caregiver, which can result in their being unable to respond behaviorally to the needs of their child (Almqvist & Broberg, 2003). It is common for victims of IPV to become isolated from the rest of the world, cut off from friends, family, and other social supports (Lanier & Maume, 2009). Victims may perceive themselves to be alone and helpless, even if family or friends attempt to help. This type of isolation, fear, and loneliness may contribute to the belief that they are inadequate as a parent or even that their child may be better off without them. These harmful thoughts are not only crippling for the parent's well-being, but further fractures the parent-child relationship.

Similarly, children who have witnessed IPV may experience thoughts of helplessness, a belief they are somehow different from peers, or thoughts of being unworthy of love (Wood & Sommers, 2011). These distracting, unhelpful thoughts may be one reason that children who have been exposed to IPV experience significant difficulties at school, even compared to children who have experienced other forms of trauma (Kiesel et al., 2016).

Attachment Theory

Attachment theory (Bowlby, 1969; Levendosky et al., 2012) provides an additional theoretical framework to understand the importance of the parent-child dyad in protecting children against traumatic stress after exposure to IPV. Attachment theory proposes that most children form secure bonds with their caregivers early in life.

When caregivers are sensitive and responsive to children's needs, children internalize a belief that they are safe and protected. This understanding facilitates the ability to explore the environment and take risks. A secure attachment serves as a protective factor against mental health difficulties like posttraumatic stress (Daud et al., 2005). Recent attachment theorists suggest that IPV in a home can disrupt the secure attachment and harm a mother's internal response to her child (Cannon et al., 2009; Levendosky et al., 2012). Mothers may view their children as helpless, leading to over-protective and shameful parental responses. Alternately, mothers may view the child as hostile or similar to her perpetrator, leading to her rejecting the child. This failure of appropriate parental response triggers an increase in the traumatized child's negative posttraumatic stress symptoms (Ainsworth, 1973; Almqvist & Broberg, 2003; Bowlby, 1977), making it more likely that child will grow to develop a full PTSD diagnosis and, potentially, experience violence in their own relationships with intimate partners.

Current Treatments

Adult Trauma Treatments

Fortunately, evidence-based psychological therapy reduces PTSD and other trauma-related symptoms in children and adults (Cohen et al., 2006). For adults, CBTs such as Prolonged Exposure (PE; Foa et al., 2007) and Cognitive Processing Therapy (CPT; Monson et al., 2014) have demonstrated effectiveness in reducing PTSD symptoms (Benuto & Bennett, 2015; Bradley et al., 2005; Dorrepaal et al., 2014). These treatments focus on teaching adults to regulate their emotions and behaviors by challenging negative and dysfunctional thinking, increasing relaxation skill development, and processing traumatic events to change avoidance and arousal responses. Adults are typically seen one-on-one with a trained clinician once or twice per week for approximately 60 to 90 minutes per session. Usual treatments range from 8 to 15 sessions over a period of 2 to 3 months.

Child and Family Trauma Treatments

There is also strong support for psychological interventions to address PTSD and trauma-related symptoms among children and a wealth of literature that emphasizes the importance of parent involvement in children's treatment (Graham-Bermann et al., 2007; McLaughlin & Lambert, 2017; Overbeek et al., 2017). Current evidence-

based practices such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen & Mannarino, 2008), Parent Child Interaction Therapy (PCIT; Borrego Jr. et al., 2008; Eyberg, 1988), and Child-Parent Psychotherapy (CPP; Lieberman, 2004) each include parents in the treatment with the child. Child and parent components include psychoeducation about trauma, parental skill training and development, and exposure activities that help the child describe and process the traumatic events they have experienced. The parent works with a clinician to practice skills learned with the child and process the traumatic events the child has shared or expressed. Each treatment has shown to effectively reduce PTS while increasing the parent's skill to manage their child's traumatic symptoms appropriately. Similar to adult treatments, these treatments consist of weekly 60- to 90-minute sessions ranging from 3, 6, to almost 12 months of treatment, depending on client progress and treatment adherence.

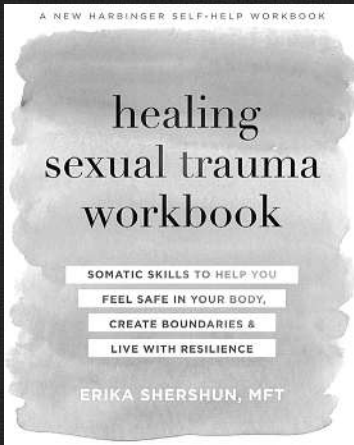
Current Treatment Limitations

Despite the existence of these effective therapies, it may be challenging for families who have experienced IPV to access comprehensive care for multiple members of the family (Kazlauskas, 2017). Community practice does not always reflect the practices that are supported by research (Reid et al., 2017). Even when community practitioners do offer evidence-based treatments, these treatments can be costly (Southam-Gerow et al., 2012; Stewart et al., 2012), too few practitioners are available to meet the need for services (Stewart et al.), and families experiencing adversity like IPV may encounter significant logistic barriers (e.g., lack of available childcare from a co-parent while they pursue their own treatment).

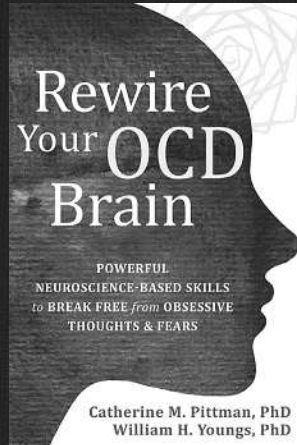
When families can access effective PTSD treatments, they may find that existing treatment approaches have a limited ability to comprehensively meet the complex needs of families that have experience IPV. For example, adult-focused treatments do not specifically target parenting skills that could help adults effectively support their trauma-exposed children. Child-focused treatments do include parents but focus on parenting skills without addressing the parent's own mental health needs. Parents are, instead, referred out for their own treatment with another provider. The need to schedule additional appointments with other providers while also contending with regular access barriers (time, cost,

Essential Resources

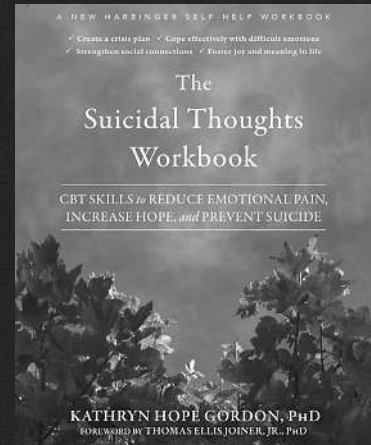
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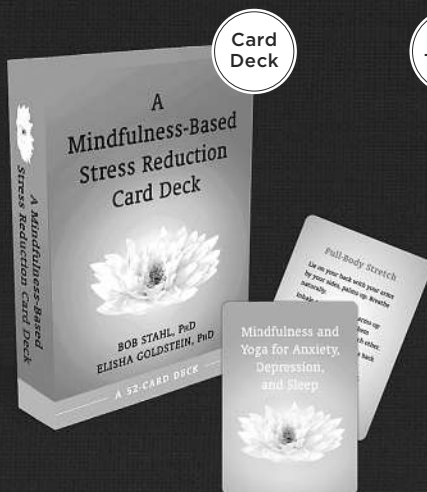
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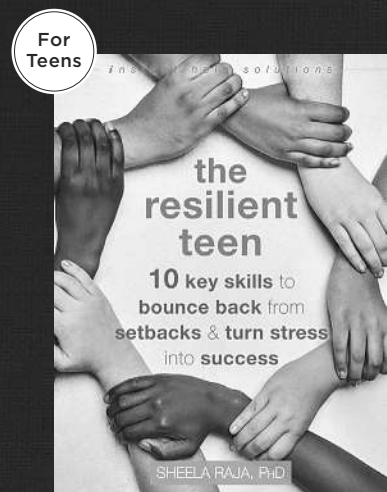
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available childcare) may deter some women who have experienced IPV from fully utilizing therapeutic services that are likely to be helpful (e.g., a mother opting to enroll a child in therapy while foregoing her own treatment due to logistical barriers). Treatment developers must work to optimize existing effective treatments to better serve families that have experienced IPV.

A 2Generational Approach

Introduction to 2Gen

A 2Gen approach is a method by which children and parents are treated simultaneously to target intergenerational problems and promote family stability (Department of Education, 2016). The rationale for the 2Gen approach is based in the theory of multiplier effects (Crul et al., 2017). When a parent and child participate in services together, the parent is to be spurred on by their child's treatment success. Parents work harder, pursue their own betterment of self, and seek their own success whether it be education, employment, or substance recovery. Additionally, the parent's improvements expose the child to better living conditions and enhance the parent-child relationship. Ultimately, the parent and child receive increased treatment benefits from these multiplier effects when seen together that they would not be able to achieve if they were treated separately.

Historical Background

Policymakers across the U.S. have been at the forefront in support of 2Gen strategies to combat impacts of adversity such as poverty, inequality in education, and substance abuse (Mosel et al., 2015). Early 2Gen approach programs were piloted by public agencies in an effort to inform public policy (Mosel et al.; Department of Education, 2016). The first wave of "Two-Generation 1.0" programs (McLanahan et al., 2014) focused on early childhood, with the occasional program providing adult education or job training. Another wave of programs targeted young mothers and their children to reduce long-term welfare participation (Bronfenbrenner et al., 1984; Ceci & Bronfenbrenner, 1985; National Head Start Association, 2015). Currently, there has been a revitalization of 2Gen programs. These "Two-Generation 2.0" programs (McLanahan et al.) expand upon the work of the first generation, aiming to test whether these programs improve outcomes for families (Mosel et al.).

Preliminary Findings

Program 1

The Chicago Young Parents Program (CYPP; Burkhardt et al., 2020) is a 35-week parent engagement, youth development, education and employment program designed by the Chicago Department of Family and Support Services (DFSS) and SGA Youth Family Services. The program combined comprehensive Head Start programming with youth employment and mentoring for participants' children and their families. CYPP targeted 16- to 24-year-old parents of children ages 0–5 who were enrolled in Head Start programs. The goal of CYPP was to address the complex career, education, and developmental needs of both the parents and children to complete the 2Gen service modality. The program was implemented during a 3-year period from 2016 to 2018. The program evaluation of the results demonstrates the CYPP program was associated with improvement in young parents' education, personal growth, employment, and parenting (Burkhardt et al.).

Program 2

Kids Club and Mom's Empowerment Group (KCME; Graham-Bermann et al., 2007) was designed to target women and children who have experienced IPV. KCME is held in a community setting consisting of two separate groups held on the same night, one for children and one for mothers. Children learn to develop a sense of safety, increase emotion regulation skills and interpersonal relationship skill building. The parenting group program is a chance for mothers to be empowered by discussing the way IPV has impacted their child's development, learn parenting skills, and discuss their parenting concerns in a supportive group setting.

A controlled trial, conducted with 110 boys and 111 girls, consisted of a child-only condition (CO), child-plus-mother condition (CM), and a wait-list comparison that did not receive treatment. Researchers gathered measures of family violence, child adjustment problems, social desirability, and children's attitudes and beliefs about the acceptability of family violence. Results indicate the CM condition was superior to the CO and wait-list control in reducing the percentage of children in the clinical range on the adjustment measure (Graham-Bermann et al., 2007). Additionally, after an 8-month follow-up the CM condition showed the greatest improvement over time in externalizing problems and attitudes about violence. While this

program is a step in the right direction for addressing the needs of trauma-exposed families, no data exist to indicate whether this treatment helps to reduce PTS symptoms among participants.

Future Directions

It is clear from the literature that parents' mental health protects children from the risk associated with exposure to IPV. Outcomes for children in trauma treatment are significantly improved when parents participate (Brown et al., 2020). Further, concurrent treatment for parents and children may improve parents' access to their own care because it mitigates the barrier of needing to arrange childcare while attending therapy appointments. Working at the large level of public policy change, the 2Gen approach has garnered significant support from policymakers throughout the U.S. Despite the work that has been done, there remains a lack of clinically oriented treatment utilizing the 2Gen modality.

To date, there has been little research conducted on the effectiveness of the 2Gen approach to treating posttraumatic stress, despite the strong rationale for doing so. In our future work, we plan to pilot 2G4T to put this theoretical model into practice. We look to expand on the preliminary findings of KCME to fill the gap in the 2Gen literature. While KCME conducts parent-child empowerment groups simultaneously, there remains a lack of clinically trauma-focused treatment to reduce PTS. Utilizing the same group-style format, the 2G4T treatment program will look to assess PTS for both children and adults as well as parental stress, competence and sense of efficacy in their child's ability to make positive changes. Additionally, the groups will allow for children and adults to meet separately for 60 minutes then together for an additional 30 minutes to enhance parent-child relations and parenting skills.

While the theoretical benefit of 2Gen approaches is clear, we have not yet tested whether 2Gen approaches improve access for families that have experienced IPV. If such approaches do improve access, we would expect to observe a higher service utilization among families who have experienced IPV. Moreover, we would expect these families to report higher satisfaction with services. Offering services in the modality and at the times most needed by our clients is consistent with client-centered care and can optimize outcomes for families who have experienced IPV by

making effective therapeutic services more accessible. Furthermore, these services can be more impactful by addressing clinical outcomes in multiple family members (decreases in parent and child psychological symptoms) and enhancing the parent-child relationship. We expect this innovative 2G4T treatment modality can help to address the gap in the literature to enhance our scientific understanding of the range of the 2Gen efficacy as well as aid in the needed treatment of intergenerational trauma among families facing IPV. Such advancements are required to meet the needs of a postpandemic society.

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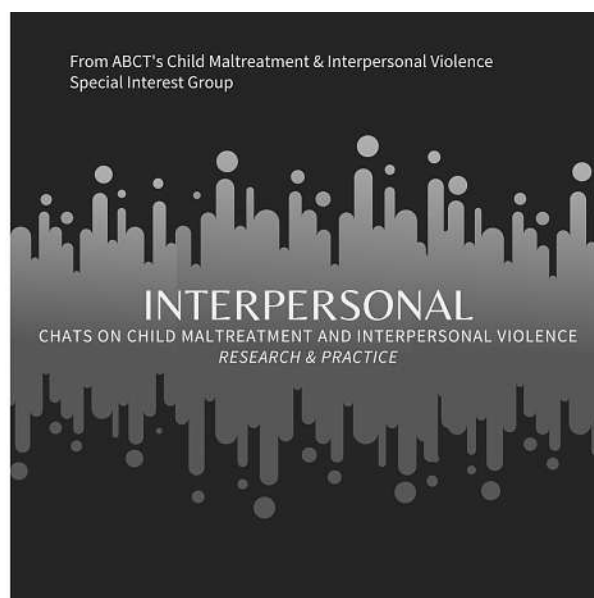
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CLINICAL PRACTICE FORUM

Collaborative Approaches to Reduce Domestic Violence–Related Homicide: Program Description, Outcomes and Lessons Learned

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DOMESTIC VIOLENCE (DV) is a complex public health problem that encompasses physical violence, sexual violence, stalking, and psychological aggression (Breiding et al., 2015). Intimate partner violence, which specifically refers to DV by a current or former romantic partner, is widely prevalent in the U.S. Throughout their life, roughly 1 in 4 women and 1 in 10 men report experiences of intimate partner violence, with the majority of survivors reporting their first experience of violence occurring before the age of 25 (Smith et al., 2018).

There are a variety of negative physical and mental health sequelae resulting from experiences of DV (Black, 2011; Smith et al., 2018). Long-term physical consequences include respiratory conditions (e.g., asthma, bronchitis), gynecological and urinary problems (e.g., urinary tract infections; Loxton et al., 2006), and traumatic brain injury (TBI) from head injuries and strangulation (Baxter & Hellewell, 2019; Kwako et al., 2011). Mental health consequences include major depressive disorder and posttraumatic stress disorder (Ahmadzad-Asl et al., 2016; Stein &

Kennedy, 2001), postpartum depression (Adamu & Adinew, 2018), and anxiety (Ahmadzad-Asl et al.). Domestic violence is also associated with an increased risk of attempted suicide among victims (Indu et al., 2020; Kavak et al., 2018). Evidence suggests that there is an association between victimization and/or perpetration of DV and completed suicides, however, the strength and reliability of the evidence remains unclear in the context of cross-cultural definitions of DV and potential mediating factors (MacIsaac et al., 2017). In addition to these complex physical and mental health consequences, survivors of DV also experience economic and social harms (e.g., financial consequence of job loss, legal services, and/or higher health-care service utilization) (Waters et al., 2004).

One particularly profound consequence of DV is homicide, specifically femicide, or the killing of a woman because of her gender (Campbell et al., 1998). Femicide is often the culmination of ongoing violence but the lack of systemic definitions and data (on the victim-offender relationship and homicide intent) has made it challenging to understand the scope of femicide (Campbell & Runyan, 1998; Stockl et al., 2013). One systematic review found that globally, more than one-third of femicides were committed by intimate partners with prevalence rates being higher in Southeast Asia (59%), the Americas (41%), and Africa (40%) (Stöckl et al., 2013). In the U.S., DV-related homicides constitute 40% to 50% of all femicides (Campbell et al., 2003; Catalano et al., 2009; Cooper & Smith, 2011). Risk factors for DV-related homicide are history of DV, stalking, and estrangement (particularly the combination of physical and legal separation), history of violence by perpetrator, survivor and perpetrator substance use, access and availability to guns, strangulation, and abuse during pregnancy (Aldridge & Browne, 2003; Campbell et al., 2007; Campbell et al., 2003).

Strangulation, or the external compression of the blood vessels of the neck causing reduced blood flow to or from the brain, is a particularly dangerous form of DV that can increase the risk of homicide (Wilbur et al., 2001). Data from a case control study demonstrated that women who experienced strangulation by a partner/ex-partner were 7.5 times more likely to be homicide victims as compared women who did not experience strangulation (Glass et al., 2008). Another study of women who had been strangled in abusive relationships

found that 87% of women had been threatened with death by their abuser; 70% believed they were going to die (Wilbur et al., 2001). Despite the high prevalence of strangulation and prior history of DV among strangulation victims, studies examining victim and system-partner (law enforcement and DV service provider) understanding and response to strangulation have identified a lack of awareness about the impacts and severity of strangulation and resulting TBI among victims and system-stakeholders alike (Haag et al., 2019; Higbee et al., 2019; Nemeth et al., 2019). Further, unlike other lethal mechanisms of DV (e.g., assault with a firearm) evidence of strangulation is hard to detect and document by untrained law enforcement and medical professionals, due to a lack of visible external injuries (Armstrong & Strack, 2016). Until recently, nonfatal strangulation was not treated as a serious crime, often being prosecuted as a simple misdemeanor (Training Institute on Strangulation Prevention, 2020). Combined, these factors impede life-saving service linkage for survivors and successful legal prosecution (Armstrong & Strack).

Survivors and perpetrators interface with numerous systems as a result of a DV incident (Campbell et al., 2007). One study examining femicide and attempted femicide across 11 U.S. cities found that while a small proportion of women directly reached out to DV crisis lines or shelters (2.5%) in the year preceding the woman's death, 42% of women were seen by a health care provider, 25% reported visiting a provider for mental health problems; 30% of women who reported being stalked or harassed reached out to law enforcement and 44% of perpetrators were arrested in the year leading to homicide (Sharps et al., 2001). Thus, policymakers, practitioners, and researchers suggest that collaborative community partnerships between law enforcement, criminal legal partners, medical professionals, psychologists, social workers, and DV social service providers could enhance existing services for survivors, reduce injury, and prevent DV-related homicides (Giacomazzi & Smith, 2004; Reuland et al., 2006; Wilson & Websdale, 2006). Jurisdictions that implement a coordinated community response to DV make more felony arrests of offenders (Bledsoe et al., 2006) and have an increased likelihood that DV survivors will seek help from the criminal legal system in the future (Smith Stover, 2012). Similar, multidisciplinary team approaches have been successful in addressing other, related areas,

including investigating child abuse through Child Advocacy Centers (U.S. Department of Justice, 2000).

The purpose of the present article is to describe the work of two multidisciplinary, collaborative initiatives that share the goal of reducing the incidence of DV-related homicide. The first, the Domestic Violence Multidisciplinary Team (DV MDT), leverages a system of agencies to reduce the risk of lethality at the individual level by addressing needs via case planning and support to a high-risk domestic violence survivor. While the second collaborative work group, the Strangulation Task Force (STF), employs a system-level approach to identify effective practices and resource gaps in order to create a cohesive plan for supporting DV survivors who have experienced strangulation.

Program Description

Setting and Context

The average number of women (35%) and men (31%) in California who survive DV annually is comparable to national estimates (37% and 31% of women and men, respectively; Smith et al., 2018). The California Department of Justice recorded more than 150,000 annual DV-related calls to law enforcement between 2005 and 2014 (Becerra, 2019). From 2010 to 2019, 8% to 12% of all homicides in the state were related to DV (Becerra), compared to the nearly 16% of DV-related homicides occurring nationwide in 2016 (Ertl et al., 2019).

Contra Costa County is located in northern California in the East Bay region of the San Francisco Bay Area. The county is large geographically (804 square miles) and its population of roughly 1.15 million is racially and ethnically diverse (i.e., ~10% Black, 18% Asian, and 26% Hispanic; U.S. Census, 2021). The county is comprised of 26 law enforcement jurisdictions. In 2015, with funding from the Department of Justice, through the Office on Violence Against Women, Contra Costa County was selected as one of four sites nationally to implement a program intended to reduce DV homicides. This program, the Lethality Assessment Program (LAP), provides a brief and effective protocol for law enforcement and other community professionals to identify survivors of DV who are at the highest risk of being seriously injured or killed (via a brief screening tool), and immediately connect them to community-based DV supportive services (Maryland Network Against Domestic Violence,

2020). During this implementation period, two pieces of legislation were passed: Senate Bills 40 and 1331. Senate Bill 40 (SB40), passed in response to the severity of strangulation in DV cases, requires that law enforcement responding to a DV incident (a) inform the survivor that strangulation may cause internal injuries and (b) encourage the survivor to seek medical attention (California Legislative Information, 2020). Senate Bill (SB1331) requires that law enforcement officers receive DV-specific training that includes procedures and techniques for assessing for lethality (California Legislative Information, 2018). To support county-wide programmatic and policy efforts to prevent DV-related homicide, a group of law enforcement, service-providers, and criminal legal partners developed the two DV task forces in an effort to address individual survivors' needs (DV MDT) and system-level responses (Strangulation Task Force). The participating agencies and systems had some contact with each other prior to LAP implementation; however, they largely operated to serve survivors within their own systems, in isolation from each other. In this context, cross-system communication was episodic, focusing on one case at a time. The LAP and the resulting multidisciplinary teams formalized these relationships, establishing a cross-systems partnership that facilitated dialogue on developing a more cohesive county-wide response to

addressing DV. Below we present a description of each collaborative group, highlighting the timeline, goals, activities, and accomplishments (Figure 1).

