

The Alabama Counseling Association Journal



- Enhancing human development through the lifespan
 - Promoting public confidence and trust in the counseling profession
 - Caring for self and others
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Letter From the Editors

Greetings,

It is that time of year when we welcome in the fall leaves, cool breeze, and the start of the holiday season. We are excited to present to you the October 2024 edition of *The Alabama Counseling Association Journal*. We received several articles and were not able to publish them all in the April issue, so we decided to have a second issue to disseminate the research that is being conducted within the counseling field. It is our desire that you enjoy these articles as much as we have enjoyed reading and preparing them for your perusal.

This process would not be possible without the amazing editorial team and reviewers. We would like to send out a very special thanks for the awesome work they do to make this journal a reality. Additionally, we would like to take this opportunity to request you to read these articles and feel free to reach out to the authors and let them know how much you appreciate their contributions. They are providing literature that will enhance, elevate, and broaden the knowledge base for mental health providers and counselor educators.

We strongly encourage each of you to submit articles to the next issue of the journal, which will be released in April 2025. You can do it, and we are counting on you! Once again, thank you for your continued support in making this journal what it is today. Without your contributions, we would not have articles for these journals.

Please do not hesitate to contact the editorial team with any recommendations and suggestions you might have for the upcoming issues. It is our goal to make this journal the best state journal around.

Respectfully,

Brad Willis
Editor

Linda J. M. Holloway
Editor

Brittany Dennis
Editor



Alabama Counseling Association

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**Deep Reasons for Simple Language: The Shared Discoveries of
Michael White’s Narrative Therapy and William Stafford’s Poetry**

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Correspondence concerning this article should be directed to Bill McHenry at wmchenry@stedwards.edu. The authors wish to thank Madeline Putnam, MA, and Emily “Em” Pencis, graduate student in counseling, for their editorial and research efforts in making this article come to fruition.

Abstract

This paper is an exploration of the similarities in the work of therapist Michael White, who co-founded narrative therapy with David Epston, and poet William Stafford. Although they worked in different milieu, both provide strong male voices for the progressive post-modern world. Both therapy and poetry are based on co-constructed narratives, between therapist and client and between poet and reader, respectively. In addition to building narratives, both White and Stafford advocated deconstruction of those narratives and playful manipulation of language to intensify the communicative impact and uncover implicit meanings. Both promoted adopting a collaborative stance and employing straightforward language to re-author these narratives, whether they be therapeutic interchanges or poetic expression. Their work aligns with the post-modern imperatives to challenge assumptions and stereotypes, shift (or expand) perspectives, and pursue the thread of deeper meaning. The legacies of Stafford and White illustrate that a receptive, sensitive, and nonauthoritarian male can lead and can effect change while maintaining strength.

Keywords: narrative therapy, Michael White, post-modern, William Stafford, poetry

Deep Reasons for Simple Language: The Shared Discoveries of Michael White's Narrative Therapy and William Stafford's Poetry

Tell me quietly, here in this room, what you really think. The speaker who forces his thoughts on you is not cherishing your thoughts. -- *William Stafford, 1980*

Background

Michael White, a therapist born in Australia in 1948, co-founded narrative therapy with David Epston. Although this paper focuses posthumously on White's writings, it is important to note that Epston's contributions are inextricably woven into White's conceptualizations. In addition to being a therapist, White worked with the disenfranchised, advocated for social justice, and wrote books.

Born in Hutchinson, Kansas in 1914, William Stafford was a prolific author of both poetry and books on teaching and writing. Stafford's work is widely anthologized; he received numerous awards including the National Book Award and was appointed the United States Poet Laureate in 1970. In addition to his work as a writer, Stafford was a peace activist and conscientious objector during World War II, a teacher, and a family man.