Domestic Violence Multidisciplinary Team (DV MDT)

Developed in 2016, the purpose of the DV MDT is to review complex DV cases that may benefit from additional resources. Complex DV cases are those where the survivor is experiencing significant barriers accessing supports and services (e.g., limited social support, language access, or immigration status issues) and/or the client is identified as being at high risk for DV-related lethality (as indicated on their LAP screener). The DV MDT is survivor-driven, such that the survivor and their goals are at the center of the team's discussions. Meetings are comprised of representatives from law enforcement, county agencies, and service providers. DV case nominations (<4 per meeting) are made by any of the participating agencies. In advance of the meeting, the nominating agency meets with the survivor to obtain their consent, gather background information, and to identify goals related to their safety and connection to services. Survivor goals are categorized into five domains: (a) civil/legal; (b) health and mental health; (c) law enforcement and criminal court; (d) parent and children's goals; (e) safety net (financial and self-sufficiency). Each

member of the DV MDT is given case information and asked to review their database to identify relevant information in advance of the case being presented, including to identify what services and resources the survivor has already been connected to. In the instances when a client's consent is unable to be obtained prior to the meeting (e.g., because the client cannot be contacted), the DV MDT discusses the case without any identifying information to organize services and support for the client and their needs.

Goals

The DV MDT operates in pursuit of short- and long-term goals. Short-term goals (to be achieved in the first year), are as follows: (1) review >25 high-risk DV cases; (2) ensure that >35% of reviewed cases were from a high-incident, low-resource region of the county; (3) close >75% of cases within 3 months of nomination as a result of survivor's goals being met; (4) reduce the incidence of re-assault (<10%) during the case review time frame. While addressing the short-term goals of each of the survivors, the DV MDT is simultaneously making progress towards their long-term goals, which include: (1) improve the number of services available to high-risk DV survivors in the county; (2) offer a wider range of culturally responsive services; (3) expand the geographic reach of DV services throughout the county; (4) enhance cross-sector collaboration and

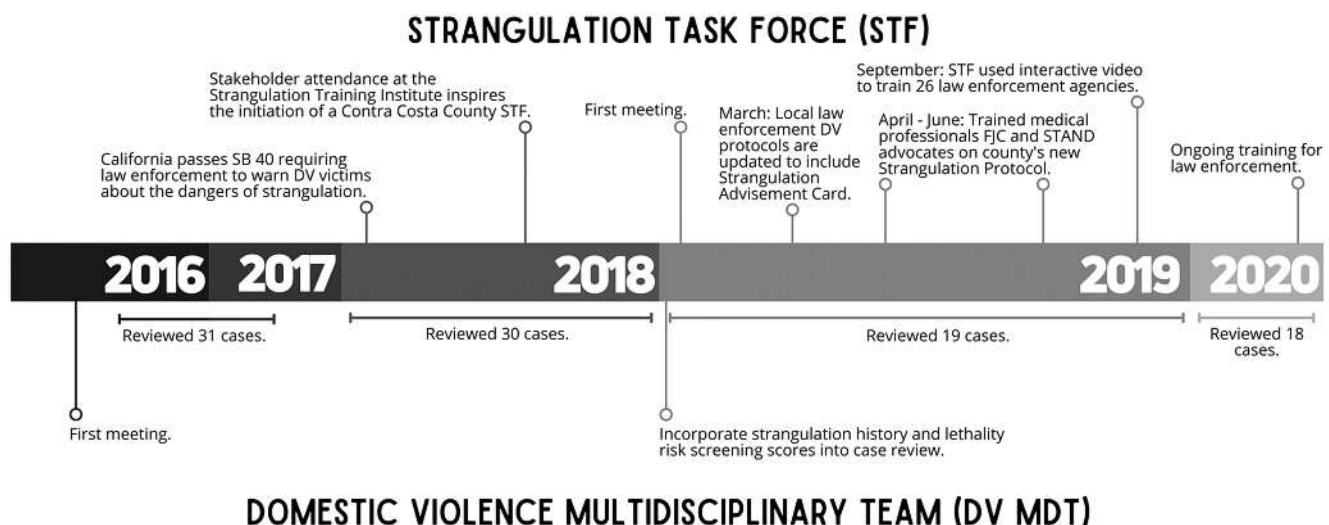


Figure 1. Overview of Collaborative Team Timelines and Activities (2016-2020)

Note. Figure 1 provides an overview of the activities that each of the two multidisciplinary, collaborative initiatives engaged in in the context of relevant policy and programmatic changes from 2016 to 2020. Activities the Strangulation Task Force (STF) engaged in began in 2019, and are presented in the top half of the figure (above the dated timeline). The activities of the Domestic Violence Multidisciplinary Team (DV MDT) began in 2016 and are presented in the lower half of the figure (activities presented below the dated timeline).

knowledge about supports and services available to DV survivors; (5) identify DV-specific programmatic gaps across participating systems.

Activities and Accomplishments

Figure 2 provides an overview of DV MDT meetings, including the number of cases reviewed and closed, and number of survivor connections to partner agencies. From 2016 to 2020, over the course of 51 meetings, the DV MDT reviewed 118 high-risk or complex DV cases. Survivors were connected to a total 301 partner-agencies. Of the cases closed for review, an average of 60% of goals set by survivors were achieved (range: 50% [2018] to 78% [2019]). Figure 3 presents a brief case study highlighting the success of one DV survivor whose case was reviewed. The case study highlights the variety of agencies involved and the breadth of services and support provided by the DV MDT, including therapeutic services.

The membership of the DV MDT has grown considerably over the course of its implementation, reflecting both an increase in size (i.e., number of members) and sector coverage. At the start of the DV MDT, the collaborative included 146 members from 26 agencies, with representation from a DV service agency ($n = 1$), police departments ($n = 5$), criminal legal agencies (e.g., Probation Department; $n = 8$), social service agencies (e.g., Counseling Options and Parent Education [C.O.P.E.]; $n = 14$), county agencies (e.g., Adult Protective Services; $n = 4$), and health care organizations (e.g., Kaiser Permanente; $n = 1$). Individual members from these agencies include social workers and clinicians. In 2020, the number of participating agencies increased to 102. DV MDT agency membership grew through a combination of targeted outreach to agencies in under-represented regions of the county, program and policy implementation (i.e., LAP and SB40), word of mouth from participating agencies, and use of video conferencing (e.g., Zoom) to facilitate meeting attendance. The expansion of the DV MDT has allowed the working group to identify a number of broader, system-wide issues, including the need for additional training on DV for key stakeholders in reducing DV in the county (e.g., judges), challenges identifying high-risk DV cases (e.g., not all law enforcement departments use LAP), and discrepancies in mandated child abuse reporting (resulting from DV incidents) that might limit disclosure of DV across agencies and systems.

Notably, in line with the stated goals, the monthly meetings also allow for learning opportunities for the DV MDT membership. These learning opportunities cover a broad range of topics: organizations presenting an overview of their agency's mission, and program offerings specific to DV survivors; training on local DV-related policies and/or requirements (e.g., mandated reporting requirements presented by Child and Family Services); reviewing DV-related screening tools (e.g., DV-related lethality screening for survivors [LAP]); offenders' risk of future violence perpetration [i.e., Ontario Domestic Assault Risk Assessment; ODARA] (Waypoint Center for Mental Health Care, 2020); receiving relevant content education (e.g., stalking prevalence and risk for DV-lethality).

The DV MDT meetings have continued on a monthly basis throughout the COVID-19 pandemic. This sustained collaboration has been critical given that rates of DV have increased nationally (by 8.1%; Piquero, 2021) and locally (Cabanatuan, 2020) during the pandemic, leading DV to be referred to as "a pandemic within a pandemic" (Evans et al., 2020). Several characteristics of the pandemic and resulting public health policies (e.g., shelter-in-place orders) have created conditions believed to contribute to this increase, including increased unemployment and household

stress associated with childcare and financial insecurity. In this vein, several unique issues emerged for DV survivors during this time that have impacted how DV MDT partners collaborate to coordinate supports and services. Examples of such issues include: participating agencies have observed an increase in the number and severity of calls from survivors seeking assistance (Cabanatuan); survivors have experienced difficulties obtaining restraining and emergency protective orders due to court closure; difficulties identifying housing solutions for survivors (i.e., shelters are closed). Further, system partners have experienced difficulties navigating rapidly evolving policies that impacted their ability to provide and/or link survivors to services (e.g., ability to identify short-term housing). Members of the DV MDT have worked collaboratively to overcome these barriers as much as possible. For example, in response to the limited housing availability, members of DV MDT worked to partner with organizations to provide financial support for rent assistance or motel vouchers.

Next Steps

In 2021, in addition to continuing case planning for DV survivors, the primary goal for the DV MDT will be to evaluate how participating in the collaborative has impacted agencies' understanding and knowledge of local DV services and sup-

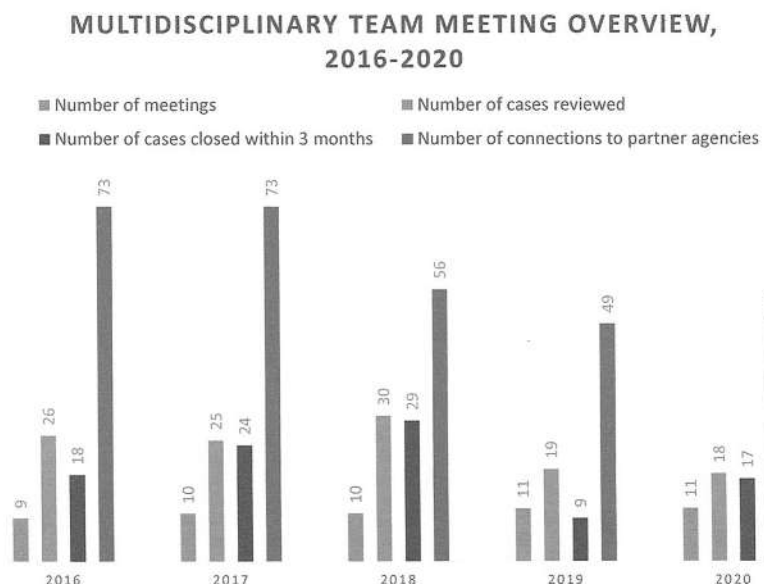


Figure 2. Domestic Violence Multidisciplinary Team (DV MDT) Meeting Outcomes, 2016-2020

ports (in line with the group's long-term goals). Additionally, the DV MDT will seek to better understand how participating in the collaborative shaped how each agency is able to support DV survivors. For example, key questions of interest include: What benefit did participating in the DV MDT bring to your system's work? and How did participating in the DV MDT change the type of services/support your system provides to DV survivors?

Strangulation Task Force (STF)

In late 2018, after attending a training with the Training Institute on Strangulation Prevention in San Diego (CA), a

health care provider contacted the Family Justice Center (Concord, CA) to express interest in creating a local Strangulation Task Force. Leadership at the Family Justice Center reached out to existing LAP community partners to gauge interest and plan for the development and implementation of this multidisciplinary task force. Team members include representation from a DV service agency ($n = 1$), police departments ($n = 3$), criminal legal agencies (e.g., Office of the District Attorney; $n = 1$), and health care organizations ($n = 1$). The STF includes a total of 13 members, across the 6 agencies.

Nominating agency: In August 2017, a Deputy District Attorney nominated Maria's high-risk case for DV MDT review.

Case overview: Maria is an undocumented, monolingual Spanish speaking, 43-year-old mother of three. She survived a violent attack from her husband. Her teenage son witnessed the attack.

DV MDT review and connections: Maria's four goals included that she would like to: 1) file for divorce and sole custody of her children (Civil/Legal); 2) obtain ongoing medical care and therapy (Health and Mental Health); 3) acquire a Criminal Protective Order (Law Enforcement and Criminal Court); and 4) engage children in therapy (Parent and Child). The DV MDT reviewed the case and created a plan of action to support the successful completion of the survivor's goals. Three examples of case planning activities including connecting Maria to legal aid, housing assistance, and therapeutic services (described below).

| | |
|----------------------|--|
| LEGAL AID | Bay Area Legal Aid's Regional Immigration Coordinator took on the representation for Maria's nonimmigrant status (U-visa) case. A U-visa is for survivors of certain crimes who provide assistance to law enforcement or government officials in investigating criminal activity. The Deputy District Attorney (DA) and the DA's Victim/Witness Advocate collaborated to ensure that the survivor's supporting documentation to receive temporary immigration benefits (e.g., I-918 Supplement B, Certification of Cooperation) was signed off; allowing Maria to receive public benefits. |
| HOUSING | The Family Justice Center, a service agency assisting families who have experienced violence, helped Maria find an apartment and connected Maria to Catholic Charities that provided rental assistance for the first few months at her new home. Advocate organizations worked with the victim to ensure that she would receive relocation reimbursement through The California Victim Compensation Board. |
| THERAPEUTIC SERVICES | Maria began individual therapy with a Spanish speaking therapist at COPE Family Support Center. The costs associated with therapeutic services were paid by The California Victim Compensation Board. |

Case Closing: Maria's case was nominated in August 2017 and her goals were achieved October 2017. When the Family Justice Center last spoke with Maria over the phone, she was crying tears of joy for the overwhelming support she had been given.

Figure 3. Domestic Violence Multidisciplinary Team (DV MDT) Case Study
Note. "Maria" provided their consent to have their case discussed as part of the Domestic Violence Multidisciplinary Team (DV MDT) meeting. The details in the case presented above are significantly deidentified to protect the survivor's identity.

Goals

The STF has two goals. The first is to raise awareness of the available supports and services for survivors of strangulation and community agencies serving those survivors. The second goal is to ensure county-wide implementation of California SB40 by developing a unified response to incidents of strangulation. To achieve these goals, STF meetings, coordinated and facilitated by leadership from the Family Justice Center, meet on a quarterly basis (1.5 hours).

Activities and Accomplishments

During the initial meetings, the STF realized that DV-specific law enforcement protocols had not been updated in the county in 10 years (2009). Further, the existing protocols were not responsive to the SB40 legislation. Consequently, the STF outlined a set of standardized procedures to improve law enforcement's response to strangulation. The resulting procedures include that when law enforcement respond to a DV incident, they provide a verbal warning informing survivors that strangulation may cause internal injuries, encourage survivors to seek medical attention, and dispense a Strangulation Advice Card (Figure 4). The Strangulation Advice Card reinforces the verbal warning provided to the survivor by outlining the risk of morbidity and mortality resulting from strangulation, describing the signs and symptoms of strangulation, and provides information to a health care provider regarding the risks associated with strangulation should the survivor seek medical services following the incident. The revised protocols include language around specific survivor groups (e.g., human trafficking, LGBTQAI). Once the revisions were finalized, members from the District Attorney's Office presented the protocols to the Police Chiefs, where they were accepted and adopted by all law enforcement jurisdictions in the county.

To support the new protocols, the STF developed and implemented trainings for law enforcement, health care professionals, and DV service providers (including DV-advocates) throughout the county. The goal of the training is to educate stakeholders on strangulation-specific health risks, SB40 legislation, and the newly enacted policies. Trainings lasted between 30 and 120 minutes, depending on the agency and available resources; police officer trainings were brief (30 minutes) as they were included as part of other required training opportunities. A train-the-trainer model

was employed to facilitate dissemination. Task force champions (n = 5) were sent to the Training Institute on Strangulation Prevention's (Alliance for Hope International; San Diego, CA) 4-day training (Training Institute on Strangulation Prevention, 2020). Upon completion, champions facilitate trainings with other jurisdictions. The training addresses strangulation from medical, law enforcement, criminal legal (i.e., District Attorney) and DV-advocate perspectives. For example, the trainer presents a strangulation case study and describes how a DV strangulation survivor may present or interact with each of the participating systems. There is an emphasis on noting how each sector can uniquely address the survivor's needs. To date, train-

ings have been facilitated with 15 of the 26 law enforcement jurisdictions and the three largest medical providers in the county (Kaiser Permanente, John Muir, Contra Costa County Regional Medical). Trainings are ongoing and are currently conducted via Zoom.

Last, the task force incorporates data collected as part of the county-wide LAP into their planning efforts. The LAP protocol dictates that when responding to a DV incident, police officers implement an 11-question screener to identify survivors' risk of homicide. Data gathered from this screener is used to provide survivors with information about their risk of DV-related homicide and refer individuals identified as high-danger to services. One of the

screening items asks the survivor whether or not the perpetrator involved in the incident has ever tried to choke them. The STF reviews these data to better understand the prevalence of strangulation, the risk profiles of DV survivors experiencing strangulation, and inform future training and outreach. Examples of STF outreach efforts include contacting culturally specific agencies about the revised protocols and inviting them to join the STF, and presenting at community events and health fairs to improve public understanding of the risks of strangulation.

Next Steps

There are several planned next steps for the STF. First, the STF is focused on expanding outreach of their training efforts

| LAW ENFORCEMENT STRANGULATION ADVISEMENT TO VICTIM | | | | | |
|--|--|--|--|--|--|
| <ul style="list-style-type: none"> After a strangulation assault, you can experience internal injuries with a delayed onset of symptoms, usually within 72 hours. These internal injuries can be <u>serious or fatal</u>. Stay with someone you trust for the first 24 hours and have them monitor your signs and symptoms. Seek medical attention or call 911 if you have any of the following symptoms: difficulty breathing, trouble swallowing, swelling to your neck, pain to your throat, hoarseness or voice changes, blurred vision, continuous or severe headaches, seizures, vomiting or persistent cough. The cost of your medical care may be covered by your state's victim compensation fund. An advocate can give you more information. The Stand! (Domestic Violence Crisis Center) hotline number is 1-888-215-5555. <p>"As a law enforcement officer, I have a duty to warn you that strangulation is serious and can cause internal injuries, brain damage and/or delayed health consequences such as strokes, thyroid issues, miscarriage and/or death. Research shows that if you are strangled even one time, you are 750% more likely to be killed by your partner. I strongly encourage you to seek immediate medical attention at an emergency department and ask for support from an advocate."</p> | | | | | |
| SIGNS | | SYMPTOMS | | YOUR SIGNS | |
| <ul style="list-style-type: none"> Scratch marks Pinpoint red spots <ul style="list-style-type: none"> - On eyes - On scalp/face Bruising Swollen tongue/lips | <ul style="list-style-type: none"> Ligature marks Fingernail impressions Cuts/abrasions Bloody/broken nose | <ul style="list-style-type: none"> Voice changes Swallowing changes Neck pain Nausea/vomiting Breathing changes | <ul style="list-style-type: none"> Behavioral changes Vision Changes Involuntary urination or defecation Hearing changes | Date: _____ Signs/Symptoms: _____ Date: _____ Signs/Symptoms: _____ | |

| NOTICE TO GIVE MEDICAL PROVIDER | |
|--|--|
| <ul style="list-style-type: none"> In patients with a history of a loss of consciousness, loss of bladder or bowel control, vision changes or petechial hemorrhage, medical providers should evaluate the carotid and vertebral arteries, bony/cartilaginous and soft tissue neck structures and the brain for injuries. Life-threatening injuries include evidence of petechial hemorrhage, loss of consciousness, urination, defecation and/or visual changes. If your patient exhibits any of the above symptoms, medical/radiographic evaluation is strongly recommended. Radiographic testing should include: a CT angiography of carotid/vertebral arteries or CT neck with contrast, or MRA/MRI of neck and brain. Consult Neurology, Neurosurgery and/or Trauma Surgery for admission. Consider an ENT consult for laryngeal trauma with dysphonia, odynophagia, dyspnea. Discharge home with detailed instructions to return to ED if neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens. | |
| Date of Incident: _____ Police Department: _____ Police Report Number: _____ Officer Name/Badge Number: _____ | |

Figure 4. Strangulation Advisement Card created by the Strangulation Task Force

to include additional medical service providers (e.g., emergency department and primary care settings), clinicians (e.g., social workers, mental health professionals), and criminal legal partners (e.g., judges, court staff). Training for judges and court staff will focus on informing court officers on the increased risk of strangulation on DV survivors when processing cases. Additional trainings for clinicians may include, for example, review of emergent policies in handling strangulation-specific cases (e.g., protective orders, documentation) and identifying signs of strangulation when survivors are unable to recall their experience as a result of cognitive impairment or memory loss associated with strangulation, or hesitant to disclose their experience due to fear of unintended consequences (e.g., involvement of child protective services). In addition, the STF is interested in expanding their efforts to include training a forensic nurse in strangulation identification and treatment. With the addition of the forensic nurse, judges, and court staff, the STF plans to develop a strangulation response team similar to a Sexual Assault Response Team (National Sexual Violence Resource Center, 2020), a community-based multidisciplinary team that coordinates the response to survivors of sexual assault. This team would provide assistance to survivors immediately following their assault, beginning with a forensic exam. The team would also provide services akin to the case planning work being done as part of the DV MDT, where the response team would help survivors navigate the complicated network of medical, therapeutic, criminal legal, and community services available to support them.

Lessons Learned

Facilitators and Challenges to Implementing a Multidisciplinary Team to Address DV-Related Lethality

There are a number of facilitators that supported the work conducted by the DV MDT and the STF. The most notable facilitator across both collaborative groups was to have a unifying, county-wide goal of improving service provision for survivors of DV. Having partner agencies align their activities with a cohesive purpose sustained momentum and deepened agency investment in team activities. Further, having existing and ongoing partnerships (e.g., established via LAP) was integral to developing and sustaining these multidisciplinary teams. Another facilitator, particularly relevant to the DV MDT, was open

communication between system partners, which was critical to the success of client case and safety planning. Partners needed to be able to identify and address barriers both within and across agencies to address client needs to improve their overall health and well-being. Relatedly, the COVID-19 pandemic led multidisciplinary partners to regularly review emergent programs and policies that impacted how DV survivors interacted with their respective system. Through this process, system partners were able to rapidly identify challenges and pool resources to navigate these barriers much more efficiently than if operating in siloes.

There were several implementation challenges identified across the collaborative groups: funding, scope of the program, and cross-system collaboration. To date, the primary challenge for both collaborative groups is funding. While some funding was available, it was limited to supporting a small percent effort of one member of a participating agency. For example, in the DV MDT, funding from the Improving Criminal Justice Responses to Sexual Assault, Domestic Violence, Dating Violence, and Stalking program (Office of Violence Against Women, 2021) supported a member of the coordinating agency to plan meetings, lead training activities, and facilitate protocol revisions. Individual agencies did not receive any financial support to participate in collaborative meetings or programmatic work. To address the funding shortfall, the partnerships leveraged ongoing initiatives (e.g., LAP) and other county-wide partnership to support the work. The second challenge is related to scope of the program; Contra Costa County (CA) is home to 26 law enforcement jurisdictions. In thinking about developing or implementing new policies and procedures, such as those outlined as part of the STF, there is an incredible amount of outreach, advocacy, and planning that is necessary to successfully execute county-wide changes. Each participating agency has their own system to navigate to facilitate system procedural updates. For example, to update the advisement documentation for law enforcement, the STF had to notify all 26 agencies that the form was being changed, ensure that obsolete versions are removed from the shared law enforcement database, and provide training so officers are not inadvertently using antiquated protocols (i.e., carrying old versions in patrol cars). The third challenge is related to fostering new collaborations. For example, the STF is interested in collaborating with 9-1-1 dispatchers and

fire departments; however, achieving buy-in with these systems, for which addressing strangulation is not standard practice, is challenging. All of the partners outlined above would be new to the work; requiring significant outreach and education to inspire interest. This challenge has been exacerbated by the final disruption to this work—the ongoing coronavirus pandemic. COVID-19 has led to the overwhelm of many systems, resulting in a shift in priorities and resources. This is particularly problematic given that the severity of DV has increased in the county, and the typical systems of care and social service delivery (e.g., housing) have been disrupted.

Based on the experiences of the DV MDT and the STF, we propose several recommendations for developing multidisciplinary teams to address DV-related harms (including mortality):

1. *Identify community need.* There may be no single model of a multidisciplinary team response that successfully addresses DV across all communities. In order to be maximally effective, the needs of the community should directly inform the depth and breadth of the multidisciplinary team's work. The need to develop a multidisciplinary team may be in response to new legislation, new resources or sources of funding, or an identified service gap. Importantly, community needs evolve and therefore should be examined on an ongoing basis to inform the long-term efforts and activities of multidisciplinary teams addressing DV-related harms. Related, how these needs are communicated or are presented will differ in each system and should be reviewed and discussed on an ongoing basis. Social workers and victim advocates may be in a unique position to understand these needs as they assist survivors throughout their contact with a variety of systems (e.g., health, legal).

2. *Develop a cohesive goal or vision.* Individual members and groups may enter into multidisciplinary teams with different expectations and system-responsibilities with respect to DV-related outcomes or goals, leading to confusion or conflict. During the early stages of developing a multidisciplinary team, participating agencies should communicate their individual goals, successes, and challenges with respect to addressing DV-related lethality. For example, some systems have mandated reporting requirements that may shape where and how survivors dis-

close their experiences and seek care. These conversations will help identify shared priorities, barriers to service delivery and case planning, or areas of growth, all of which are critical components to developing a unified agenda. Once the goal is determined, it should be formalized (e.g., through member agreements, team guidelines).

3. *Regularly review system-specific and county-wide policy and program changes.* Programs and policies that impact how DV survivors interact within one system can change rapidly and may not always be communicated to other systems. Having standard procedures for when and how to present programmatic and policy changes at multidisciplinary team meetings will allow for collaborating systems to prepare for changes that may impact how a survivor interacts with their system, thus reducing negative impact.

4. *Establish financial resources.* Funding is critical to support the successful implementation and maintain agency engagement in multidisciplinary teams like the DV MDT and STF. Resources could support a full-time project coordinator, training and technical assistance for participating agencies, community education, partner outreach, and data collection and evaluation.

5. *Center survivor needs.* Finally, it is essential that all efforts to address DV-related homicide, including the implementation of multidisciplinary teams, center the needs of the survivor. Each policy, program, or initiative that is reviewed or proposed should be interrogated to ensure that it is not introducing further harm to survivors and their families. Additionally, participating agencies and systems need to realistically examine where and how their mission, vision, or culture may perpetuate harm for DV survivors, with a particular focus on survivors from vulnerable or marginalized groups (e.g., racial, ethnic, sexual or gender minorities), and actively work to reduce these harms.

Conclusion

Domestic violence-related harms, including homicide, are preventable. However, no single agency or discipline possesses sufficient resources or expertise to effectively resolve DV and its consequences. Multidisciplinary team approaches can be employed to improve service delivery and care planning for indi-

vidual survivors of DV. These multidisciplinary teams can also be used to strengthen system-wide responses to DV to ensure that they are both coordinated and comprehensive. By employing these approaches, lives can be saved and communities can be strengthened.

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Mental Health Service Delivery for IPV Victims During the COVID-19 Pandemic: Technology as a Path Forward

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AS HUMAN BEINGS are social creatures, limited social interactions can have deleterious mental health effects (Argyle, 2017). The current COVID-19 pandemic has led to social distancing recommendations that have resulted in increased negative mental health concerns such as heightened stress, depression, and anxiety (Montano & Acebes, 2020). Of particular relevance to this article, lockdown measures have impacted rates of intimate partner violence (IPV; Zero & Geary, 2020).

According to the 2015 National Intimate Partner and Sexual Violence Survey (NISVS) data brief, IPV is defined as including “sexual violence, stalking, physical violence, and psychological aggression,” which affects millions of Americans each year (Smith et al., 2015). Specifically, throughout their lifetime, 1 in 4 women and 1 in 10 men experience sexual violence, physical violence, and stalking by an intimate partner and report IPV-related harm (Smith et al.). According to Gosangi et al. (2020), the frequency and severity of physical IPV were higher in 2020 when compared with data from 2017 to 2019. Gosangi et al. also concluded that victims are reporting abuse and reaching out for health care services later in the cycle of abuse. Research suggests that the increase in IPV during COVID-19 is likely exacerbated by the intersection of mandates to socially distance and the culmination of social factors that have been impacted due to the pandemic (Evans et al., 2020). Inequalities in social determinants are magnified during times of global crisis (Cénat et al., 2020; Kofman & Garfin, 2020). For example, economic independence plays a crucial role in IPV prevention; however, the pandemic has made

financial struggles that exacerbate IPV among intimate partners worse due to overwhelming furloughs and job loss (Evans et al.). Delays in reporting and seeking health care services are also a consequence of the mandates for social distancing. During the height of the pandemic, individuals were instructed to stay home or seek telehealth services for nonurgent medical conditions, which may have resulted in delays in seeking health care services.

The health care system is a major avenue for victim identification. Decreased access to health care and contact with health professionals would inevitably reduce victim identification and opportunities for victims to divulge their abuse (Evans et al., 2020). Although they are convenient and help provide much-needed access to services, home-based teleservices may not be private, with abusers potentially being within the same vicinity and within earshot of victims. Thus, filing reports can be unsafe when victims are unable to leave their abusive environments, potentially perpetuating IPV victimization (Kofman & Garfin, 2020).

Nevertheless, to reduce the spread of the coronavirus by complying with social distancing practices while also providing much-needed mental health services, many mental health organizations have begun thinking about more useful service delivery methods (Zero & Geary, 2020). Digital and online tools have gained popularity as the pandemic has progressed (Ghai et al., 2020). Indeed, the Department of Health and Human Services (DHSS) has provided a list of 10 teleconferencing platforms (e.g., Zoom, Doxy.me) that are Health Insurance Portability and Accountability Act (HIPAA) compatible (DHSS, 2021). For

marginalized and lower-income populations who disproportionately experience IPV and have historically had less access to mental health care (Davidson et al., 2019), telehealth might enable greater access to psychological services. Of note, for the past few decades, health care has steadily been moving towards more provision of telehealth services as a means of reaching underserved populations (Alegría et al., 2016). However, the COVID-19 pandemic and social distancing recommendations have fast-tracked the need for telehealth (Reay et al., 2020; Zhou et al., 2020).

This paper focuses on outlining factors to consider for mental health service delivery during the COVID-19 pandemic. More specifically, we aim to discuss the advantages and disadvantages of the rapid shift in the use of technology-based programs within family violence crisis centers. First, we discuss the advantages and disadvantages of the use of technology with IPV populations. Specifically, we are interested in how teleservices (particularly telehealth) assist and hinder service delivery and survivor outcomes. Second, two reputable and longstanding violence-prevention organizations in the Greater Houston Area (Houston Area Women's Center [HAWC] and Montgomery County Women's Center [MCWC]) will be used to illustrate some of the benefits and advantages resulting from the abrupt shift to telehealth-based service delivery for IPV victims and survivors. Both HAWC and MCWC are in the process of making adjustments to their programming. They provide insight through their first-hand experience of what needs to be done for efficient and effective care using technology. Our recommendations are based on empirical research and tested and tried methods through HAWC and MCWC. Ultimately, this project aims to provide a guiding framework for organizations that work with IPV victims and are in the process of transitioning some or all of their operations to teleservices.

Advantages and Practicalities of Telehealth

The different telehealth approaches to mental health—videoconference, telephone, smartphone apps, and even email—may have unique benefits and drawbacks in terms of both performance and access for IPV victims. Varker et al. (2019) described telehealth as “the next big frontier in the efficient and effective delivery of health care” (p. 621), and telehealth has become an increasingly routine compo-

nent of mental health service delivery throughout the world (Haun et al., 2018). The advantages of using telehealth include that it may be more cost-effective and provide greater access to health care for underserved populations, such as individuals with limited mobility (Egede et al., 2020), individuals living in rural communities where service access is limited (Schopp et al., 2006), and IPV victims (Adams & Campbell, 2012). Many IPV victims prefer to stay discreet about receiving mental health treatment (Constantino et al., 2015), and telehealth may be a good option in order to address this issue. Clients receiving telehealth treatment have expressed less anxiety about being seen entering a mental health clinic or service facility (Kramer et al., 2013). For some IPV victims, telehealth may be the sole avenue to obtain support and resources. Telehealth provides an additional opportunity for IPV screenings and supports such as contraceptive counseling, mental health counseling, and safety planning (Zero & Geary, 2020). The different telehealth options for treatment and other beneficial telehealth features, such as flexibility, cost-effectiveness, improved accessibility, and remote delivery, reduce service delivery barriers that frequently hinder marginalized IPV populations from both treatment initiation and continuity of care (Gerber et al., 2020).

Moreover, the delivery of mental health treatment through telehealth has been found to be effective and feasible for IPV victims. Hassija and Gray (2011) investigated the efficacy and viability of videoconferencing technologies in the care of 15 female rural domestic abuse and sexual assault survivors and discovered significant decreases in PTSD and stress, along with high client satisfaction with videoconferencing. Tschirch et al. (2006) found that telemental health was helpful in addressing unmet needs of IPV victims. Further, email interaction and text messaging with a mental health provider has shown to be protective for IPV victims (Constantino et al., 2007; Constantino et al., 2014). Constantino et al. (2007) demonstrated that email interaction was useful in providing information, screening, safety instructions, and follow-up care (Constantino et al., 2007), and Constantino et al. (2014) showed that text messaging improved study participants' confidence in their knowledge of IPV and willingness to intervene in IPV situations.

Finally, telehealth has allowed many individuals to access mental health treatment during the COVID-19 pandemic

while keeping them safe (Gerber et al., 2020). By receiving mental health care through telehealth, clients avoid being at risk of contraction of the coronavirus as they do not have to commute, use public transportation, be in touch with other people on their way to treatment, or be in a room with their mental health provider (Zhou et al., 2020). Moreover, parents are spending more time with their children at home during the COVID-19 pandemic due to social distancing regulations that have altered families' lives and routines, as many schools have moved to distance learning (Reay et al., 2020). Therefore, telehealth allows parents to receive mental health care without going out of their way to arrange for childcare provision, which might be limited during the pandemic (Reay et al.). In general, telehealth has proven to be a practical and effective alternative to delivering mental health treatment during the COVID-19 pandemic that minimizes virus transmission risk for both clients and clinicians (Zhou et al.).

Disadvantages and Impracticalities of Telehealth

Telehealth cannot overcome all barriers to mental health care access among IPV populations, and it may pose new challenges. For example, rural and underserved communities may not have reliable internet connections, limiting the use of telehealth platforms that require internet (Berryhill et al., 2018). Not only do clients need to ensure that their internet connectivity is reliable, but providers also need to address any connectivity issues that may interrupt treatment (Chakrabarti, 2015). Videoconferencing session interruptions due to unreliable internet connection is of professional concern as it may decrease clients' adherence and influence the therapeutic alliance (van Gurp et al., 2015). To address such issues, Zhai (2020) recommends creating a database that can help identify broadband barriers, especially in underserved regions, and concentrating on projects that can expand internet services in these communities. Additionally, clinician training should also focus on addressing technology issues to help clients (Zhai, 2020).

Therapists working with both individuals and groups should be mindful of confidentiality and safety (Weinberg, 2020). Privacy and confidentiality may be threatened through online platforms as breaches can occur due to unsecured electronic files and limited privacy in a client's home (Kramer

et al., 2013). In the context of IPV victimization during the current pandemic, the lack of privacy and confidentiality may be pronounced as victims may occupy the same space as their abusers, who may be monitoring their activities. Living with your abuser with limited opportunity for escape can also impact access to treatment and compromise adherence to treatment. That is, victims may fear that their abuse may retaliate against them for seeking treatment and be less inclined to access treatment or be forthcoming during therapy sessions (Zero & Geary, 2020). Indeed, safety, privacy, and client consent are among the most significant concerns reported by therapists who use telehealth services (Reay et al., 2020). While of considerable concern, measures can be taken to ensure clients' confidentiality in cyberspace. Specifically, telehealth can be safe if providers take necessary measures such as protecting client/patient health information (e.g., use of HIPAA-compliant technology, encrypting and password protecting protected health information) and educating clients about steps they can take to improve safety (e.g., use of VPN and antimalware programs; having sessions in one's car, which might offer a more private space; and discussing a safety plan; Kramer et al., 2013). In addition, telehealth modalities that do not require verbal communication, such as app-based mental health treatment, e-mail, and text messaging may be initially suitable to mitigate privacy concerns when clients are fearful that their partners may be listening in on their conversations (Lustgarten et al., 2020). Certainly, therapy cannot occur through text or email alone. However, encouraging IPV clients skeptical of telehealth to use these platforms before altogether opting into more audio and video-based systems may limit fears, increase comfort levels, and enhance treatment seeking.

Although the aforementioned steps can reduce privacy and confidentiality concerns, they may also be barriers to treatment as clients have varying levels of digital literacy. Clients may find taking these steps complicated, reducing their treatment adherence (Yuen et al., 2012). Thus, it behooves organizations to educate clients about telehealth platforms and seek feedback from clients about their level of comfort using telehealth. Another barrier to telehealth use is provider skepticism, that is a result of clinicians' concerns related to establishing a successful alliance with clients (Jones et al., 2014), reduced non-verbal communications (e.g., gestures,

tone, mannerisms; Khatri et al., 2014), inadequate training, lacking experience in technology-based interventions (Douthitt et al., 2015), and difficulties with medical reimbursement (Brooks et al., 2013). While clinician satisfaction and overall attitudes are mostly positive and tend to further improve with use and experience in telehealth approaches, provider skepticism and the negative attitudes of clinicians are potential barriers to the dissemination and implementation of telehealth interventions (Connolly et al., 2020). As such, training programs and organizations shifting to telehealth service delivery models should provide the necessary telehealth training in order to increase clinician competence with telehealth services. Moreover, ethical and legal concerns (Egede et al., 2020), regulatory issues (Chakrabarti, 2015), requirements for licensing (Egede et al.), and the fact that paying for these services would require changes in insurance billing (Alegria et al., 2016) has also thwarted advancements in telehealth. Therefore, legislation and regulation should also advance in making it easier for clinicians to deliver health care (Zhai, 2020).

Montgomery County Women's Center (MCWC)

The Montgomery County Women's Center has been operating the only family violence and rape crisis center in Montgomery County, Texas, for nearly 40 years. Montgomery County, Texas, is located in the Southeast portion of Texas with a population of 590,925 residents, a median age of 37.5 years old, and a median household income of \$76,929. English is the primary language in Montgomery County and the racial/ethnic breakdown includes 21% White/Hispanic, 65% White/Non-Hispanic, 4.84% Black or African American/Non-Hispanic, 2.5% Other/Hispanic, and 3.05% Asian/Non-Hispanic (Data USA, n.d.a.). Today, in addition to emergency shelter and transitional housing, survivors have access to supportive services. These services assist in the facilitation of trauma-informed, person-centered survivor restoration, including psycho-educational support groups (e.g., on unhealthy relationship dynamics) and classes on nutrition, cooking, safety planning, parenting, job readiness and financial literacy/money management. Translation is provided to survivors with limited English proficiency. Once a week, an agency attorney conducts a legal clinic at our shelter to answer questions related to civil and

legal assistance, and representation. MCWC attorneys also provide survivors with assistance with protective orders and other civil legal aid. In addition, survivors have access to professional licensed counselors in partnership with coaches to identify needs and formulate service plans.

Despite the COVID-19 pandemic, MCWC continued to operate the only community-based, 24-hour family and sexual violence crisis response center in Montgomery County. In 2019, the MCWC counseling and advocacy/medical accompaniment programs provided services to 1,290 and 798 victims/survivors, respectively. Sadly, MCWC's ability to maintain previous organizational capacity was impacted during the pandemic. In 2020, the same programs provided services to 907 and 614 victims/survivors, respectively.

The decline in medical accompaniment services that occurred since March can be credited to public health protocols and social distancing measures. Like many community organizations across the U.S., MCWC discontinued medical accompaniments during the second week of March. However, by the end of March, MCWC staff resumed accompaniments by appointment to the local child advocacy center and reinstated its 24-hour crisis response at the Montgomery County Hospital District. During this period, all other requests for medical advocacy services were responded to via remote and virtual platforms.

In November of 2020, staff resumed accompaniment to area hospitals. Anecdotally, however, many victims have reported feeling fear with regards to spending time in the Emergency Room and/or in MCWC offices, which seems to illustrate a common narrative that has emerged since the onset of the COVID-19 pandemic: victims are staying home (often a detriment to personal safety) out of fear of contracting coronavirus. Regardless, we know that Montgomery County has been profoundly and adversely affected by the COVID-19 pandemic. Most notably, in 2020, MCWC crisis hotline advocates responded to 65,011 hotline calls. To put this in perspective, during the same period of the previous year, MCWC received 49,618 calls, representing a 31% increase in hotline calls. This data confirms what we already know: the prevalence and severity of family and sexual violence has exponentially increased since the onset of the COVID-19 pandemic.

Throughout the pandemic, MCWC have experienced a higher-than-average crisis call volume, which aligns with other voices in the family violence space. However, the pandemic complicated both survivors' ability to access services and organizational capacity. Factors that decreased the number of survivors served included (though are not limited to): (a) survivors who resided with their abusers were unable to receive remote services at home; (b) emergency shelter capacity decreased by 50% due to social isolation policies enacted in the interest of public health; and (c) in-person services remained available throughout the entire pandemic for survivors without access to teleservices and who were in imminent danger; however, capacity was reduced due to public health initiatives. Also, many survivors reported unease about receiving services in person for some time (especially at the onset of the pandemic). It also must be noted that many survivors experienced barriers (e.g., access to transportation, loss of employment, loss in availability of remote accessibility, loss in housing) in accessing long-term services during the pandemic. Conversely, while in crisis, it was much easier to pick up a phone and call our hotline. We learned throughout 2020 that an increase in hotline requests did not necessarily translate to an increase in organizational capacity.

MCWC also continued operating a Continuous Quality Improvement (CQI) team throughout the COVID-19 pandemic, which was tasked with identifying, prioritizing, developing, and implementing program improvements related to stakeholder and victim feedback. To that end, MCWC defines program evaluation as a systematic structure composed of agency stakeholders, staff, volunteers, and victims/survivors who participate in the planned change process. Throughout the pandemic, the CQI team met every month and evaluated client and stakeholder feedback related to service delivery changes due to the coronavirus. This process identified several strategies designed to promote best practices. Specifically, as it relates to telehealth and virtual services, the following represent those identified best practices:

1. Staff should provide victims with options for how services can honor principles of self-determination and safety (e.g., over the phone, via a HIPAA compliant software, or in-person while social distancing, wearing face masks and gloves, providing sanitary stations).

2. Staff should discuss safety with victims who opt into using virtual platforms. This provides victims increased knowledge about technology. Further, these conversations should create buy-in related to understanding technology-based safety and options for connecting with support systems.

3. Staff and volunteers should honor trauma-informed and evidence-based principles with regards to the comfortability of receiving services. We knew before the pandemic that victims with limited experience with technology often experienced discomfort in receiving counseling and advocacy services remotely. As a confirmation, several victims reported feeling uncomfortable with receiving services due to a lack of knowledge with regards to virtual platforms. Often, victims were more comfortable receiving service in-person or over the phone. The counseling program opted to adopt a hybrid delivery system to honor “service delivery appropriateness.” For example, play therapy and eye movement desensitization and reprocessing therapy may not be the most appropriate modality to be offered remotely; conversely, cognitive behavioral therapy and dialectical behavioral therapy are modalities that will likely garner success over a remote platform. MCWC’s CQI findings on best practices seem to confirm previous research related best practices in providing teletherapy. It is recommended that a determination of the appropriateness of services should be made on a case-by-case basis.

MCWC experienced several challenges in adapting programming throughout the pandemic. The MCWC’s CQI team worked alongside agency programs, management, front-line staff, and community stakeholders to determine the best course of action for these challenges:

1. Staff experienced challenges in terms of gathering intake information. This was especially difficult with regards to completing intake paperwork. Previously, intake guidelines were primarily mandated by federal/state regulations and funders. Given the necessary changes in gathering intake information as a result of the pandemic, the MCWC team discussed these challenges internally, with funders and with regulatory bodies to engage in an efficient data-gathering and data-management process. Of note, fund-

ing agencies and regulators listened to the challenges faced by MCWC’s staff and made every attempt to increase the accessibility of services to victims.