Stafford and White worked in different disciplines, lived continents apart, and spent time on earth a generation apart, yet their sensibility towards language, politics, and relating to others is strikingly similar. Both White and Stafford enjoyed philosophy; Stafford read Nietzsche, Wittgenstein, Pascal, and Kierkegaard, while White focused on the works of Foucault, Derrida, and Deleuze. Central themes in both of their epistemologies include the importance of story, the healing potential of language, the abandonment of an all-knowing stance, the connected nature of humanity, and the need for careful listening. Both men reconsidered the dominant story of Western culture and re-worked its tenets into a nuanced vision based on personal conviction.

Despite their different mediums of expression, one as a poet and the other a therapist, Stafford's and White's works provide remarkably similar examples of a strong male voice for a progressive post-modern world. Because of their rejection of culture-bound precepts of what it means to be a strong man, Stafford and White can be remembered in posterity as heroes, trailblazers, and innovators.

Parallels Between Literature and Therapeutic Conversation

A narrative therapist works to tease out the story of their client, whereas a poet often shares their own story. The experience of poetry is intrapsychic, and the experience of therapy is interpersonal, yet the overall goal of each is the discovery of shared threads of awareness between poet and reader, therapist and client. White (2007) highlighted many parallels between the structure of literary texts and the structure of therapeutic practice:

The authors of texts call the attention of the reader to gaps in the storyline and encourage readers to fill these gaps by stretching their minds, by exercising their imaginations, and by recruiting their lived experience... Therapists who prioritize the rich story development in their consultations with people do the same... [they draw attention to] gaps in the story lines of their lives... and encourage them [clients] to fill in these gaps exercising their imagination, and recruiting their lived experience... the outcome is people become dramatically engaged in the neglected events of their own lives. (p. 81)

W. Stafford (1978) described the shared space between poet and reader with playful poetic language:

Reading is like that. It is not all your own ideas, and not all the other person's ideas. You toss back and forth against a live blackboard. And, particularly if it is a congenial poem—or friend—you are reading or hearing, you furnish a good half of the life. The

travel circuit of an idea or impression is a series of reboundings between you and the companion, between you and the page. (p. 6)

White (1988) found similarities between Bruner's (1986) analysis of literary works and his own experiences of having co-constructed therapeutic narratives with his clients. This discovery encouraged him to propose a therapy of literary merit, a therapy that did not formulate meanings but rather created opportunities for the demonstration of meaning by the client. Good literature and poetry present a similar offering; both offer a scaffold of useful words that invite the reader to participate and co-create along with the author. The hope is that within the framework of poetry or therapeutic conversations, individuals contained in the bounds of cultural rules can become freed spirits living a fuller life (White & Epston, 1990). For practicing therapists who have a natural affinity for literature and poetry, White's identification of these similarities is affirming and contributes a heightened sense of artistry and creativity to the work of therapy.

Deconstruction of The Work

White's (2007) narrative approach supposes a different path than structured pre-meditated psychological interventions and turns toward mutual discoveries of meaning between therapist and client. White and Stafford both used the word "adventure" to describe the thrill of discovery inherent in their work. When asked in an interview how he feels when he writes, Stafford replied,

I feel exhilaration about the adventures that come to me in language...it's not like writing something that I intended to write. It's more like finding out what will happen if I begin to write about any old thing that comes along...so I like to adventure forward when writing and let the process itself bring about things to say. (Ortlieb, 1989, para. 4)

In White's (2007) words, therapeutic conversations provide people with "open opportunities to explore neglected aspects of the territories of their own lives. This provides people with avenues of possibility for addressing the predicaments and problems of their lives in ways that they wouldn't have imagined" (p. 5).