2. Overnight, the MCWC found itself significantly challenged by social distancing requirements and capacity changes. Most notably, the MCWC required additional monitors, cameras, computers, upgrades to internet infrastructure, and to the agency’s security system(s), etc. Several funders and donors made available emergency funds to purchase personal protective equipment and technology equipment, which assisted the agency in the transition from services being provided primarily in-person to a hybrid system (e.g., a combination between in-person, over the phone, and via other remote service platforms).

3. Many victims shared that they had experienced challenges related to accessing services due to lack of reliable internet, hardware, and/or decreased safety. For instance, many victims who were at home, isolated with their abuser, were unable to access remote services. For victims whose personal circumstances preclude them from safely receiving services and/or if their financial circumstances hindered their participation in remote services, MCWC continued to provide in-person services. In other instances, a hybrid approach became more suitable, which aligns with fundamental aspects of trauma-informed best practice.

4. Many victims experience language and cultural barriers when requesting services related to family and sexual violence. The COVID-19 pandemic exacerbated these barriers for victims with limited English proficiency. Even for victims who speak English fluently (while being a 2nd or 3rd language), they reported experiencing difficulty in participating with both in-person (e.g., with masks covering facial expressions) and remote therapy (e.g., losing meaning around non-verbal communication). In addition, children, their guardians and older adults also reported difficulties in relation to “the appropriateness” and “comfortability in receiving” remote services. In these cases, victims and their families were invited to receive in-person services in compliance with best practices.

Of note, the MCWC utilizes a trauma-informed, client-centered approach to survivor restoration. Towards that end, all services (whether remote or in person) are

individualized to each survivor. As such, screening is predicated on need and context. For instance, it is the MCWC’s policy to provide survivors calling the 24/7 crisis hotline with danger and risk assessments. During coaching, case management, and clinical appointments, more in-depth assessments take place as part of treatment planning, which is predicated on recommendations made by both clinical and front-line staff. This process did not change as a result of the pandemic. However, as far as emerging trends, the MCWC’s counseling department has reported an increase in adolescent suicide ideation with sexually abused and exploited youth during the pandemic.

Houston Area Women’s Center (HAWC)

HAWC was established in 1977 to aid Harris County victims of domestic and sexual violence by providing a hotline for immediate access to safety, medical attention, and a trauma-informed needs assessment. Harris County is located in the Southeast portion of Texas and is the country’s third most populous county with 4.7 million residents. It is an urban metropolis with a diverse population (32.1% White/Hispanic, 28.9% White/Non-Hispanic, 18.7% Black or African American/Non-Hispanic, 9.5% Other/Hispanic, and 6.9% Asian/Non-Hispanic) in which 44.9% of the residents speak a non-English language. The median age of the population is 33.7 years old and the median household income for Harris County is \$60,232 (Data USA, n.d.b). HAWC aims to help break the circle of violence and empower victims with the economic and psychological tools necessary to live self-determined lives. In response to the COVID-19 pandemic and the stay-at-home order implemented in Harris County, HAWC’s Non-Residential Counseling and Advocacy Program transitioned to a remote service delivery model in April 2020. Despite having intentions to introduce multiple remote service delivery models, the need for a rapid transition to remote delivery as a result of social distancing practices did not permit a fully realized service delivery plan. Consequently, the initial shift from face-to-face services began with providing a telephone-based model of delivery. Although a preliminary and temporary shift, HAWC experienced and still experiences excellent success with this model.

The intake numbers have increased extensively—before COVID-19, HAWC had roughly a 40%–50% no show rate for first-time appointments; at present, and as a result of greater need due to the COVID-19 pandemic, HAWC offers a more significant number of appointments, at a more diversified set of times, with a no-show rate of 20%–30% (a reduction from the previous year). As the stay-at-home order continued to be lengthened, HAWC became increasingly aware of the need to reinstate group counseling services and launch digital delivery methods. Initially, this presented several obstacles and challenges that needed to be overcome, including department onboarding and training in compliance with ethics boards and grant policies, establishing the necessary infrastructures by securing the digital platform and security measures, and developing policies, procedures and paperwork for the informed consent of participation among our client population. During this time, great efforts were taken to become knowledgeable and prepared to develop a digital service delivery system while prioritizing clients' confidentiality and safety. Of note, suicidality and risk for self-harm are areas of assessment that routinely take place when providing support to survivors of domestic and sexual violence via any service delivery model. Staff are trained in assessing, intervening, and constructing individualized safety plans that include discussions around situations of necessary reporting when instances arise. As noted, the existence and success of HAWC's two 24-hour hotlines have allowed for the agency to continue tried-and-true protocols around remote risk assessment informed by 40+ years of practice. Overall, the transition went as planned. HAWC was successful due to remaining open to feedback from staff and clients to ensure service provision was meeting victims' needs. HAWC elected to transition to remote delivery at a pace that allowed for a smooth implementation and adjustment for both staff and clients.

In late August 2020, HAWC began providing group and individual counseling services via a video conferencing platform. At the outset, HAWC started small, launching closed group sessions with a smaller number of clients to pilot the platforms and get feedback before opening up groups to more participants. At present, HAWC currently offers 10 children's groups, 6 adult sexual assault groups, and 18 adult domestic violence groups that take place six days a week at a variety of hours,

some daytime and some evening, in addition to the 50+ individual sessions taking place each week. These services are all offered remotely, with HAWC currently providing no face-to-face services. Since starting on Zoom (video conferencing platform), those with the technological means and ability to secure a safe environment for participation have reported: "It's not the same as group in-person, but I'm grateful and think it is great that we still have support and each other through Zoom during this pandemic." Another client noted, "COVID has forced us to learn new things and a new way of living; now I know how to use Zoom and am able to be in group even during these uncertain times." Furthermore, another client spoke to the importance of having a group for connection, saying, "I don't feel alone; I am literally waiting every Wednesday for my virtual group in Zoom." Still, given the plethora of barriers faced by members of this population, many victims remain unable to access counseling services via video conferencing platforms. Believing in the power and importance of choice, the future plan is to offer both face-to-face and remote service delivery models that allow people to access support in a manner that best fits their needs.

Conclusion

The COVID-19 pandemic has had a drastic impact on aspects of individual daily living. Moreover, the current circumstances have also led to an increase in mental health concerns and an increase in IPV. In order to provide services to populations in need during the pandemic, women's centers must integrate innovative technological-based approaches to treatment. These methods of intervention are safer in regard to limiting transmission of the virus, and they are more accessible for reaching underserved and marginalized populations, such as racial/ethnic minorities and individuals from low SES backgrounds.

Though the COVID-19 pandemic likely accelerated the move from in-person service delivery for mental health concerns to telehealth options, this shift was predictable and perhaps inevitable. Telehealth services provide flexibility and are easily accessible, making them desirable choices. Even though telehealth is not an appropriate fit for everyone, it is a viable alternative to in-person services for many. Telehealth services are likely here to stay, making it critically important that the barriers related

to this service delivery method are well understood and taken into consideration. This paper provides some preliminary insight to the advantages and disadvantages of the transition to telehealth services during a pandemic in violence prevention organization settings. Nonetheless, there is a great need for additional efficacy and effectiveness studies as this transition is new and the long-term effects are not well-known.

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ABCT is delighted to announce a partnership with **PsyberGuide**, a nonprofit website reviewing smartphone applications and other digital mental health tools. This partnership was established with the aim of disseminating reviews of digital mental health tools to a broad audience of researchers, psychologists, psychiatrists, and other mental-health practitioners. App reviews from both PsyberGuide and *Cognitive and Behavioral Practice* are integrated on both sites.

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PsyberGuide is funded by One Mind (Dr. Stephen Schueller, Executive Director), a leading nonprofit organization supporting collaborative brain research to provide patients who suffer from brain disease and injury better diagnostics and treatment. With over 325,000 emerging digital health technologies, and an estimated 15,000 of those designed for mental health, One Mind recognized the lack of advice or guidelines to help people navigate the expanding marketplace of mental health apps. Thus in 2013, One Mind established PsyberGuide to address this growing problem.

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CLINICAL PRACTICE FORUM

Adolescent Sexual Reoffending Within the Family: Challenges in Risk Assessment, Prevention of Recidivism, and Family Reunification

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ADOLESCENT SEXUAL OFFENDING is a pervasive problem that has not received a great deal of attention within child sexual abuse literature. Studies utilizing general adolescent population samples, such as the Growing Up With Media Study (Ybarra & Mitchell, 2013), found that as many as 1 out of 10 youths endorsed lifetime perpetration of sexually abusive behaviors against other youth. Of those who endorsed perpetration, approximately 4% reported that they either attempted but were unable to force someone to have sex or forced someone to engage in sex with them. In fact, some estimates suggest that

youth under the age of 18 comprise up to half of all sexual offenses against children (Ryan, 2016; Zolondek et al., 2001). However, many instances of adolescent sexual offending go undiscovered or without intervention. For example, Zolondek and colleagues found that approximately a quarter of their sample of adolescents who sexually offended ($N = 485$) reported offending on a child but never being accused of a sexual offense. Given the underreporting of adolescent sexual offenses, the true prevalence of adolescent sexual offending and the proportion of offenses that are undisclosed is unknown.

Therefore, prior research on adolescent sexual offending has largely focused on sexual offenses that have been reported and which have typically prompted legal consequences for the adolescent. This article provides a brief overview of adolescent sexual reoffending, discusses considerations and challenges associated with assessing risk of sexual recidivism, and identifies therapeutic strategies for preventing adolescent sexual recidivism within families where a child within the household was the victim of the offense.

Within the United States, adolescents who receive a sexual assault charge may face legal consequences for their offense, such as probation, placement in out-of-home care, and court-mandated treatment for the sexually offensive behaviors. However, there is variability in state laws regarding adolescent sexual offenses, and legal repercussions are determined on a case-by-case basis. Thus, greater clarity about risk and prevention factors for sexual reoffense have benefits for offenders, potential victims, and the larger community. Importantly, victims of adolescents' inappropriate sexual behaviors are often family members, including siblings or close family friends and neighbors (Frensch & Cameron, 2002). According to a 2009 report by the U.S. Department of Justice,

25% of youth-perpetrated offenses were against a family member, and roughly 69% of offenses took place within the home (Finkelhor et al., 2009; Martijn et al., 2020). Dependent on concerns of the adolescent remaining within the home with the victim, the adolescent offender may be placed in juvenile detention, in a home without the victim or other children, or in a residential treatment center following an incident of sexually offensive behaviors. Given the legal system's focus on the offense and offender themselves, there may not be integrated services provided to the family unit. Thus, services provided for the victim and caregivers may be separate from those provided to the adolescent offender.

Though there are similarities among youths who offend within and outside of the family, there may be some distinguishing characteristics associated with intrafamilial adolescent perpetration, including larger and more dysfunctional families, younger age at first perpetration, greater abnormal sexual interests, greater difficulties with sexual regulation, greater instances of child maltreatment, and internalizing symptoms (Martijn et al., 2020; van Vugt & Garofalo, 2020). Clinicians, as well as child welfare and juvenile justice professionals, need guidance about such factors and assistance in recognizing the specific concerns families face. Effective assessment procedures and targeted intervention strategies are essential to prevent recidivism and support family reunification when possible.

The possibility of reoffending following an initial instance of sexual impropriety against another child in the household is nearly always a primary concern when adolescent sexual offending is disclosed. Fears of reoffense often precipitate removal of the offending youth from the home to keep the victim and other children safe. Unfortunately, there is little to no information regarding risk and prevention of sexual reoffense within the youth developmental period, presenting obstacles to accurate assessment of the potential success of family re-unification. Some research has reported lower rates of reoffense for sexual offenders in emerging adulthood (between 0 to 10%; McCuish & Lussier, 2017); however, there is a dearth of information about factors that contribute to lower rates of recidivism into adulthood and even less related to reoffense during adolescence. As mentioned previously, many incidents of adolescent sexual offending go undiscovered or without intervention suggesting that there are gaps

in knowledge and service provision that are unaddressed in current research and practice.

In addition to risk assessment needs, barriers to intervention that may reduce risk of reoffense following an initial offense must be considered. Inevitable disruptions in the family may increase barriers to adequate services for both the victim and offender. An offense within the family may create strains in family relationships (DiGiorgio-Miller, 1998; Kreinert & Walsch, 2011; McCamey, 2010), add further distress in families that may already have high levels of dysfunction and stress (Ballantine, 2012; Caffaro & Conn-Caffaro, 2005; DiGiorgio-Miller, 1998; Haskins, 2003), and families with limited resources may experience increased challenges in promoting rehabilitation for the offender, healing for the victim, and successful family re-unification (Ballantine; Caffaro & Conn-Caffaro; DiGiorgio-Miller; Haskins).

In response to the gaps in literature regarding adolescent sexual reoffense within families, the following analysis is intended to highlight challenges in risk assessment for sexual recidivism and examine current approaches to prevention of adolescent sexual recidivism when the victim is a child in the family or household. Recommendations for clinicians working with families following adolescent sexually offensive behaviors, particularly regarding re-unification approaches are emphasized. Terminology in this area raises concerns about differentiating juvenile from adult offenders, avoiding excessive suggestions of criminality for youth, and limiting the use of stigmatizing labels. Although we attempt to be cognizant of these concerns, for brevity and clarity, we refer to adolescents who engaged in sexually harmful behaviors as juveniles who sexually offended (JSO).

Challenges Associated With Assessment of Risk of Reoffense

Risk assessment is a role that mental health professionals play in a variety of settings, including forensic and residential settings. JSO are frequently referred to treatment and/or residential programs following disclosure of the abuse. Undergoing a comprehensive clinical assessment, including a risk assessment, is a common requirement. Risk assessment carries significant implications for the adolescent and their family, including potential public registration as a sex offender for those

deemed high risk of reoffending (Caldwell et al., 2008; Sex Offender Registration and Notification Act, 2006). Please note that this paper is not intended to teach readers how to assess risk or to substitute for comprehensive training. Our intentions are to discuss factors that influence risk assessment based on empirical literature as well as clinical experience. Prior to conducting risk assessments, clinicians must obtain appropriate, supervised training and gain competency in administration and interpretation of assessment measures.

Commonly used, evidence-based risk assessment measures include the ERASOR (Worling & Curwen, 2001), J-SOAP-II (Prentky & Righthand, 2003), and JSOR-RAT-II (Epperson et al., 2006). Generally, risk assessments are based on several domains, including the adolescent's assault characteristics (e.g., number of victims, engagement in diverse sexually assaultive behaviors, use of force or violence in assaults), characteristics of the JSO (e.g., antisocial personality traits, lack of interpersonal relationships, poor self-regulation), and family environment (e.g., high-stress familial environment, environment supportive of sexual offending). Clinicians use guidelines determined by the assessment to examine if a risk factor is present for JSO. To determine an overall risk level, clinicians engage in a thorough clinical interview with the JSO, review collateral information, and utilize their own clinical judgment. While discussion of reliability and validity characteristics of pertinent measures is beyond the scope of this paper, research demonstrates that the measures listed above are well-validated (e.g., Clarke et al., 2017; Epperson & Ralston, 2015; Schwartz-Mette et al., 2020; Viljoen et al., 2012). Despite their usefulness for understanding an adolescent's context, the measures do not necessarily predict future offending accurately (e.g., Borum, 2000; Viljoen et al.). Although they can inform strategies to mitigate risk and guide intervention plans, they should not be used to predict reoffense or to justify subsequent punitive strategies (Borum).

When assessing risk of reoffense, trained clinicians should be cautious about the limitations of a given measure and the broader constraints of clinical assessment in general. In the context of adolescent assessment, many risk and protective factors are contingent upon elements that may shift throughout treatment. Broad conceptualization of risk has shifted away from a dichotomous categorization of being or not being at-risk for engaging in

violent behavior; instead, it views risk as dynamic, dependent upon context, and as existing along a spectrum (Borum, 2000). A comprehensive risk assessment considers both dynamic factors (e.g., attitudes, cognitive development) and static factors (e.g., trauma history, treatment history; Vizard, 2013).

JSO are a heterogeneous population, and assessment of static and dynamic risk and protective factors provides information to help determine the intervention needs of individual clients. Interestingly, the absence of a particular risk factor is often indicative of that characteristic serving as a protective factor (e.g., supportive, functional familial environment is protective while nonsupportive, dysfunctional familial environment is a risk factor). Recognizing the limitations of empirical identification of risk and protective factors for recidivism among this population (e.g., limited research, small sample sizes, inconsistency in variables), a summary of the existing literature and subsequent follow-up studies can be found elsewhere (Spice et al., 2013). In an overview of assessment and treatment considerations for JSO, Worling and Langton (2012) detail domains for screening and determining where more in-depth assessment may be warranted. Among the static domains identified are developmental history; past medical and mental health treatment; educational history; past employment/volunteer experience; previous nonabusive sexual activity; and past trauma. Dynamic domains include family functioning; personal strengths; cognitive functioning; affective functioning; social functioning; sexual interests and attitudes; and suicidal ideation. Additionally, Keane and colleagues (2013) emphasize the importance of determining whether family reunification is a possible outcome early in treatment. The benefit of early determination is twofold: clinicians can utilize familial support to help the adolescent through treatment, in maintenance of new behaviors, and in conveying messages of accountability and responsibility; and clinicians can address modifiable family risk factors that may contribute to decreased risk for reoffense. Inclusion of family when reunification is the goal also allows for careful planning for the safety of the child who was abused prior to reunification (McNevin, 2010).

Risk assessment for JSO must be provided with attention to the changing nature of adolescence (e.g., Cauffman & Steinberg, 2012; Vincent, 2006). Particularly in

cases of sexual offending in the home, it is imperative to describe the potential for family reunification and continually consider the safety of both the adolescent and any children who were either previously abused or who may be in close contact with the adolescent in the future (Keane et al., 2013; McNevin, 2010). Risk assessment is a useful tool for identifying risk and protective factors when it is used in conjunction with other clinical information to determine individualized risk management and treatment needs.

Prevention and Intervention Efforts in Adolescent Sexual Recidivism

Effectiveness in the prevention of sexual reoffense is often measured by recidivism rates (ter Beek et al., 2018; Walker et al., 2004). A comprehensive model for adolescent sexual recidivism reduction incorporates prevention strategies targeting the general public and those at risk for committing a sexual offense in addition to more specific intervention programs for those who have committed a sexual offense (Assini-Meytin et al., 2020; Letourneau et al., 2017). Attempts to change public perceptions about sexual violence are intended to reduce shame and stigma and to increase accessibility of services for those who experience inappropriate sexual urges and behaviors (see Knack et al., 2019; Levenson et al., 2017; Piché et al., 2018). Prevention efforts to reduce rates of adolescent sexual recidivism should not be understated, as changing public perceptions can help promote help-seeking services among families who are concerned about their adolescent engaging in inappropriate sexual behaviors with another child in the home. Prevention efforts that aim to reduce shame and stigma surrounding an adolescent's urges to engage in sexual misconduct within the home are beneficial for reducing barriers to treatment within the community prior to offending and involvement in the legal system. Despite the value of such community strategies, the current paper focuses on interventions designed to help JSO and their family members avoid further sexual offending and victimization.

A majority of intervention efforts following sexually offensive behaviors are implemented and coordinated by the juvenile justice system due to the legal charges associated with these behaviors (Letourneau et al., 2017; Piché et al., 2018). A problem with this is that not all sexually offensive behavior is reported and pursued

legally, and so those who avoid involvement with the legal system rarely receive any services. Research has shown that a significant proportion of adolescent sexual offenses go unreported, and thus it is difficult to understand the breath of this issue (Abbey, 2005; Zolondek et al., 2001). Although the intent of the juvenile justice system is to rehabilitate youths rather than punish them for past behaviors (Mears et al., 2015; Welch et al., 2019), concerning systemic issues within juvenile justice have been discussed in the literature (e.g., Dragomir & Tadros, 2020; Evangelist et al., 2017; Marrett, 2017) and can inhibit treatment approaches in some cases. When JSO are court-mandated to treatment, the treatment facility and juvenile justice system should coordinate efforts to ensure JSO progress successfully in treatment and in accordance with court orders. It is also crucial that treatment for youth is developed from a client-centered, evidence-based approach. Research has shown that treatment utilizing cognitive behavioral therapy (CBT) has produced the largest effect sizes in sexual recidivism rates (Schmucker & Lösel, 2015; Walker et al., 2004). However, it is of note that these effect sizes are moderate. Thus, additional research is warranted to understand what factors improve treatment effectiveness in reducing recidivism rates among JSO. Given the heterogeneity of JSO, individualized treatment that is relevant to the client's concerns and risk factors for sexual reoffending (e.g., building interpersonal/social skills, reducing deviant sexual arousal) have shown to reduce rates of recidivism (Schmucker & Lösel). Treatment for adolescents who have sexually offended within the family encompass work with the JSO, the victim, and the family. Individual treatment goals may include increasing accountability for the adolescent's sexually offensive behaviors; building awareness and ability to challenge thoughts, feelings, and behaviors supportive of sexual offending; enhancing victim empathy and perspective-taking; and reducing deviant sexual arousal, if present (Efta-Breitbach & Freeman, 2004; Walker et al.; Worling & Langton, 2012). Given the additional risk factors that may not appear to be directly related to the sexual offense, treatment goals may also include social skills training, improving emotion regulation, and processing personal trauma of the JSO, as it may relate to the sexually offensive behaviors, to reduce their risk for sexual recidivism (Walker et al.; Worling & Langton).

Treatment topics related to the victim and family are intertwined when working with youths who offended within the family. Therefore, the importance of family involvement cannot be overstated. While integration of family in treatment for the offender is critical, individual therapy for the victim and caregivers is often sought independently when needed. Despite the current limited ability to predict sexual recidivism with accuracy, certain risk factors may contribute to an adolescent's initial sexual offending as well as risk of sexual reoffense, including familial variables. First, if a caregiver does not believe the sexual offense happened or is not supportive of sexual offense specific treatment, the victim may experience negative consequences following the abuse, and treatment success for the JSO may be hindered (Keane et al., 2013; Tener & Silberstein, 2019). Thus, clinicians may consider beginning family therapeutic sessions solely with the caregiver(s) to assess their attitudes, feelings, and behaviors related to the sexual offense and provide psychoeducation related to sexual offending prior to integrating the JSO into family sessions. Additionally, a lack of structure within the home and inadequate supervision of children can be a risk factor for initial sexual offending as well as a risk for sexual reoffense (Ballantine, 2012; Caffaro & Con-Caffaro, 2005; Haskins, 2003). To reduce this risk, the JSO and the caregiver(s) should develop and agree to follow a safety plan that ensures protection of all children in the home. The safety plan promotes protective factors that will reduce the risk for sexual recidivism. It is not intended to punish the youth for their past behaviors. The safety plan will likely include increased supervision of the JSO, knowledge of their activities, no unsupervised contact of the youth with children, and limited access to technology (Stewart et al., 2019). Safety planning may encounter barriers, especially for caregivers who have limited resources and skills that help them to financially, physically, and emotionally support the entire household (DiGiorgio-Miller, 1998; Keane et al., 2013). Thus, clinicians should be aware of the practicality of the safety plan and encourage including additional trusted adults to help implement a successful plan.

Towards the conclusion of treatment for the JSO, clarification and reunification sessions are essential if the youth is returning to the home. Prior to beginning clarification sessions with the victim, the clinician needs to consider if this process may

negatively impact the victim. Clinicians may suggest that the victim receive individual therapy and request assurance that the respective therapist believes that the victim is ready to begin the clarification and reunification process. Clarification sessions may consist of the JSO writing a letter to the victim and presenting it in a developmentally appropriate manner (DeMaio et al., 2006; Price, 2004). The clarification letter should include acceptance of full responsibility for the assault and answer questions the victim likely has (e.g., "Why did you do this to me?" "Do you care about me?"). It should exhibit victim awareness and empathy, demonstrate a change in thoughts and behaviors that are indicative of not assaulting in the future, and provide the victim the opportunity to accept, reject, or question the letter without the expectation that the JSO will be forgiven. The clarification letter should be reviewed with the clinician prior to the youth presenting it to the victim. The clinician may ask the youth to revise the letter several times to ensure it appropriately addresses all topics and that the content in the letter is not likely to negatively impact the child victim. Additionally, this process may occur with other individuals within the household. Clarification sessions may continue until the individuals within the household are supportive of the youth reentering the home.

When considering clarification and reunification, issues of risk assessment reemerge, especially given the limited literature on the reunification process. Additionally, reunification may present differently, depending on the family situation. For example, the JSO may not return to the home but may have continued contact with the child victim, typically with close supervision. This approach may be especially helpful for caregivers who have limited resources to provide the levels of supervision identified in a safety plan. Thus, it is necessary for clinicians to approach these topics on an individual basis when evaluating if and when a youth is ready to reunify with the family. Therapists should pay close attention to the safety and emotional well-being of the child victim and the presence of any risk factors (e.g., continued denial of abuse by the JSO or caregivers, child victim's discomfort with reunification, child victim's psychological symptoms, or evidence that individuals in the home have been pressured to accept reunification). When deemed appropriate, reunification can begin with brief home visits or outings with

the family to examine and process issues that may arise as the family moves towards cohabitation. Once the JSO returns to the home, individual and family services should continue for the JSO, victim, and caregiver(s) to ensure the safety plan is working effectively, process concerns that arise, and continue to assess for any risk of sexual recidivism. It is imperative that this process remains ongoing, dynamic, and long-standing to ensure the safety and well-being of all children in the home.

Summary

This paper provided a brief overview of the current literature related to adolescents who sexually offend within the household and highlighted the challenges associated with risk assessment and intervention for them, their victims, and their families. Prevention of recidivism is a primary goal, and thorough risk assessment coupled with mental health treatment coordinated with the juvenile justice system were identified as critical needs for such youth and their family members. JSO are a heterogeneous group who need client-centered, evidence-based treatment to reduce the risk of sexual reoffense. Long-term follow-up is especially important to promote successful reintegration of the juvenile offender into the household and community. Future research can inform appropriate public policies by better understanding variables that impact risk assessment, treatment, and reunification to achieve successful rehabilitation for adolescents who have sexually offended within the family.

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ORIGINAL RESEARCH

The Perfect Storm: The Promise of Trauma-Informed Care in Reconceptualizing Psychotically Driven Maternal Filicide

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Trauma and Severe Mental Illness

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) definition of trauma includes events that are directly experienced, witnessed, learned of happening to loved ones, and/or repeatedly exposed to the details of that involve actual or threatened death, serious injury or sexual violence (American Psychiatric Association [APA], 2013). Described more broadly by the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma is “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, and spiritual well-being” (SAMHSA, 2014, p. 7) Overall, individuals with serious mental illness (SMI) are substantially more likely than the general population to have experienced trauma, including reported rates of childhood physical and sexual abuse as well as lifetime exposure to interpersonal violence (Mueser et al., 2002; Mueser et al., 2004). Further, for those in psychiatric inpatient settings, trauma histories are commonly compounded by institution-related trauma; almost all individuals in psychiatric inpatient hospitals report at least one traumatic experience occurring as a result of their hospitalization (e.g., being placed in restraints, being forcibly medicated, witnessing or experiencing physical or sexual violence within the institution; Reddy & Spaulding, 2010).

Despite this, diagnostic omission or overshadowing of Posttraumatic Stress Disorder (PTSD) among those with SMI is a common phenomenon. For instance, 95% of a community sample of individuals with serious mental illness ($N = 275$) reported experiencing at least one traumatic event and of these 43% met diagnostic criteria for PTSD; however, this diagno-

sis was reflected in only 1% of the sample’s medical charts (Mueser et al., 1998). Such a pattern holds in inpatient settings as well; for example, at a large forensic psychiatric hospital only 1.4% of adult inpatients’ charts listed PTSD as a diagnosis of record (Alexander et al., 2016) compared with a 3.5% twelve-month prevalence rate in the general population of adults in the United States (APA, 2013).

Even for those who do not meet diagnostic criteria for PTSD, the impacts of trauma on psychosocial functioning are wide-ranging, pervasive, and severe, and cause significant disturbances in self-concept, interpersonal relationships, emotion regulation, cognition, and arousal (Curtois, 2008). Nevertheless, even in state hospitals and community mental health facilities, the prevailing approach to SMI treatment has largely ignored trauma-related sequelae (Grubaugh et al., 2011; Thordarson & Rector, 2020). Recently the mental health system has begun to recognize that institutions, such as psychiatric hospitals, are designed in such a way as to perpetuate, rather than identify and treat, trauma (Reddy & Spaulding, 2010). In order to address this concern, a growing number of institutions are implementing Trauma-Informed Care (TIC), an approach that reconceptualizes problematic behaviors, such as institutional violence and aggression, self-injury, impulsivity, rule-breaking and treatment nonadherence, as being complex and adaptive reactions of individuals who have experienced psychological trauma (Clark et al., 2015). For instance, many acts of institutional violence and aggression can be reconceptualized as protective reactions in response to perceived threats that are activated by the frequently harsh environments existing within institutions. TIC is not an intervention per se, but instead a set of principles developed to enhance recognition and understanding of trauma, promote staff awareness of and sensitivity to potential causes of trauma,

and minimize institutional retraumatization to the extent possible (Harris & Fallot, 2001). Beyond this, the TIC framework seeks to empower individuals to develop adaptive, healthy coping skills in response to stressors (Clark et al.) and has the potential to significantly reduce instances of problematic behaviors, such as those outlined above, within institutions (e.g., Aremu et al., 2018; Miller & Najavits, 2012).

Unique challenges exist in applying a TIC framework with individuals who have been adjudicated as Not Guilty by Reason of Insanity (NGRI). In order to be acquitted as NGRI in California, an individual must be either unable to appreciate the nature and quality of their actions or unable to understand right from wrong at the time of the offense due to mental disease or defect (Cal. Penal Code § 25(b)). NGRI acquittees are sentenced to treatment in a state hospital until they are deemed able to be safely and effectively treated in the community or determined to be legally restored to sanity. Specific criteria must be met for discharge, including demonstrating an understanding that they committed a violent offense due to symptoms of severe mental illness. As perpetrator, they are typically perceived as wholly bad and capable only of damaging, not of being damaged. Such offenses are rarely viewed in shades of gray: perpetrators cannot be victims and vice versa. Further, traditional conceptualizations of trauma typically describe events that happen to a person through no fault of their own. What of the NGRI acquittee, then, once incapable of understanding the implications of their actions, now restored to rationality with treatment? They learn, as if for the first time, of something terrible happening—that they in fact caused to occur. In and of itself, being newly informed that one has harmed or even killed another person can be highly traumatizing, especially because in such situations the person harmed is very often a family member or other loved one (Ferranti et al., 2013). For this population, interpretations of trauma warrant a broader conceptualization. One group of NGRI acquittees for whom this is particularly salient are women whose index offenses include significant harm or death to their children.

While only 3% of homicides involve the intentional killing of a child, the most common perpetrators of these types of homicides are parents, guardians or step-parents (Dixon et al., 2013) who are disproportionately more likely to have a his-

tory of mental illness (Bourget et al., 2007; Flynn et al., 2013). Data involving the precise number of mothers who kill their children (i.e., maternal filicide) who are then acquitted as NGRI are not available. However, when such cases occur they are very often the source of media scrutiny and sensationalism, leading to the elicitation of intense emotional reactions by the public. Indeed, for many, filicide represents a violation of a foundational social task (i.e., parenting) rooted in both evolutionary biology and continually reinforced by strict social norms (Klier et al., 2019). Within the context of correctional institutions and forensic hospitals, these women continue to face stigma from staff and peers as a direct result of the nature of their offenses. Thus, while the offenses committed by these women represent horrifically traumatizing experiences in and of themselves, this trauma is then repeatedly triggered and reified in the aftermath of the offense, creating unique treatment needs for those involved in their care. The low base rate and stigmatizing nature of this type of offense places these women at particular risk for isolation and retraumatization within institutions, creating yet another layer of treatment needs that traditional treatment programs often do not address. The current paper provides a brief review of the literature related to maternal filicide followed by a discussion of the formation and course of a trauma-informed, integrative process group for women adjudicated NGRI for offenses involving serious harm or death to their children. Additionally, the implications for reconceptualizing psychotically driven acts of violence as traumatic as part of a wider movement toward TIC will be discussed.

Theories of Maternal Filicide

While literature related to maternal filicide remains scant, a handful of theorists have attempted to extract subtypes of filicide primarily through analysis of case studies. In the first of these discussions, Resnick (1969) noted maternal filicide was differentiated from other types of homicide by the fact that in well over half of case studies he examined, the act was motivated by altruism and/or acute psychosis (i.e., the presence of hallucinatory experiences or delusional beliefs) on the part of the mother. This included attempts to alleviate real or imagined suffering or killing the child during the course of a conjoint suicide attempt. Interestingly, 10 years later, d'Orban (1979) identified similar motives

of protection or altruism stemming from delusional beliefs as the primary motives among mothers who were mentally ill at the time of the offense. While Scott (1973) did not classify cases based on motive, arguing that doing so was too subjective, he did point out that out of 39 total mothers studied, 32 killed as a direct result of symptoms of mental illness, although he did not provide further clarification about specific symptomatology. Finally, Holden et al. (1996) attempted to identify differences between mothers who were found criminally responsible for killing their child and those who were found NGRI. They found the only factors that distinguished between the groups were the presence of a suicide attempt and psychotically driven motives in the NGRI group. The common psychotically driven motives included a belief the child was defective (i.e., possessed by a demon, half-human/half-animal), command hallucinations (i.e., auditory hallucinations that commanded the mother to hurt the child), and a belief that the child could only be saved from a disaster (i.e. rape, torture) through death.

Kunst (2002) offered a psychodynamic explanation for so called “pathological filicide” based on her work with 20 women acquitted as NGRI for murdering their children. Specifically, she conceptualizes this type of crime as stemming from early disruptions in parent-child attachment on the part of the mother which, combined with other biopsychosocial vulnerabilities, culminate in psychotic symptoms rife with fears of danger, persecution, and annihilation. Consistent with the motives identified above, the homicidal act serves as an attempt by the mother to protect her child from these fears.

Mugavin (2008) synthesized these theories with additional case studies to develop a Maternal Filicide Theoretical Framework (MFTF), which provides an explanation of the root causes of maternal filicide as a tool for identification of at-risk mothers and, ultimately, prevention. Specifically, Mugavin (2008) outlines historical vulnerabilities commonly experienced by mothers who kill their children, including: genetic predisposition to mental illness, previous exposure to abuse (particularly in childhood), history of substance use, disruptions in attachment, and socio-cultural factors. These vulnerabilities (many of which represent traumatic experiences in their own right) are then activated by particular triggers, which could include: religiosity (particularly in the context of delusional beliefs), revenge against a

significant other, poor parenting skills, desperation, mercy killing, lack of interest in parenthood, maternal stress, and substance use. Mugavin further recognizes that the mother's grieving process surrounding the loss of her child is often thwarted by negative experiences due to stigmatization and blame from family, others in prison or hospital settings, and society more broadly.

While the above explanations for maternal filicide are helpful in conceptualizing the offense, they provide little guidance for treatment providers tasked with helping these women cope simultaneously with the following: the loss of their children; symptoms of their severe mental illness; intense stigma and scrutiny from staff, peers, family, and members of the public; and planning for a meaningful and safe future beyond their hospitalization. In recognition of this, we developed a group at a large, inpatient forensic hospital specifically for women who were found NGRI for offenses involving severe harm or death to their children. The group ran from May 2019 until it was temporarily suspended in March 2020 due to the COVID-19 pandemic. Interventions used in the group were chosen based on their efficacy as reported in the trauma literature and in accordance with emerging findings that emphasize the importance of treating trauma with a holistic approach. As such, we incorporated ideas and interventions from various modalities such as TIC and Dialectical Behavior Therapy (DBT; Linehan, 2015), while simultaneously capitalizing on Yalom and Leszcz's (2008) therapeutic factors.

Formation of the Group

Inclusion Criteria

The group was open to female patients whose committing offense included serious harm or death to their child. We considered whether to limit the group only to those individuals whose index offenses involved death to their children, but we believed that women whose offenses involved serious harm to their child faced many of the same barriers to recovery as members whose children had died. From an interpersonal process perspective, we also believed this contrast in experiences and outcomes introduced dynamics to group interactions that would be especially

therapeutic for all members, as elaborated on in a later section. Additionally, we sought to limit participation to individuals who were relatively psychiatrically and behaviorally stable, although we reasoned that a mild degree of symptomatology (i.e., ongoing delusional ideation, transient mood-related difficulties) was acceptable and provided additional "grist for the therapy mill" (Yalom, 2002). We further considered whether to include male patients with index offenses involving harm to their children but ultimately decided against it for several reasons. First, we reasoned that societal expectations regarding the "mother role" and the characteristics of the mother/child relationship made this type of index offense especially unique, which potentially gives context regarding why the majority of the published literature on filicide has focused primarily on women. Second, consistent with a trauma-informed approach, we were aware that several prospective group members had previously been victims of various forms of abuse by male perpetrators and were concerned that including men in the group could result in retraumatization. Finally, our search identified only two male patients who met criteria for inclusion.

Recruitment

Identification of potential group members involved a thorough inspection of the details of index offenses for all female patients committed to the hospital as NGRI and as Offenders with a Mental Disorder (ODM).¹ In total, we identified nine women who met inclusion criteria. Once a list of group-eligible individuals was established, a facilitator from the group met with each woman individually to explain the purpose of the group, address any questions or concerns, and elicit participation. Recruitment was done by group facilitators (each of whom are doctoral level psychologists) in order to create an initial opportunity for rapport building in the hopes that this would allow the women to feel more comfortable participating in the group. Of the nine women we initially approached, six agreed to participate. Reasons for declining included concerns about confidentiality or that participation in the group would be damaging in some way. For example, one woman noted she feared that her participation in the group would alert

others to the nature of her index offense and make her a target for her peers, which she feared would compromise her physical safety and readiness for discharge. Another woman communicated significant concerns about the emotional and psychological impact that discussing her index offense would have on her, even in a safe and supportive environment. A third similarly communicated that she "just [could not] face what [she had] done yet."

Clinical Considerations Related to Confidentiality

We took considerable precautions to maintain confidentiality, as we believed protection of privacy was absolutely crucial in promoting a safe space for members to share their experiences. First, the group's name made no allusion to the group's true purpose, describing its general principles rather than its content (e.g., hope, recovery). Additionally, we collaborated with the group members to formulate answers to their peers' questions regarding the nature of the group (e.g., "an aftercare and recovery group"). Transportation to groups was also done discretely, with group facilitators accompanying each group member individually. Further, whereas most treatment groups at our hospital are conducted in on-unit conference rooms, we chose to hold our group in a secluded area of the hospital to promote privacy and decrease the likelihood of interruption. We also hung up signs explaining that treatment was in progress and asking for privacy. As in all group therapy settings, there was no formal means to prevent discussion of group content outside of group sessions; however, as discussed in the following sections, confidentiality remained a constant topic of emphasis throughout the group and we aimed to create a milieu in which concerns related to confidentiality could be openly explored.

Exploration of Group Process

We used an Interpretive Phenomenological Approach (IPA; Smith & Osborn, 2003) to analyze themes that emerged as the group progressed. The IPA framework emphasizes the process of meaning making for a particular, often unique, group of individuals and allows researchers to remain active participants in the meaning-making process. After analyzing common themes that emerged as the group progressed, we found they coalesced into three superordinate categories: (a) processing past traumas and their acts of violence

¹The ODM statute in California allows for an individual to be civilly committed to the Department of State Hospitals following a prison term if they meet a specific set of criteria connecting their offense to symptoms of a severe mental disorder (see Cal. Penal Code § 2962).

against their children, (b) coping with current challenges, and (c) preparing for life after involuntary hospitalization. Each of these superordinate themes and their subordinate components are discussed below. Consistent with the IPA framework (Smith & Osborn, 2003), once themes were generated based on the group process, they were contextualized within the existing literature related to maternal filicide.

Processing the Past

Kunst (2002) sums up her discussion of filicide by stating, "In subsequent treatment, as [the mother] becomes more free from the clutches of psychosis..., [the] complex and painful psychic realities [of the index offense] will be as challenging for her to understand as they are for us" (p. 37). This statement perfectly illustrates the challenge of therapeutic work in this population, as outlined in the following section. Although the time since the offense differed between group members (for some it had been over a decade while for others only a year had passed), each of the women were still struggling to reach an understanding of the offense, which was complicated by several universal factors.

- *Stigma: "We're more hated than sex offenders"*

As previously discussed, when cases of psychotically driven maternal filicide arise, they are often extensively covered by the media in a way that villainizes the mother. Each group member recalled that while incarcerated prior to trial and sentencing, fellow inmates and jail staff learned about their cases from media reports. Simultaneously, members were often still experiencing symptoms of acute psychosis, which impeded their understanding of the offense. Thus, as they were attempting to grapple with the reality of the offense, they were also contending with being targeted and victimized as a result of it. Group members also described the trial process itself as particularly traumatic because of repeated exposure to reminders of their offense as well as questions and comments about their culpability from the media, attorneys, and their families. Even within a more therapeutic hospital setting, the women were careful not to disclose their offense to others because they feared being ostracized, targeted, bullied, or possibly worse. For most of the members, the group was the first and only place they were able to openly and safely discuss their experiences. Universality, therefore, was a uniquely powerful factor in uniting the

group and promoting disclosure (Yalom & Leszcz, 2005).

- *Confidentiality: "I just want to say – I don't want any problems"*

Based on prior victimization experiences, confidentiality was the chief concern for most members who feared word of their offense would spread to unit peers and result in further stigma, targeting and maltreatment. In keeping with TIC principles, this topic was revisited frequently to reinforce its importance and reduce potential breaches, recognizing that this could cause retraumatization. Additionally, the group facilitators remained vigilant about interruptions when staff members entered the room; on each occasion group process paused while a facilitator asked the staff to return at a different time. This served not only to protect the group's confidentiality, but also as an important socializing technique (Yalom & Leszcz, 2005) for group members to observe assertive behavior and the maintenance of appropriate boundaries. Upon resuming, the group processed reactions, which typically involved annoyance or fear that details of someone's index offense would become known to hospital staff.

- *Contributing Factors: "It really was the perfect storm"*

One of the core components of the group was members' construction and presentation of a behavioral chain analysis of their index offenses based on the DBT model, which examines vulnerability factors, precipitants, linking events, problem behaviors, and consequences (Linehan, 2015). Chain analysis was included because it helps address trauma as an informal exposure technique; teaches and improves individuals' ability to see patterns in thoughts, behaviors and emotions; provides opportunities for in-group skill learning; and can be used in a relapse prevention plan, a requirement for discharge. Notably, the factors identified by group members as having contributed to their offenses are remarkably consistent with theories regarding psychotically driven maternal filicide (Resnick, 1969; d'Ordan, 1979; Holden et al., 1996; Kunst, 2002; Mugavin, 2008) and the interaction of trauma and SMI (Grubaugh et al., 2011).

Complex Trauma. Most group members reported extensive histories of trauma predating their index offenses, including physical and sexual abuse in childhood and adulthood. In addition to processing the effects of such experiences, members were

provided psychoeducation regarding the multiple and pervasive effects of trauma, and the potential effects preoffense traumatic experiences have on the development and maintenance of SMI symptoms (Grubaugh et al., 2011).

Isolation. Consistent with Kunst (2002), and perhaps a direct consequence of extensive trauma histories, group members described experiencing psychotic symptoms characterized by intense paranoia and fears of danger, persecution, and annihilation for some time prior to the index offense. As these symptoms emerged, members began isolating themselves from family and friends, believing these relationships were a source of the danger threatening them and their children. As their isolation grew, available sources of reality-testing decreased and reliance on internal processes increased, which intensified the psychotic symptoms (Grubaugh et al., 2011).

Reaching Out for Help. While themes of isolation were pervasive in the group, each group member identified a point prior to the offense when they realized something was amiss and reached out for help from people they were closest to. Unfortunately, in each instance these requests were unrequited. Discussions about this shared disappointment were rich and productive, as defensiveness lessened when blame was shifted, avenues for exploration of important relationships and interpersonal fluency opened, emotions members felt previously feel unentitled to were expressed, and opportunities for skill-building in assertiveness and interpersonal effectiveness were presented (Linehan, 2015).