White and Stafford relished the process of wandering into unexpected discoveries and sparkling moments. In his poetry, Stafford set aside frameworks of form, meter, and rhyme to follow what he described as "meandering sequences of thoughts, or patterns of words" (Ortlieb, 1989, para. 1). He subscribed to an unseen structure in his poetry that followed language and meaning as tool for discovery rather than a means to an end. Stafford's brand of post-modernism was unnamed, naturally occurring, and implicit. Stafford embraced a new movement in writing that was removed from academic formality, structure, and tradition. He strove to achieve direct, spontaneous encounters with language. In his book, *Writing the Australian Crawl*, W. Stafford (1978) named a chapter "Whose Tradition?" and spoke of the need to wrestle poetry and art away from educational institutions and return it to ordinary people and ordinary language:

Today a grotesque discrepancy is widening between critical formulations and what thousands of people are experiencing in their reading and writing. The "tradition" from which individual talents are deriving has transformed, but the old terminology is lingering and making a separation between writers and the authorities who identify and teach and analyze their work. (p. 76)

For W. Stafford (1978), poetry was accessible and existed around people at all times in all conversations: "Anything we say and anything we write comes to us sequentially with a host of moving, bobbing opportunities" (p. 52).

White and Epston (1990) also expressed a desire to wrest therapy away from the influence of *logico-scientific mode*, which tends to reduce people to objects and represents personhood as a passive, impersonal arena. They rejected diagnostic tools, pathologizing language, and anything that lumps people into categories and fails to recognize an individual's lived experience. The *narrative mode* locates the person as a central "protagonist or participant in his/her world" (White & Epston, 1990, p. 82). The exploratory nature of the narrative form allows previously unknown, unfelt, and subjugated truths to surface into awareness and enhance the client's sense of personal agency and identity.

Re-Authoring Conversations

Narrative therapy holds a strong conviction that people's problems are located outside of them and do not exist within them as internal deficits (White & Epston, 1990). Simply put, the person is not the problem; the problem is the problem. Externalization of problems provides people with the space to step back, gain perspective, and map the effect of the problem on their lives across time (White & Epston, 1990). White's (2007) conceptualizations of re-authoring conversations, mapping narratives across time, and thickening the client's story in a collaborative setting dovetail with Stafford's ethos on writing. The title of one of W. Stafford's (1986) books on the art of writing, *You Must Revise Your Life*, is a declarative statement about the ethical and artistic urgency of re-authoring your own lived experience through language and memory. In his poem, "Just Thinking," W. Stafford (1993a) described a reflective moment spent dipping into the narrative of life:

Let the bucket of memory down into the well
bring it up, cool. Cool minutes. No one
stirring, no plans. Just being there.

Within this personal reflective space, people can rescue the events of their life from obviousness and formulate what White (2007) referred to as “a reconstruction of identity” (p. 91).

In one poem, “Traveling Through the Dark,” W. Stafford (1977) described the experience of finding a dead doe along the side of the road. As he reaches down to push her into the canyon below, he realizes that she is still warm and pregnant with an unborn fawn. The poem finishes with the line, “I thought hard for us all – my only swerving / then pushed her over the edge into the river” (p. 61). This moment in the story is reflective and sensitive yet decisive and strong. For Lund et al. (1993), this poem represented

the way poetry redeems negative experiences, by rendering them in beautiful language and teaching the reader to feel again. The poem suggests that every life is worth writing about, and it is a testament to Stafford’s love of the world that he helps complete. (para. 10)

If you rework this statement by replacing the word “poem” with the words “narrative therapy,” the word “talking” with the word “writing,” and the word “reader” with the word “client,” you have a succinct description of post-modern therapy. It would read as such: This represents the way post-modern therapy can redeem negative experiences by rendering them in beautiful language and teaching the client to feel again. Post-modern therapy suggests that every life is worth talking about.

Abandoning the One-Up Stance

The post-modern approach to therapy abandons the one-up authoritarian stance of the psychotherapist in favor of a transpersonal experience of shared discovery. Anderson (1997) described how a therapeutic theoretical perspective is inherently undergirded by a collaborative approach. Anderson further suggested the role of the therapist is to join the multiple authors

reworking with the client new narratives. Rather than focusing on direct intervention and diagnoses, post-modern therapists offer evocative questions that enhance the stories of the client's experiences. According to White (2007), narrative therapists

privilege the voices of the people consulting them in the attribution of meaning to selected events of their lives, in their interpretation of the links between these events and the valued themes of their lives, in their deduction about what this reflects in terms of what is important to them, and in their conclusions about what this suggests about their own and each other's identities. (p. 82)

Similar language can be found in Stafford's approach to teaching. William Stafford's son Kim Stafford (2002) wrote,

In response to student writing, my father did not correct or make suggestions about writing. Instead, he posed questions...The class was a village honoring each student's native discoveries and learning occurred as a process of mutual discovery in which the teacher's principal concern was to avoid the occupational habit of hoarding authority. (p. 165).