Drive to Protect. Consistent with previous theories and explanations of maternal filicide, a unifying theme emerged from members' descriptions of the psychotic processes underlying their behavior toward their children. All believed that their actions would protect their children from imminent death or torture caused by supernatural forces (e.g., demons) or nefarious actors (e.g., the Illuminati). In each case, while the mothers knew they were physically harming their children, they were certain that in doing so, they were saving their children from Biblical damnation or extreme and irreparable harm. Understanding these processes was often the most complex and painful part of treatment, again underscoring the unique power of universality for this particular group. As Yalom and Leszcz (2005) explain, "Many individuals enter therapy

with the disquieting thought that they are unique in their wretchedness, that they alone have certain frightening or unacceptable problems, thoughts, impulses, and fantasies" (p. 6). Thus, perhaps the most powerful and transformative intervention of the group was to shine a light into the darkest corners of the group members' minds and, in doing so, prove they are not alone.

Focusing on the Present

In the midst of the quest for an understanding of the precipitants of the instant offense, group process also provided fruitful opportunities to discuss the "here and now," including both the dynamics that emerge in the therapy room and in the immediate moment (Yalom, 2002). Our work included assisting groups members in describing and managing difficulties associated with grief and trauma, processing others' unhelpful or inaccurate perceptions, and navigating the interesting interpersonal dynamics that manifested between members whose children had died and those whose had not.

- *Coping with Grief: "I can't believe my child is gone"*

Because of their experiences with lingering symptoms of psychosis as well as the need to protect themselves from ongoing stigmatization, the grieving processes of the women in the group were disrupted and incomplete. As their understanding of the contributing factors to the offense sharpened, many group members experienced a resurgence in grief and trauma-related symptoms, including nightmares, flashbacks, and dissociative experiences, and some became aware of the complexity of their grief due to its cause. One group member explained that as her understanding of the offense became more reality-based, she was increasingly aware of the need to "let go" of her son in order to move on; however, she remained reluctant to do so because she relied on memories of her son to keep her psychologically "safe." As tolerated, members' grief was worked through in group, and such discussions often benefitted from the introduction of coping skills, such as those included in the Mindfulness and Distress Tolerance modules of DBT (Linehan, 2015).

- *The Have's vs. the Have Not's: "Y'all are lucky your kids are still alive"*

Briefly discussed above is the decision to include group members whose offense could have, but did not, result in the death of their children. During some group

meetings, the fact that some members' children survived sat politely in the corner as the quiet elephant in the room. During others, the elephant trumpeted loudly with discussions of fairness and belief in a just world. The children who survived their mother's assault did so because others intervened at just the right moment to prevent their death. Thus, the discussion often centers not only around feelings of envy for the members who had the possibility of reconciliation with the surviving children, but also related to differential access to resources and a support network.

- *Coping With Stigma: "The staff/other patients have it out for me"*

The unit milieu can often take on schoolyard characteristics, complete with cliques and schoolyard bullies. What separates these dynamics from the schoolyard are often the choices of insults spewed, with jeers such as "babykiller" being the highest level of insult available. Thus, while some group members were able to successfully conceal the nature of their offense from peers, they continued to face constant reminders of the discrimination they face due to other's revulsion about their instant offenses. For those who are not so lucky, they often face direct victimization by peers and, at times, insensitive responses by staff. Many group sessions were spent helping the women disentangle feelings of being targeted for offense-specific reasons versus dealing with the normative experience of living in a forensic inpatient hospital. Regardless of the root cause of the problem, these interactions were constantly retraumatizing for group members. Unfortunately, this stigma often extended to members of the women's treatment team and evaluators, who have been known to cite the stigma surrounding the offense as grounds for continued hospitalization.

As the group progressed, several interesting changes occurred. Rather than insisting on individual transport, members eventually elected to walk to group together. When the group was interrupted by a staff member, some group members said hello or exchanged pleasantries with them rather than sitting quietly or making efforts to not be seen. These changes suggested to us that group members were experiencing decreased shame associated with their index offense, brought about by an increased understanding of the myriad factors that caused the offense to occur and increased cohesion among members. After the temporary suspension of the group in March 2020, several group members resid-

ing on the same unit have continued to show support for each other's treatment progress. Additionally, group members have continued to stay in touch via unit phone and through encouraging letters to members on other units.

Preparing for the Future

During the course of the group, one group member successfully achieved discharge to community outpatient treatment. This development both catalyzed a powerful expression of the instillation of hope (Yalom & Leszcz, 2005) and led to practical discussions of life beyond hospitalization.

- *Discussing Future Disclosures: "How am I going to tell people?"*

While most individuals with a criminal history face the possibility of discrimination based on that fact alone, the women in the group also must contend with discrimination based on their mental health history and the taboo nature of their instant offense. Discussions and role-plays about when it's appropriate, who to tell, and how to tell others about the offense were initiated when a group member was informed of her impending discharge in an attempt to prepare group members to face potential stigma and misunderstanding upon their return to the community.

- *Future Family Relationships: "Should I have another child?"*

Perhaps unsurprisingly, the instant offense had a profound impact on group members' familial relationships. While many of the women were able to visit with family members during their hospitalization, most had lingering concerns about how to discuss both the offense and their mental illness with them. The grieving processes of family members of women whose children did not survive often blame the mother, even going so far as to explicitly suggest to them they should not consider having children in the future. The group members whose children did survive were faced with a different but similarly challenging dilemma of repairing their relationships with their children (some of whom were old enough at the time of the offense to form a clear memory of the events). Universally, group members also reported that family and close friends continued to fragilize them, remaining vigilant about any stressor that might set off a cascade of mental health symptoms leading to further undesirable events.

Although the women in the group describe resentment of this fragilization, its

existence added to the uneasiness the women themselves had about the stability of their mental health and possibilities for a future. For instance, a weighty question shared by group members was whether or not to have children in the future. While no correct answer to this question exists, of the most profound aspects of the group was a space to freely explore this, and many other, painful intricacies of an unimaginable situation.

Discussion

While the themes identified in the current study arose from the responses of group members during the group process, they bore striking resemblance to the limited literature available related to maternal filicide. This not only adds support to the current literature, but further highlights the uniqueness of this clinical population. Our intention with this article is not to condemn anyone for personal beliefs they may hold regarding violence perpetrated against one's loved ones. The stigma surrounding filicide is given the sensationalized media portrayals of mothers who have harmed their children, the intimate nature of the mother-child relationship, and the prevailing belief that "something like that could never happen to me." Instead, we aim to promote an accurate understanding of maternal filicide among laypersons and mental health professionals alike, and to advocate for an empirically based approach to treatment that is trauma-informed, effective, and compassionate. To that end, we believe it is necessary to examine one's own personal and professional beliefs about filicide, the factual bases upon which they are built, and whether they might impede our ability to provide appropriate care to those with whom we work. This task is particularly salient in light of our group members' descriptions of unhelpful interactions with treatment providers that left them feeling misunderstood or, worse, looked down upon for their actions.

Broadly, results of the current study suggest that a broadening of current definitions and conceptualizations of traumatic events may be warranted. As mental health treatment providers increasingly seek to expand the provision of trauma-informed models of care, it is incumbent upon current practitioners to identify and recognize all potential causes of trauma, particularly those not typically viewed as trauma-inducing, such as that described herein. This calls for an expansion of traditional conceptualizations of trauma, which have

historically focused on adverse events happening to a person to the exclusion of acts of violence perpetrated by the traumatized person. Anecdotally, trauma responses stemming from psychotically driven acts of violence (particularly those involving significant harm or death to loved ones) are more often the rule than the exception among the forensic inpatient population with whom we work. This response often includes significant guilt, feelings of sadness or anger, flashbacks or intrusive thoughts about the act, and overwhelming concern that such an act might occur again in the future. In the most severe cases, it appears the individual's symptoms can reach diagnostic threshold for PTSD. A TIC approach in such captive settings, therefore, should account for this possibility and address trauma-related symptoms when clinically indicated.

Discussions of psychotically driven acts of violence most often center around whether the individual experiences remorse for the offense, but rarely leave space for the consideration of additional emotional responses. Namely, the possibility that one's remorse is part of a larger constellation of emotional difficulties associated with the act of violence remains largely novel. For myriad reasons, the individual, and perhaps even family members or treatment providers, may believe the process of grieving this loss is unwarranted or undeserved, often stunting the grieving process and negatively impacting the recovery trajectories. In searching for the origin of this disenfranchised grief within this population, it is not unreasonable to implicate the compounding effects of stigma associated with mental illness and with the violent nature of their committing offenses.

The current study also has considerable implications for the provision of trauma-informed models of care within forensic inpatient settings. The reconceptualization of psychotically driven acts of violence as trauma has promise as a crucial piece of the movement toward TIC in forensic treatment contexts. While the current case study provides a beginning framework for this reconceptualization, we relied on a small sample that differs even from the population of individuals adjudicated NGRI as a whole. Quantitative data about these differences is currently unavailable, which further limits the generalizability of the themes outlined above. This lack of data, however, leaves the reconceptualization of violence as trauma an issue that is ripe for empirical investigation, particu-

larly given that the prevalence and etiology of trauma-related symptomatology among individuals who have committed psychotically driven acts of violence remains unknown. As an important first step, we should seek to clarify how often this reaction occurs, for whom, and under what conditions. Additional exploration is also needed to identify relevant risk factors associated with psychotically driven violence against one's children or other primary family members (i.e., parents). Such inquiries have the potential to inform both risk assessment and risk management strategies, which form the cornerstone of treatment for individuals found NGRI. Indeed, an accurate conceptualization of one's past violence is essential in designing appropriate treatment programs for this population, both during their hospitalization and upon discharge to less restrictive settings. It is our hope that the themes and experiences we have shared will inform the assessment, conceptualization, and treatment of patients who have harmed loved ones due to psychosis or other symptoms of severe mental illness, and promote a trauma-informed perspective on violence perpetration in individuals in captive settings.

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The statements and conclusions in this article are those of the author(s) and do not necessarily represent the view or opinions of the California Department of State Hospitals or the California Health and Human Services Agency.

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Framing Gender-Based Violence: Implications for Effective Intervention

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HOW WE CONCEPTUALIZE violence matters. As psychologists, social workers, clinicians hailing from many training backgrounds, and members of ABCT, the way we frame the problem of violence has real bearing on our work and world. When we better understand our problem definitions, we may better understand which interventions we choose and why.

Problem definition is the framing of an issue; it is your understanding (or best guesses or assumptions) about what causes a problem, who or what is responsible, how that problem operates, and how to address and potentially change what the problem looks or feels like (Caplan & Nelson, 1973; Rappaport, 1981). For example: What causes gender-based violence? Is this an issue of temperament? One person's difficulty expressing frustration in the relationship? The escalation of conflict and poor conflict management skills? Someone focusing too much on their partner's negative affect because they've had too much to drink? A childhood trauma survivor's struggle to pick a healthy partner later in life? A victim's "learned helplessness"? A survivor's lack of vision of what life could be like outside of abuse? All of these theories have received some empirical support over the years and all reflect assumptions made about why gender-based violence remains so prevalent despite our prevention and intervention efforts.

Of course, some aspects of the latter examples are blatant manifestations of victim blaming. But there is more: What most of these examples share is an orientation to viewing violence as a problem or deficit that resides within an individual (be that individual a victim/survivor, perpetrator, or both). In large part, these examples frame violence as a problem of one person causing harm to another, or of one person finding themselves in abusive relationships throughout their life because of their own internal processes.

An alternate problem definition would paint that same violence as a manifestation of social norms, systemic inequalities, and a

broader question of power and oppression rooted in privilege. The truth may very well be in between; the answer could include both—violence as an individual-level concern that can be intervened with CBT, as well as violence as a community/societal-level issue that calls for a reshaping of our norms, values, and the ways our systems (e.g., healthcare, housing) operate in the everyday. Certainly, there is evidence of individual differences among those who perpetrate; in a review of risk and protective factors for sexual violence perpetration, the majority of factors documented so far were indeed at the individual level (e.g., willingness to perpetrate, rape myth acceptance, empathetic deficits; Tharp et al., 2012). Then again, if you only have a hammer (or a psychological lens), everything looks like a nail (or an individual psychological problem; Caplan & Nelson, 1973). Gender-based violence persists as widespread and has long been conceptualized as a social problem with socio-structural roots in patriarchy/sexism, racism, homophobia, and ableism (Crenshaw, 1991; Dobash & Dobash, 1992; Matthews, 1994).

Problem definition is not just a thought experiment: research has supported the notion that the way we conceptualize an issue influences how we respond to it (Campbell et al., 1998; Lehrner & Allen, 2008). Once we (meaning you, individually, or even a culture) latch on to a problem definition, it can be hard to let it go (Caplan & Nelson, 1973). As we head into the rest of this article, now might be a good time to consider: What is your problem definition regarding gender-based violence? What are your assumptions about why gender-based violence persists in someone's life? What have you imagined needs to change when you are working with a client who has been a victim/survivor of gender-based violence? If you work with people who have been impacted by violence, how does your own problem definition tangibly map onto your work?

Here, we'll introduce you to some key concepts and rationale behind domestic violence advocacy work. As we'll discuss, advocacy work does not perfectly overlap with therapy (and we know we are writing in the Behavior Therapist). When distilled to their most basic ideas, advocacy and therapy interventions take up gender-based violence in different ways. We do not compare therapy and advocacy for the sake of competition or to elevate one approach over the other. We write about these two approaches to illustrate how problem definition structures our action and to think about what is implicit in the way that we approach intervention with violence survivors. To keep us grounded in a specific example, we'll introduce you to the Community Advocacy Project (an example of an evidence-based intervention for domestic violence survivors; Sullivan, 2000; Sullivan & Bybee, 1999), an example of what robust advocacy interventions can look like for violence survivors. In our closing, we will also address how therapists might increase their awareness of advocacy resources in their area, take up survivor-driven approaches, and support their clients in accessing resources and opportunities.

Why GBV?

Gender-based violence (GBV) is a pervasive and complex issue; it is perhaps a particularly good example of an issue for which problem definition is particularly conspicuous. By calling sexual and domestic violence gender-based violence (GBV) here, we're showing you a large piece of our own problem definition. While the "G" of "GBV" certainly stands for gender, by calling this violence gender-based violence, we ourselves (no writer is without a problem definition) are framing the violence as being rooted in inequalities, with gender being but one important aspect of inequality in our society (Combahee River Collective, 1977; Sokoloff & Dupont, 2005).

Prevalence rates of GBV highlight it as a pervasive concern: for example, in 2019, the National Crime Victimization Survey estimated a rate of 2.7 rape or sexual assault victimizations per 1,000 people 12 or over (Morgan & Truman, 2020). Taking a deeper dive, we see that rates of GBV are concentrated in minoritized populations. This does not mean that GBV is only a problem for people with marginalized identities; rather, it suggests that understanding power and oppression may be important to understanding GBV. For

example, Native Americans report some of the highest rates of GBV, and many of these assaults are from non-Native perpetrators (Rosay, 2016). Similarly, a layered analysis is needed to understand how transgender people are targeted with GBV at disproportionately high rates (James et al., 2016). Disabilities, neurodivergence, and more have been highlighted as identities that are associated with perpetrators targeting them for violence more often. Lydia X. Z. Brown (2017) wrote:

The complexity of inhabiting a body at once deemed disabled, queer, or transgender—transgressive in multiple ways—changes the ways in which gender-based violence targets us, exploits us, retraumatizes us, and isolates us from possible avenues toward support, recovery, and healing. (p. 163)

Additionally, research from intersectional scholars suggests that current ways of measuring GBV may systematically miss documenting experiences of abuse that occur at the intersections of, for example, being both Asian American and a woman (Buchanan et al., 2018). The COVID-19 pandemic has laid bare many health disparities, and the potential impact of this unique context onto GBV rates further highlights the complications when trying to capture the problem of GBV in prevalence rates (Rieger et al., in press).

GBV has an interesting history (and present) with problem definition. To give you just a sneak peek into this layered history: The domestic violence movement has advocated for recognition of intimate partner violence as a social problem requiring social change, rather than (or in addition to being seen) as an individual problem requiring traditional service provisions (e.g., therapy) since its beginning (Lehrner & Allen, 2008). Some fields, such as community psychology and social work, emphasize such foundations more than some training programs in psychology do. Grassroots movements to eradicate such violence began as pushes for broad social change (Campbell et al., 1998) and have a powerful history of antiracism efforts led by Black survivors (e.g., McGuire, 2010). Some accounts of the movement's history have described current efforts as curling back to an individual-level of analysis (e.g., Campbell et al.), while others emphasize that modern grassroots GBV efforts—particularly those led by communities of color—maintain this orientation to social change (e.g., Baker & Bevacqua, 2018). In

any event, the GBV movement has been noted as an interesting example of a change effort that combines individual direct service provisions (e.g., victim/survivor therapy) alongside sweeping sociopolitical analyses (e.g., proposing root causes in patriarchy, inequality, and/or racism—analyses that might better fit with community interventions; Lehrner & Allen, 2008).

Intervention at the Individual Level

Psychology has a history of identifying the deleterious effects of experiencing trauma and GBV (e.g., Dworkin et al., 2017). This history is both useful and complex. Given that the effects of trauma can include many urgent concerns for an individual's life (e.g., symptoms of anxiety, substance use, and suicide; Dworkin et al.), there is certainly an essential role for and need of therapeutic responses for trauma. This commentary does not negate that need. But it is likely, given that survivors are often navigating their safety through complex and confusing systems, that individual-level interventions will not suffice; even empowerment has been delineated as involving individual and organizational components (Christens, 2019). We also need interventions that actively intervene with the context of survivors' lives and this is the core aim of advocacy. Otherwise, we risk intervening with victims/survivors endlessly, leaving the roots of GBV and the inequities that sustain this widespread social problem untouched.

Individual- and community-level approaches certainly interact with each other. For example, therapy can support people in adapting to difficult situations (including the realities of violence that stems from/is connected to structural issues beyond a survivor's control) and challenging responses to these situations (e.g., the punitive labyrinth of a legal system we have for violence survivors in the U.S.). Until some science fiction utopia is established, these individual-level therapeutic approaches will be relevant and for some will indeed be helpful. But when you conceptualize violence and responses to violence as something beyond the individual, then these approaches alone are not enough.

The Context of Survivors' Lives

While intervening with individuals can be an important part of addressing GBV effects, potent outcomes have been demonstrated by intervening in the context of survivors' lives. Community psychology arose

as a response to concerns with taking an individual-focused approach to the exclusion of recognizing additional influences (outside of the individual, e.g., relationships, environments, and policies; Kennedy et al., 2012). Community psychology utilizes key theories regarding intervening with social context and empowerment-based interventions, carrying forward the idea that psychological well-being can be promoted through intervention on community and societal levels (Jason et al., 2019).

When taking a conceptualization that GBV is a problem that lives and thrives outside of an individual (while, of course, still personally impacting said individual), then intervention is not just about enhancing one's coping skills. Then, intervention is about changing the context of individual's life. The emphasis is on the context, not the person alone, and not the person primarily. Abstractly, this means not centering the root causes of violence—and even the impact of violence—within the individual.

What does an emphasis on context tangibly look like? In domestic violence advocacy work, it looks like emphasizing access to opportunities that people may not have had before (i.e., education, employment, relocating, social support, recreation) and on keeping a vision for longer-term resources rather than “getting stuck” in shorter-term resources (e.g., longer-term safe housing vs. securing emergency, temporary shelter). The short-term resources are and always will be incredibly important; in advocacy work, the intervention just does not end there. As you read this, you might be noting similarities between advocacy work and therapy.

A Bigger Picture for a Larger Context

A problem definition of GBV as being rooted in social inequalities also maps onto interventions that seek to change the context of many of our lives, whether we're working one-on-one with someone or we never meet a given individual (e.g., via policy change, practice/systems interventions). In theory, this might sound good (at least, it is exciting to us). Experts encouraging a push to community and societal-level interventions have themselves noted a need for more research on what community-level approaches for GBV prevention might entail precisely (DeGue et al., 2012a). Even community psychology, a field focused on “community,” has been criticized as not truly investigating com-

munity-level change (e.g., Luke, 2005); intervening at the community-level is an elusive and challenging goal. Exciting initiatives are under way: since roughly 2000, a Centers for Disease Control and Prevention initiative, Rape Prevention and Education, has been leveraging federal funding to encourage rape crisis centers (community based organizations that provide therapy, advocacy, and prevention services) to shift public perception of sexual violence towards a public health conceptualization, encourage rape crisis centers to focus their prevention efforts on primary prevention of perpetration, and—most relevant to our discussion—encourage adoption of community change strategies (DeGue et al., 2012b).

For now, regarding intervening at the level of the context of survivors' lives, there is an evidence-based advocacy approach that has been implemented and studied in various communities: The Community Advocacy Project.

The Community Advocacy Project

Community psychologists developed the Community Advocacy Project (CAP) in the mid-1980s, originally specifically designed to support women exiting domestic violence shelters (Sullivan, 2000; Sullivan & Bybee, 1999). CAP involves intense collaboration between an advocate and a survivor (4–6 hours per week for 10 weeks). Survivors determine their goals and needs, which often involve mobilizing multiple community-based resources (e.g., housing, health care, childcare, employment, social support, recreation, education). The advocacy is highly individualized and, thus, there are no set goals with which advocates enter the relationship. Rather, advocates (who are paraprofessionals) focus on helping the survivor increase access to resources and opportunities. This emphasis on opportunities is critical; advocacy is not about providing a service—rather, advocacy is all about securing access to longer term community supports (Sullivan & Goodman, 2019) and encouraging community change via institutionalized advocacy that may benefit other survivors. Thus, even advocacy rooted in changing the context of one survivor's life has the potential to highlight the need for systemic, institutionalized change.

The advocacy intervention involves five phases (some of which can occur simultaneously): gathering information about the survivor's needs and desires, implementing/mobilizing community resources (a

phase that often involves both individual and systems-level work—e.g., securing a rental agreement for the individual survivor and advocating for shifting housing policies in the broader community), evaluating with the survivor how the implementation is going, trying something new as needed, and terminating the advocacy at an agreed upon time, with the advocate equipping the survivor with written resources (Sullivan, 2003). As a CBT therapist, some pieces of this might sound parallel to your work. Particularly if your training may have been in the field of social work, these foundations may sound quite familiar.

But, this might still be unclear. Indeed, advocacy is comprehensive and highly individualized for each survivor and can look quite different between participating survivors. All advocates work intensively with survivors over a period of time; they all work on wants and needs identified by survivors. Sometimes, survivors work on educational goals, changing fields of employment, locating housing, navigating civil and criminal justice processes (e.g., divorce court, orders of protection), obtaining additional financial resources, mobilizing greater natural support, seeking more opportunities for recreation and restoration, obtaining material goods for their homes, meeting children's educational needs, advocating for their children within the school system, managing complex medical needs, and pursuing counseling to address mental health needs. In this list, mental health needs, explicitly, are one of many possible foci. To pursue survivors' goals, advocates and survivors meet multiple times a week, often while the advocate is accompanying the survivor to mobilize needed resources and provide community-based advocacy (e.g., legal, medical). Whereas in many therapy providers deliver interventions to clients, even if collaboratively, advocacy is explicitly built to be a survivor-driven partnership, and much of advocacy occurs “on location.” Advocacy emphasizes passing the development and maintenance of advocacy skills to survivors. This is not done only through didactics or conversation; it is done through “going with” people in many senses of the phrase. In addition to planning and role playing, advocates also support skill transfer through modeling advocacy behavior by accompanying survivors in real time as they engage with complex systems.

Importantly, CAP is an empirically supported intervention that has been implemented in the United States and—recently,

with cultural adaptations and delivered by local therapists—in Mexico (Sullivan et al., 2019). Trainings for CAP are being planned and/or delivered in even more places, including Portugal and Australia. In research trials, survivors who worked with advocates were safer, had more social support, a higher quality of life and greater well-being when compared to survivors who did not work with advocates (a services as usual control group). These differences persisted even 2 years after the intervention ended (Bybee & Sullivan, 2002; Sullivan & Bybee, 1999). Further, Bybee and Sullivan (2002) found that a critical process, the increase of social support and resources, in turn increased quality of life; quality of life was then associated with lower rates of abuse in the future.

The way that advocacy services are delivered is important. Critically, CAP advocates assume that the survivor is the foremost expert on her life (here, we use “her” because the intervention was tested specifically with women survivors of intimate partner violence perpetrated by men, but we posit that advocacy interventions can support people of all genders). While advocates bring expertise, they never assert that they know what would increase a survivor's safety and well-being. The survivor is uniquely situated to make this determination. Advocates are explicitly not in a service provider or “expert” role (Sullivan & Goodman, 2019). This is essential because working to become safe from an abuser requires a myriad of complex decision-making. An advocate supports this decision-making, but never overrides or shapes a survivor's actions. Thus, survivors make the final decisions in advocacy. This requires that advocates be nonjudgmental, supportive, and validating throughout this process.

Advocates are also strength-based. This means that advocates take a problem definition of domestic abuse as violence that stems from and is perpetuated by society not because of something the survivor did or failed to do (e.g., choosing the wrong partner). For example, rather than viewing survivors as people who have learned to be helpless, survivors in CAP are assumed to be actively seeking help, an empirically supported assertion (e.g., Kennedy et al., 2012). Advocates are trained to notice strengths and to view survivors as people with many capabilities that can be fortified in ways that the survivor deems most fitting at that time. The emphasis is on recognizing and then actively building skills to capitalize and fortify those strengths, not

just by building strengths at the individual level, but by identifying and creating changes in context that allow those strengths to be realized (e.g., finding new employment opportunities aligned with a survivor's capacities and strengths; facilitating new opportunities to pursue hobbies of interest and building social support around those hobbies; pursuing a new educational opportunity and mobilizing the many resources needed for a successful return to school: financial, childcare, transportation).

Advocate training centers on familiarity with many community resources, as advocates need to be well connected to local supports and opportunities. When advocates develop and sustain partnerships with community leaders and people at community-based agencies, they can push for policy and practice change (Sullivan & Goodman, 2019). Advocates do attend to present emotions as they share "emotional support as it emerges naturally in the relationship" (Allen et al., 2013, p. 3), but not in the way that therapists are trained to do.

Advocates are also expected to be culturally humble (emphasizing reflection and continuous learning; Sullivan & Goodman). The central purpose of advocacy is to actively engage survivors in the mobilization of community resources and to support the survivor's ability to apply knowledge of resources/options and new skills (so that the advocate is not needed—or less needed—as a result of the advocacy intervention). Thus, advocates focus on the transfer of the skills regarding mobilizing community resources. This skill transfer is nurtured throughout the intervention as advocates work with and on behalf of survivors rather than doing things for them or to them (Sullivan & Goodman).

What Does This Mean for Therapists?

Therapy and advocacy for people impacted by violence are both important, and are different. They share some overlap, and elements of each might be incorporated into the other. For example, you might have read the description of CAP

spotting similarities with your implementation of CBT or envisioning similar required skills for advocates and therapists. Yet, distilled to their basic forms, therapy and advocacy take up violence in different ways. Because advocacy and therapy, while complimentary, are distinct approaches, the suggested solution here is not to tack advocacy onto whatever therapy your practice is currently engaged with. Yes, incorporating elements of advocacy work into therapy is possible (i.e., supporting survivor's decision-making; taking a nonjudgmental, strengths-based stance), and many therapists do this regularly. The goal of this commentary is to introduce comprehensive, community-based advocacy as an essential part of effective intervention in survivors' lives and to invite you to consider various problem definitions regarding violence. You may have already noted that our problem definition includes a proposal that when working with survivors, it is essential that the intervention not only support the individual, but actively work to change the context of the individual's life; this is key to fostering longer-term safety and freedom from abuse. When CAP was designed, one intention was that advocates' systems-level advocacy would combine and crescendo into community-level change, with project supervisors spurring policy change in some areas. The emphasis, thus, is on community responsibility for this violence (Sullivan, 2003).

See Table 1 for take-aways/applications to your work as a therapist. See Table 2 for resources to learn more about advocacy and advocacy resources in your area. It is perhaps all too easy to misapply societal-level understandings of domestic violence causes as individual-level interpretations (Lehrner & Allen, 2008). When working with survivors of violence, including gender-based violence, it is important to attend to the context of a survivor's life—and to be thoughtful and intentional about how you, as a researcher/practitioner/community member yourself, frame violence. As you see in Table 1, and may have already reflected on yourself, how you frame violence maps onto how you might plan to intervene and support survivors and communities. Still, it is not just about what you think—for you, too, are a person within a context. Shifting to or continuing to use interventions that act on context is more than about you, as one reader, buying into an ecological analysis of GBV or not. It is about the larger field.

Table 1. Problem Definition and Intervention Takeaways

| | |
|-----------------------------------|--|
| Problem definition | There are many ways to conceptualize what violence is and why it exists/is so pervasive. How you frame violence as a practitioner and/or researcher has real influence on your work. |
| Levels and kinds of interventions | In part because there are so many ways to conceptualize violence, there are so many ways to intervene Therapy, as well as some forms of advocacy, intervene at the level of the individual. Advocacy, at its heart, focuses on supporting individuals in connecting to community resources (i.e., education, housing, healthcare, food security, employment, social support). This is one way to attempt to intervene at the context of a survivor's life (some therapists and therapies already take up this work in various ways). If we understand/frame violence to be, at least in part, fueled by inequalities, then intervening at the level of the context of a survivor's life, whether by connecting a person to more resources that they did not have before, or by fighting for broader evidence-based policy change, may be especially fitting. |
| Advocacy tenets | Survivor-centered Strengths-based Nonjudgmental, validating Comprehensive, individualized Focused on changing the context, not the survivor Emphasize community resources and actual access to opportunities Emotionally support survivors as needed |

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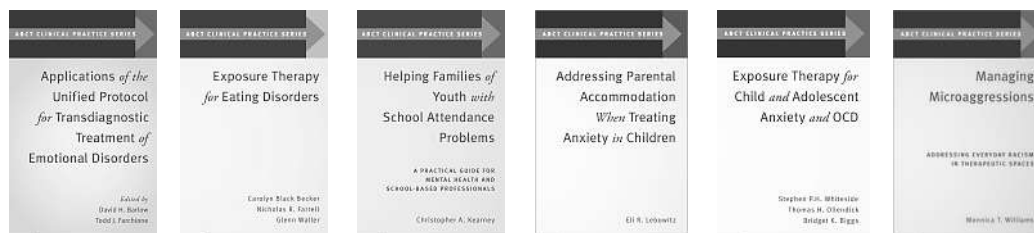
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Table 2. Example Next Steps to Learn More

| | |
|--|---|
| Gender-based advocacy resources near you | Find the rape crisis center nearest to you: centers.rain.org Find the domestic violence shelter nearest to you: domesticshelters.org See https://cap.vaw.msu.edu/ for more information about the Community Advocacy Project (CAP) |
| Policy/practice change | Learn from the Centers for Disease Control and Prevention about how research can inform practice: https://www.cdc.gov/policy/polaris/index.html Learn how researchers can partner with policy makers from the Research-to-Policy Collaboration: research2policy.org |
| How your work already connects with, and can grow to connect with, community psychology principles | Check out community psychology and the Society for Research and Action (APA Division 27) |
| Connections between gender-based violence and inequalities from activists and advocates | Explore the work of INCITE!, a grassroots anti-gender-based violence organization led by radical feminists of color that centering women and transgender people of color: incite-national.org View the Futures Without Violence Anti-Racism as Violence Prevention video series: https://www.futureswithoutviolence.org/health/racism/ Browse resources from the National Resource Center for Domestic Violence's 2020 theme "No Survivor Justice Without Racial Justice": https://www.dvawareness.org/node/69 Be inspired by practice-based work by browsing PreventConnect's webinar bank for practitioners: preventconnect.org |

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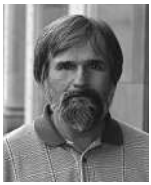
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OBITUARY

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ONCE IN A GREAT WHILE, if you're lucky, you meet someone who will be part of your life forever. Jeffrey M. Lohr, Ph.D., our mentor, colleague, and dear friend, was one of them. From the first day we met him to the last day we spoke to him, he was as he always was—a deeply thoughtful, genuinely kind, intensely curious, and outspoken individual who did not really look like most people's notion of a clinical psychologist at all. To the outside observer, Jeff looked more like a woodsman (more on this later), with worn jeans, rolled-up sleeves, and various Band-Aids on his hands as a testament to his work ethic and the never-ending sense of drive and responsibility to how he approached life. In all fairness, he did clean up well when the occasion called for it—blazers when presenting at ABCT and Hawaiian shirts for other times of importance. On April 27, 2021, we learned that Jeff had passed away. Among the many “Lohrisms” we were taught along the way, he reminded us to “press on through the fog.” Press onward we will, and in doing so, a smattering of his graduate students would like to share with you the insiders' perspectives on those things that will keep Jeff Lohr in our hearts forever.

Jeff received his Bachelor of Science degree in Psychology with Honors at the University of Wisconsin. He then received his Ph.D. in clinical psychology from the University of Hawaii in 1973, where he studied under Arthur Staats in the early days of cognitive-behavioral therapy. He then went on to complete a predoctoral internship at the University of Hawaii's Counseling and Testing Center and a postdoctoral fellowship in behavioral modifica-

tion at SUNY Stony Brook. ABCT was very much his professional home, where he chaired the Academic Training Committee and served as Editor of the Science Forum in *the Behavior Therapist*.

As a professor of psychology at the University of Arkansas, Jeff's research encompassed a wide range of issues. His early research efforts focused on the measurement and mechanisms of irrational beliefs. A significant contribution of this work was the identification of distinct facets of irrational beliefs, their association with various symptoms of psychopathology, and their differentiation from other psychological constructs.

Jeff also made significant contributions to the study of domestic violence. This work was instrumental in highlighting gender differences in the initiation of partner violence as well as the differential functions of violence by men and women. His work also identified anger expression as a substantive interpersonal context or motivation for domestic violence. This finding informed his subsequent research on cognitive-behavioral strategies for anger management.

Jeff was especially interested in the cognitive and affective processes of anxiety and related disorders, mentoring his students in the basics of the scientific method using experimental psychopathology designs. In fact, his research on disgust sensitivity has been foundational in better understanding how individual differences in disgust proneness confer risk for the development and maintenance of anxiety and related disorders. This program of research has identified reliable disgust measurement properties, cognitive biases

associated with disgust, and unique patterns of behavioral avoidance that characterize the experience of disgust.

Jeff possessed a keen ability to intricately critique and analyze the experimental effects of psychological interventions, consistent with the mantra of open-minded skepticism that he ingrained in his trainees and students. He made meaningful contributions to the conceptual discourse on the value of experimental analysis of treatment effects, especially as they relate to trauma and anxiety disorders. Indeed, his publications on specific and nonspecific treatment effects derived from methodological examinations of psychological interventions are required reading for many of our own students and trainees.

Many of our favorite memories of Jeff were around his inquiry into pseudoscience, which culminated in his book *Science and Pseudoscience in Clinical Psychology*. We all have a copy of this classic work, perhaps in part because it was required reading for his course on the topic, for which he gave each student exactly \$2 (his per-copy royalty income) so as not to compromise his ethics for requiring the purchase of his own text. He was genuinely passionate about being a clinical scientist and a scientific clinician, always pushing the field of psychology to do what is right, guided by the evidence. He was vocal about his disdain for non-evidence-based treatments. His opinions were strong, yet thoroughly informed. Along the way, Jeff established and maintained a working group of like-minded professionals who shared his interest in strengthening the scientific roots of clinical psychology.

Jeff was an exceptional teacher. The standards and expectations he carried for his students were high. Right out of the gate in his foundational Behavior Therapy seminar, he reminded everyone that just because they got into graduate school, that did not mean they would pass his course. He was true to his word. Clear and fair—you needed to earn your grade. His teaching style was unique and dynamic, sincere and animated, often shifting tempo to drive home the core messages of his craft in a “back-alley” Shakespearean manner. Jeff had many loves—including his love of overheads, which he used long after PowerPoint had been invented. They were always loosely organized in semi-tattered manila folders, with an organizational scheme only known to him. He would emphatically transition between the overheads like an inspired playwright. His overheads always felt somewhat akin to the

Dead Sea Scrolls—browned, faded, handwritten, and absolutely full of knowledge. How we wish to have one more day, one more lecture, and one more chance to take in what his overhead projector put out.

Jeff mentored a long line of graduate students in his career at the University of Arkansas—his “merry band of pranksters.” Work ethic, research experience, character, and humor were the raw materials he looked for in building his lab. Jeff was intent on forging strong connections between senior and junior graduate students, modeling the essential role we all play in learning from and supporting each other. Graduate students were always engaged with the new students, whether it was to continue and grow the research program, to co-author presentations and publications, or to offer advice on internships, postdocs, and jobs. It is this network that he cultivated that many of us continue to lean on. It was never about him and always about his students. As maturity caught up with us, it became more apparent that it meant the absolute world to him knowing that his graduate students have a common lineage and share lifelong friendships with each other.

Sleeves rolled up were figuratively and literally how he approached mentorship. Elbow to elbow, side by side. From the first to the last draft of any academic product, he pushed his students to learn, to think, to do. No student of Jeff's can forget that red pencil means edits, and blue pencil means comments. He was a master at using Socratic questioning to guide his students to think critically and creatively fostering their self-confidence along the way. Jeff understood the importance of struggling, offering guidance and wisdom (often peppered with Latin phrases) when needed, yet did not shield his students from the lessons life was giving them at that moment. One “Lohrism” passed on to a graduate student who was anxious about defending his

master's thesis was “You need to be a duck today. Calm on the surface with your feet paddling like mad underneath.” He did not allow us to feel sorry for ourselves when the task at hand was difficult or when we failed. He was demanding but dutiful, critical but compassionate, formidable but fair. The truth is he was both our toughest critic and our greatest advocate. The production of good psychologists seems like one of his “highest callings” and best achievements. We recall his own words at his retirement dinner at ABCT. Surrounded by his graduate students across the decades, he simply stated that the opportunity to serve as a mentor is what gave his career the most meaning.

Jeff embodied the principle of service in the way he lived, mentored, and taught. His integrity inspired his students to do the same. The impact and reach of his guidance have extended far beyond their professional lives and have shaped the people they have become. He was a role model in every sense of the word.

Our professional and personal lives have been both enriched and entertained by Jeff's rare combination of intellect, wit, and compassion, all surrounded by his rugged exterior. Jeff had an iron-clad work ethic, perhaps owing to his own Midwestern upbringing or belief in the simple value of habit, that served as an example to many of his students. His students knew it was 5 p.m. without looking at the clock because that's when Jeff left the office, not a minute before or after. Of course, on rare occasions, you might catch him slipping out a little early—“playing hooky” as he would say—because the nymphs were hatching and the trout were biting. True to form, though, he would just as often be in the office on a Saturday, likely making up for that minor indiscretion.

The passion with which Jeff approached academic life was even more evident in the fierce intensity to how Jeff approached all

things in life outside of academics. His enjoyment of life was evidenced by his enthusiastic laugh, which could be heard echoing through Memorial Hall on any given day. Jeff absolutely loved animals, who in turn had a natural affinity towards him. He and his wife were particularly fond of pet rescues, especially pugs. A skilled woodworker, Jeff also loved making furniture in the Arts and Crafts style, as well as reclaiming old furniture and turning it into things of beauty. His lab always had the best chairs and desks, lovingly and painstakingly crafted. The apartments of his graduate students were outfitted with furniture refurbished by his own hands. We all have parting gifts from this master craftsman adorning our homes to this day that, like his mentorship, will last a lifetime.

Those who were close to him often saw his softer side in the way he nurtured what and who he loved. He noticeably and immediately softened when he spoke of his wife and their beloved pets. He also tended to the needs of his expansive garden and countless plants. Long after retirement, he returned to the halls near his old office to make sure that the plants he had left there were still thriving. Although Jeff was a dedicated scientist devoted to the improvement of the field of clinical psychology, there was never any doubt that his deepest love was for his wife, Mary Beth, with whom we believe he spent his best moments.

Jeff is survived by his wife, four brothers, and two sisters. He was loved and will be sorely missed. We would like to share Jeff's own personal closing from his retirement speech at the University of Arkansas: “What a long, strange, winding road of a trip it's been.” Thank you for allowing us to be part of your trip.

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ABCT PIONEERS SERIES

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Explore

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Changing Face of ABCT

David Teisler, *ABCT Director of Communications/Deputy Director*

Dakota McPherson, *ABCT Membership and Marketing Manager*

Denman Wall, *Dolci Interactive*

BIG CHANGES are afoot and should be materializing some time in June. Likely you will notice the website first, with its new color schemes, slightly modified focus, larger font sizes, and mobile responsiveness. Our new site will be totally mobile friendly, designed from inception with a growing mobile-dependent constituency in mind.

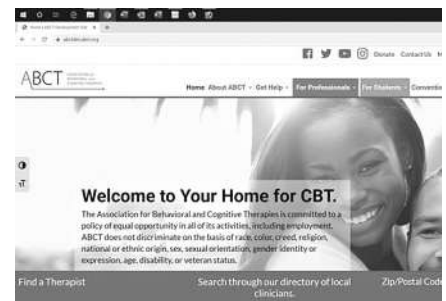
You'll likely note, too, a shift in organization, as we combine various tabs with the goal of making the information you value easier to find.

Some of the changes have more to do with the back end, the database (or AMS, Association Management Software) on which it is built. For instance, we have smoothed the login path for Convention Registration (RCS) and Journal Access (*BT* and *C&BP*), greatly enhancing the integration with our online partners. In essence,

your access to those services is now an extension of your abct.org login.

Look for a new list serve; no longer email-based, it is web-based, and allows you to create, follow, and save threads. We will start with just a few groups, but plan to expand to more niche groups once we have our feet under us.

We've streamlined the taxonomy, making the directories consistent in terminology. For those of you in the clinical directory (or who should be), you will want to look at the specialties you offer and populations you serve. We've consolidated these, and you may wish to refine them. You could use the week when we have both systems open to make some changes to your records. That is a perfect time to reset login and passwords (for added security).



Feel empowered to utilize the forms on the home page to tell us things that can be improved, or use the form to volunteer for committees looking for expertise or to contribute to ongoing projects, like our fact sheets and how-to videos.

You still get the broad and deep content, from syllabis to a directory of mentors, and from commentary on CBT to extensive COVID resources.

Enjoy!

CHAMPIONING CBT

ABCT 2021

Hyatt Regency New Orleans Hotel
November 18-21, 2021

Save the date!

*This year's Annual
Convention will be live!
It will take place on-site
at the Hyatt Regency
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Visit our convention
page for updates!*

Teaching an Experimental Therapeutics and Science of Behavior Change Approach

Michael W. Otto, *Boston University*

Jeffrey L. Birk, *Columbia University*

Rebecca E. Lubin, *Boston University*

A CORE FEATURE of the National Institute of Mental Health Strategic Plan for Research, as it impacts treatment development, is an emphasis on an experimental therapeutics approach (<https://www.nimh.nih.gov/health/publications/strategic-plan-for-research/index.shtml>). The experimental therapeutics approach focuses on how treatments work as a core stage in treatment development. With this approach, research begins with identification of a hypothesized target mechanism (a risk, causal, or maintaining factor) through which the intervention is expected to have its effects. The next step is to show that the intervention adequately engages (modifies) the mechanism. With successful modification of the putative mechanism, the final step is showing that engaging the mechanism exerts a measurable effect on treatment outcome. As compared to standard clinical trials, studies utilizing an experimental therapeutics approach are designed to provide the field with richer information about the nature of both disorders and clinical interventions by ensuring that mechanistic information is known at the outset, so that interventions can be evaluated with respect to “how disorders work.” One would think that this approach already is widely used within intervention trials focused on health behaviors, but a 2018 research report reveals this isn’t the case. A systematic review of the inclusion of mechanisms of action in National Institutes of Health (NIH)-funded intervention trials to improve medication adherence indicated that only 3% of such trials conducted or planned to conduct tests of behavior change mechanisms (Edmondson et al., 2018). Clearly, more attention needs to be given to the dissemination of the experimental medicine approach.

Help is on the way! There is an NIH-wide effort to apply the experimental therapeutics approach to understanding behavior change in the context of the NIH

Science of Behavior Change (SOBC) Common Fund (<https://commonfund.nih.gov/behaviorchange>). Common Fund initiatives are designed to address pressing challenges in biomedical research that no single NIH Institute can address on its own. Consequently, these challenges are engaged through a fund that cuts across multiple institutes but has one common set of goals. The SOBC Common Fund is devoted to discovering the underlying mechanisms (again, “the how and the why”) behind successful behavior change, with a primary focus on health behaviors. The SOBC Common Fund has been active over the last decade, and currently is in a continuation phase that includes offering resources to behavioral scientists through the SOBC Resource and Coordinating Center. The goal is to develop sustainable resources for the broader community of behavior change scientists. These resources include a measure repository, which is available to all clinical scientists (<https://measures.scienceofbehaviorchange.org/>) to view, download, or contribute measures for use in behavioral science, or related fields. These resources also include the focus of this article—offering teaching/dissemination resources to ensure the dissemination of the experimental therapeutics approach to the next generation of scientists through both undergraduate and graduate teaching. ABCT is part of this effort. Your society has now included on the ABCT web site (<https://www.abct.org/Resources/?m=mResources&fa=Slides>) a slide set for teaching about the experimental therapeutics approach and SOBC resources. The slide deck includes 48 slides that are accompanied by notes to provide background information for presenters. Teaching resources are also offered through the SOBC Channel on YouTube, where Grand Rounds sponsored by SOBC can be viewed (<https://www.youtube.com/channel/UCGDb2EzUBnXnScW2UnVtIIQ0>).

com/channel/UCGDb2EzUBnXnScW2UnVtIIQ0.

There are a number of specific advantages to utilizing and disseminating this approach for ABCT members and their students. First, the approach attends directly to the core question of “why does a treatment work” that motivates so many behavioral scientists within ABCT. Second, an experimental therapeutics approach places a much-needed focus on principles of treatment. As such, for subsequent treatment manual development and utilization, it guides psychological scientists and clinicians at the level of principle (what sort of target needs to be modified) rather than at the level of protocol (just do “this”). This approach has the potential to address one of the putative practitioner complaints about manualized treatments: that they represent a rigid protocol that stymies individual adaptation and innovation (cf., Addis et al., 1999; Gunter & Whittal, 2010). Finally, attention to the experimental therapeutics approach is important for obtaining research funding. Use of the experimental therapeutics approach is evident across institutes at the NIH, and is an encouraged or required element of the research plan for a wide range of funding opportunities (e.g., <https://commonfund.nih.gov/behaviorchange/related>). So, for purposes of good science, good dissemination, and good funding, we hope you will consider adopting the Experimental Therapeutics/SOBC slide set for teaching for one of your courses.

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Students!

Stay tuned for the complete Call for Award Nominations at abct.org

Visit our Awards page for full criteria, applications, deadlines

Student Travel Award

This award recognizes excellence among our student presenters and is intended to defray some of the significant travel costs associated with presenting at the convention with a cash prize of \$500. This award money is to be used to facilitate travel to the ABCT convention.

Submissions for the Student Travel Award will be accepted until July 23, 2021.

Elsie Ramos Memorial Student Poster Awards

This award is given to student first authors whose posters have been accepted for presentation at ABCT's Annual Convention. The winners each receive an ABCT Student Membership and a complimentary general registration at the next year's ABCT's Annual Convention.

Submissions for the Elsie Ramos Memorial Student Poster Awards will be accepted until July 23, 2021.

ABCT's Champions of Evidence-Based Interventions

This award recognizes outstanding individuals who have shown exceptional dedication, influence, and social impact through the promotion of evidence-based psychological interventions, and who have thereby advanced the mission of ABCT. Importantly, the goal of the award is to identify individuals who translate the impact of research into community health and well-being outside of the scope of their job requirements. Individuals who perform this function as part of their normal job (clinical or research) will not be considered for the award. Champions may not be members of ABCT at the time of their nomination.

► Potential Candidates

Nominees should demonstrate the characteristics of champions, broadly construed, as recognized in the implementation science literature (see Knudsen, Gutner, & Chorpita, 2019, for examples relevant to ABCT: <http://www.abct.org/docs/PastIssue/42n1.pdf>). Champions are those individuals who support, facilitate, diffuse or implement the core assets of evidence-based interventions. Champions' efforts expand the scope and impact of evidence-based interventions beyond the reach of researchers alone. They differentiate themselves from others by their visionary quality, enthusiasm, and willingness to risk their reputation for change. Ideal candidates should have demonstrated the following: (1) How the individual has recognized the potential application and impact of evidence-based psychological interventions; (2) How the individual has gone beyond their formal job requirements within an organization to relentlessly promote innovation; and (3) How they actively lead positive social change.

► Recognition

Nominees will be reviewed in June and October by the Dissemination and Implementation and Stakeholder Engagement Committee (DISEC), and those meeting criteria will be forwarded to the ABCT Board of Directors for approval. Recipients will be notified by the ABCT President, and their names and photographs will be posted on the ABCT website, along with the rationale for their recognition. Each year's champions will also be acknowledged at our annual awards ceremony at the ABCT Convention.

► How to Nominate

Email your nomination to Champions@abct.org. You can download the nomination form from the Champions web page: <https://www.abct.org/Members > Champions>. Be sure to include "Champions Nomination" in the subject line. Once a nomination is received, an email will be sent from staff, copying the DISEC Chair. The nomination will be reviewed by DISEC, and if deemed appropriate for our program, will be forwarded to the ABCT Board of Directors for final approval. Once reviewed and approved by the Board of Directors, the nominee will be contacted directly by the President, followed up with an ABCT staff member for a final review of the copy to be posted on the ABCT website.

Deadline for Nominations: June 22

abct.org > For Members > Champions

Revised Fellow Status for ABCT

ABCT Fellows Committee

OVER 50 YEARS AGO, the professional organization now known as the Association for Behavioral and Cognitive Therapies (ABCT) was created. In this time, there had been occasional discussions about creating a new membership category. In 2014, the Board of Directors voted to formally create a new and distinguished category, Fellow status. The Fellow status was intended to be an opportunity for full members to be recognized by a group of their peers for distinguished, outstanding, and sustainable accomplishments. ABCT named a group of distinguished members to serve on the first Fellows Committee, who then rolled out a plan and criteria for soliciting full members for Fellow status. Currently, there are 214 Fellows, including some members who were grandparented as they served ABCT in a distinguished and outstanding manner (i.e., 48 past presidents, 3 of the 10 founding members who were not president of the organization, and all ABCT's Lifetime Achievement award recipients).

After the first 3 years of reviewing applications, the Fellows Committee (FC) asked the Board of Directors to suspend the Fellow status selections to allow us to reevaluate the selection procedures with the goal of developing criteria that are more inclusive and representative of a greater number of full members. In addition, an explicit commitment was made to equity, inclusion, and supporting diversity in Fellow status, across all diversity dimensions. Although this was always implicit, we felt it important to encourage applications from all eligible members, with attention to underrepresented groups among those considered for and receiving Fellow status. In their review, the FC recommended to the ABCT Board of Directors that there be five major areas of consideration (i.e., criteria areas) that better reflect outstanding and sustainable contributions to the field of behavioral and cognitive therapies. The six areas of consideration that will be used to review and select new Fellow members are as follows: (a) clinical practice, (b) education and training, (c) advocacy/policy/public education, (d) dissemination/implementation, (e) research, and (f) equity, inclusion and diversity.

semination/implementation, (e) research, and (f) equity, inclusion and diversity.

The FC also revisited the Fellow status application process, mission statement, criteria, guidelines, and wording of ads, and also developed a new marketing plan. Lastly, the FC came up with written examples that members and their letter writers could use to describe the applicant's contributions for Fellow status. The remainder of this article will describe these revisions. If you want to apply for Fellow status, please visit <https://www.abct.org/Members/?m=mMembers&fa=Fellow> for a complete description.

In its role related to changing criteria for being considered for Fellow status, the committee examined professional statements from similar professional organizations and adopted the following mission statement: "Fellowship status is a high honor bestowed by ABCT to distinguished full members. Fellows of ABCT shall be members in good standing who have made outstanding and sustained contributions in one or more of the following areas in the field of behavioral and cognitive therapies: (a) clinical practice, (b) education and training, (c) advocacy/policy/public education, (d) dissemination/implementation, (e) research, or (f) equity, inclusion and diversity."

Revised Criteria for ABCT Fellow Status for Full Members:

- Receipt of a terminal graduate degree (e.g., Ph.D., Psy.D., M.D., MFT, MSW) in behavioral and cognitive therapies or a related area.
- Full (not student) membership in ABCT for ≥ 10 years (does not have to be continuous).
- At least ≥ 15 years of acceptable professional experience subsequent to receiving a graduate degree.
- Evidence documenting impact beyond the immediate setting in which the nominee works.
- Evidence of distinctive contributions to behavioral and cognitive therapies that are recognized by others as excellent.
- Fellows shall be full members in good standing who have made outstanding

and sustained contributions in at least one or more of the following areas: (a) clinical practice, (b) education and training, (c) advocacy/policy/public education (d) dissemination/implementation, (e) research in the field of in behavioral and cognitive therapies or a related field, (f) significant contributions in equity, inclusion and diversity.

- To demonstrate outstanding and sustained contributions or performance in an area, both applicants AND their letter writers must provide evidence of such accomplishments.
- Evidence documenting impact beyond the immediate setting in which the nominee works.
- Service to ABCT should be included, if relevant, but it is not itself sufficient. Annual attendance and presenting at the conference, ABCT being your professional home or having sat on a committee—these are all expected and necessary, but not sufficient to achieving Fellow status.
- Two letters of reference, including one from a current Fellow of ABCT. Not knowing a Fellow should never be an impediment to attaining Fellow status. If a potential applicant does not know a current Fellow who could write a letter of recommendation, he/she/they should reach out to contact the Chair of the FC: fellows@abct.org. To help applicants as well as letter writers address the criteria for fellow status, the revised FC's website contains a list of statements that reflect how to write statements supporting an applicant's strengths as well as statements that are weak and should be avoided. The examples are broken down by category.
- Active engagement at the time of the member's fellows application in the advancement of the field of behavioral and or cognitive therapies.

To learn more about the ABCT Fellows application process and criteria, interested applicants should go to <http://www.abct.org/Members/?m=mMembers&fa=Fellow>. Applicants and letter writers are strongly encouraged to include detailed and specific descriptions of the contributions that are considered to be outstanding and sustainable. In this regard, the FC has offered guidelines to help everyone, including applicants, letter writers, and future committees who will be reviewing applications, by providing very specific ways to present recommendations. The list of recommendations for how to write letters of

reference for potential fellow applicants is on the FC web page at <http://www.abct.org/Members/?m=mMembers&fa=Fellow>

It is on the onus of applicants as well as letter writers to clarify the contribution AND the impact of the work/activity. It will be important to elucidate the ways in which the identified contributions are above and beyond what would typically be expected in the job. Although only one of the six content domains needs to be identified in any given application, it is likely that multiple domains will be identified due to the overlapping nature of the categories. Regardless of the number of domains identified, the FC will adjudicate the application in its entirety. Because members' career paths come with unique opportunities, the committee will be sensitive to the environment in which the prospective applicant is functioning and will weigh the contributions against the scope of the current/primary career. Because ABCT is also committed to fostering equity and inclusion at all levels, the application also provides an opportunity for applicants to describe how their own diversity may have contributed to the impact that they have made in their local and broader professional contexts.

Examples of weak and strong statements for the content domain of Education and Training is as follows:

Examples of Statements for Applicants

Weak: *I am training director for XX program.*

Strong: *I created/updated XX program from a nonempirical training model to a strong evidence-based, cognitive behavioral training at <location>. In the past # of years, we have graduated XX students and consulted with ## other training programs to improve their training in cognitive behavioral therapy.*

Weak: *My course evaluations are routinely very high.*

Strong: *I have mentored and trained a number of underrepresented students and individuals from low-income environments who have gone on to develop well-respected careers and have advanced evidence-based care. These individuals include <names>.*

Examples of Statements for Letter Writers

Weak: *This individual is a Full Professor at XX University.*

Strong: *<Name>'s textbook is the seminal volume for learning about cognitive behavioral treatment of XX. Moreover, their teaching ratings are exemplary. A typical comment from a student expressed "<name>'s enthusiasm for this subject was infectious and has made me want to learn more."*

Weak: *<Name> has done a series of talks at the local library and has a blog that addresses XX.*

Strong: *<Name> has provided the first series of talks at the local library on XXX, which have resulted in requests for learning more cognitive behavioral therapies from professionals, media representatives, and patient advocates. <Name> has also maintained a well-subscribed YouTube channel that contains numerous videos of mini-lectures, case examples, and clinical tips.*

The Fellows application page, <https://www.abct.org/Members/?m=mMembers&fa=Fellow>, on the ABCT website contains examples for the remaining five content domains. Please remember that these examples are but a few of what could be considered a meaningful and exemplary contribution.

In closing, the members of the Fellows Committee hope version 2.0 of the Fellows criteria are more inclusive of the full range of accomplishments across the membership. If you believe that you have made a sustained and meaningful contribution that goes above and beyond the expectations of your primary position, we look forward to receiving your application.

The FC encourages qualified and diverse applicants to apply. The FC selected July 1, 2021, as the deadline for applications and letter writers to submit their references for the 2021 pool of applicants. Applicants will be notified of the decision on their application by October 1, 2021. ■

ABCT Fellow Status



Fellow status is a high honor bestowed by ABCT to distinguished full members. ABCT is committed to equity, inclusion, and supporting diversity in Fellow status across all diversity dimensions; we encourage applications from all eligible members, with attention to encouragement of underrepresented groups among those considered for and receiving Fellow status. Fellows of ABCT shall be members in good standing who have made outstanding and sustained contributions in one or more of the following areas of consideration: (a) clinical practice, (b) education and training, (c) advocacy/policy/public education, (d) dissemination/implementation, (e) research, or (f) equity, inclusion, and diversity. Service to ABCT is important, but not sufficient for Fellow status.

Before submitting an application, please visit the web page below and review ALL information about the Fellows application process and criteria:

<http://www.abct.org/Members/?m=mMembers&fa=Fellow>

► **All materials must be received no later than
July 1, 2021**

Core Leadership Values for ABCT

Patricia Marten DiBartolo, *Chair, Leadership and Elections Committee*

SCIENCE, DIVERSITY, mentorship, accountability, and quality—these are the core values that undergird ABCT's strategic plan. In these challenging and tumultuous times, as we focus on healing in our personal and professional roles, these values are more important than ever before. They undergird and enable ABCT's strategic mission—to foster human health and well-being through scientific understanding and evidence-based principles—and are likely part of what drew you to the organization in the first place.

In this difficult moment in our collective history, let us keep in clear focus how these values can propel ourselves and the communities we serve toward renewal and recovery. How can we enact them? Our organization's nomination and election annual process is an opportunity for each of us to strengthen our commitment to ABCT's values and to hold our governance accountable to these same commitments. Your Leadership and Elections Committee is responsible for shepherding elections with a slate of candidates energized by our organization's values and mission. Consistent with one of ABCT's central strategic initiatives, we seek to diversify our notions

of leadership in order to build a more just organization that can reflect those same values in our varied collective work.

As we launch our 2022 election cycle, we ask you to think about your community within ABCT and consider: Who embodies these commitments? What about you?

For the upcoming 2022 election, we seek nominations for ABCT's next President-Elect (2022–23; President, 2023–2024; Immediate Past President, 2024–2025) and for a Representative-at-Large (RAL; 2022–2025). Each RAL serves as a liaison to one of the governing branches of the association. The representative position open for 2022 will connect and coordinate with the Academic and Professional Issues Coordinator and committees. You can nominate any full member in good standing in the organization and there is no limit to the number of nominees you can put forward for any position. Candidates with the most nominations will be the only official names on the ballot once voting commences.

Membership on the Leadership and Elections Committee, approved by ABCT's Board of Directors, includes a chair and two members. Our Chair is Patricia DiBar-

tolo (pdibarto@smith.edu), from Smith College, who has served on the committee since 2016. Kristen Lindgren of the University of Washington School of Medicine is a continuing member (kpl9716@u.washington.edu), joined recently by Simon Rego at the Albert Einstein College of Medicine (dr.rego@gmail.com). Any one of us, as well as ABCT's Executive Director, Mary Jane Eimer (mjeimer@abct.org), would be happy to answer your questions and encourage your involvement in the organization.

If you do not have time to commit to run, we hope you will express your investment in ABCT's future by voting in the election. One measure we track of whether we have hit our mark as a committee is the percentage of members who cast votes. Not surprisingly, our voting participation felt the hit of the pandemic last year; never complacent, we seek to increase rates of membership participation in the voting process this year. The election will again run in the fall, overlapping with the timing of our Annual Convention. Mark your calendar and do not forget to cast your vote. It matters.

For many of us, ABCT is an intellectual home, one whose mission aligns with our professional values. Exert your privileges of ABCT membership—nominate and vote—so that together, we can realize the organization's loftiest goals: to enhance and promote human health and wellness. We look forward to hearing from you, in the voting booth and outside of it.

I nominate the following individuals:

► **PRESIDENT-ELECT (2022–2023)**

► **REPRESENTATIVE-AT-LARGE (2022–2025)**
Liaison to Academic and Professional Issues

► **NAME (printed)**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years.

Only full and new member professionals can nominate candidates. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions. Candidates for the position of President-Elect shall ensure that during his/her term as President-Elect and President of the ABCT, the officer shall not serve as President of a competing or complementary professional organization during these terms of office; and the candidate can ensure that their work on other professional boards will not interfere with their responsibilities to ABCT during the presidential cycle. Please complete and sign this nomination form. **Only those nomination forms bearing a postmark on or before September 1, 2021, will be counted.**

Send your form to Patricia DiBartolo, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001 by Wednesday, **Sept. 1, 2021**. Or email to membership@abct.org (Subject line: Nominations)



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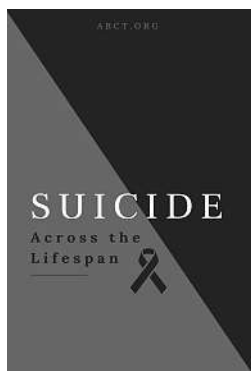
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ABCT Launches Inaugural Briefing Books Initiative



To coincide with the its 54th Annual Convention, ABCT launched its inaugural Briefing Books project. The initiative is the brainchild of Emily L. Bilek, Ph.D., ABPP, of the Public Education and Media Dissemination (PEMD) Committee, and David Teisler, CAE, Director of Communications/Deputy Director. PEMD coordinates projects with the Publica-

tions Committee and handles press relations for ABCT. The driving force behind the Briefing Books was the desire to provide resources for media and the public who want quick access to materials that explain evidence-based treatments for mental health. In January the committee put out a call to members asking for volunteers to spearhead the project and manage a small team to produce these resources. Fast track to November and the first Briefing Book is available to download on the ABCT website.

The first Briefing Book is entitled *Suicide Across the Lifespan*, with 160-plus pages covering the prevalence of death by suicide in youth (5 to 24 years), adulthood and midlife, and seniors. In addition, death by suicide within sexual and gender minorities and veterans is included, as well as the contributing role of nonsuicidal self-injury, trauma, and disease.

The book's editor and contributing author of the Seniors & Veterans section of the Briefing Book's project, Rita Hitching, MSc., explains the reasoning behind the decision to cover suicide in the first edition: "Our first issue is being released at a time when society is experiencing an unprecedented level of

stress. Emotionally demanding circumstances, persistent stress, and depression are strong risk factors for suicide, and when someone ends their own life, the impact is felt by the entire community, and often, long after the event. The global coronavirus pandemic has led to a substantial increase in the number of people experiencing anxiety and depression, and 2020 has highlighted many social injustices and inequities. We felt that by providing evidence-based information that was accessible to all on death by suicide would be very timely."

By design, and with the needs of the reader in mind, flexibility has been built in by providing the option to download the entire book or individual sections. The book, or its sections, can provide useful background information for the busy journalist, as well as supplement the available expertise offered via phone or Zoom conversation by volunteer ABCT subject matter experts through the ABCT office.

Each of the six Briefing Book sections can stand alone, and covers the risk and protective factors, assessment, and treatment of suicidal behavior. Sections are co-authored by ABCT members and leading experts in their field, including Peggy Andover, Ph.D., who contributed to the Non-Suicidal Self-Injury section; Emily Bilek, Ph.D., who wrote the Adults & Mid-Life section; Lily Brown, Ph.D., who wrote the Trauma & Disease section; Mitch Prinstein, Ph.D., and his team Benjamin W. Nelson, Ph.D., Maya Massing-Schaffer, M.A., who penned the Youth section; and Iliana Seager van Dyk, Ph.D., who contributed the section on Sexual & Gender Minorities. The Briefing Books team hope, in future, to write about other topics such as PTSD, stress, gun violence, school shootings, grief, and survivor's guilt, to name a few. ■



Visit ABCT's YouTube and discover valuable, enlightening, and educational videos—including interviews, past presidential addresses, demonstrations, and presentations spanning a variety of topics.

Webinar

www.abct.org/Conventions/?m=mConvention&fa=Webinars

Part I: Leveraging Diverse Family Systems to Promote Dignity and Prepare for Discrimination: Racial Socialization for Black Youth **— Shawn C.T. Jones, Ph.D.**

MODERATOR: Abigail Angkaw, Ph.D.

11 am – 12:30 pm Eastern | 10 am – 11:30 pm Central

9 am – 10:30 am Mountain | 8 am – 9:30 am Pacific


Keniston (1978) asserted that Black youth are “the most endangered children in our society.” Indeed, Black children and teens are exposed to myriad risks, particularly those that emanate from the legacy of racism in this country. Yet, despite historical deficit-oriented narratives concerning them, Black youth—and their families—have continued to demonstrate positive psychosocial outcomes. Moreover, assisting diverse family structures in cogently providing racial socialization may optimize the historical psychosocial protection of this racially-relevant factor. In this presentation, conceptual and empirical work on mechanisms undergirding the salutary benefit of familial racial socialization will be discussed. Specifically, mixed-methods (i.e., survey, observation, interview) research will be presented that addresses how diverse families of Black youth navigate teaching their children about race. This presentation will conclude with a discussion of ongoing and future research, including how both experimental and prospective studies can serve to promote the resiliency of Black youth.

► **July 15, 2021**

\$20 for ABCT members
\$30 for nonmembers

CE Credit: 1.5

ABCT Has Links to Incredible Resources Pertaining to COVID-19 and Telehealth

 <https://www.abct.org/Information/?m=mInformation&fa=COVID19>

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- COVID-19
- Resources for Anxiety
- Coping in the Real World
- Telehealth Resources

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For further questions, call the ABCT central office at 212-647-1890.

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