In the practice of narrative therapy, the collaborative stance is enhanced by the therapist's use of tentative language and a *not-knowing stance*. Anderson (1997) described the therapist as "a not-knower who is uncertain and regards knowledge as evolving" (p. 4). In the poetic voice of Stafford, "one must be willingly fallible to deserve a place in the realm where miracles happen" (K. Stafford, 2002, p. 253). W. Stafford warned readers, "You can lose the tentativeness you need as an artist by freezing into the pose of an expert" (K. Stafford, 2002, p. 8).

White's (2007) tentative, not-knowing stance facilitated unexpected discoveries that thickened the narrative of the client's underlying subordinate story and cleared space for bursts

of meaning that he called *unique outcomes*. William Stafford described the equivalent of unique outcomes in poetry as unexpected events that were “utterly surprising but strangely inevitable” (K. Stafford, 2002, p. 253). In narrative therapy, the therapist follows and actively engages in the rich description of the client’s words to reach hidden truths about their lives. In his poem, “Way It Is,” W. Stafford (1993b) described the sensation of following something vibrant, shimmering, and barely perceptible yet important:

There’s a thread you follow. It goes among
things that change. But it doesn’t change.
people wonder about what you are pursuing.
you have to explain about the thread.
But it is hard for others to see.
While you hold it you can’t get lost.
Tragedies happen; people get hurt
or die; and you suffer and get old.
Nothing you do can stop time’s unfolding.
You don’t ever let go of the thread. (p. 1)

Simple Language

Stafford’s and White and Epston’s use of accessible, plain language further supports the abandonment of the one-up stance. William Stafford’s poetry uses simple language to convey deep meaning. In some instances, the plainness of his language caused critics to question whether what he wrote was poetry. Similarly, Epston and White employed markedly simple and playful language in many of their interventions (Freedman et al., 1997; White, 2007).

The linguistic contrasts within their academic essays are noticeable. In one section, they employ the academic language of philosophy, pedagogy, and anthropology. In another section, White and Epston (1990) used therapeutic examples such as sneaky poo, the aggro, mischief, resigning from guilt, getting into trouble, winning against bad habits, escape from misery, and so on.

This willingness to toggle between intellectual discourse and playful simplicity is a characteristic of narrative therapy that privileges effective communication ahead of intellectual discourse. In their words, “The unique arrangement of ordinary and poetic or picturesque descriptions is encouraged over technical descriptions, and conversation is less purpose-driven and more exploratory” (White & Epston, 1990, p. 82). This linguistic flexibility and freedom enables people to take a “lighter, more effective, and less stressed approach to deadly serious problems” (White & Epston, 1990, p. 40).

White and Epston’s (1990) disarming approach is also evident in their affable letters to clients and their formal declarations and certificates. Clients were given certificates of completion declaring them to be “Monster Tamers” or “Fear Catchers.” The therapists also endowed clients with recognition of “Special Knowledge” and declarations of victory against “Bad Habits.” In *Narrative Means to Therapeutic Ends*, White and Epston (1990) suggested that informal narrative letters provide a more intimate and inclusive record of a client’s work than formal therapeutic notes.

Conclusion

The works of Stafford and White illustrate how post-modernism exerts influence through synchronicity of thought across subject matter, time, and place. While the mechanisms were different, the truths uncovered are universal. The works of Stafford and White reveal a cascade

of similarities and distinctions that are compatible from a post-modern perspective but contradictory and confusing from a modernist perspective. How is it that a masculine gun-owning poet from Kansas can be a pacifist? How can social workers from Australia and New Zealand successfully question the influential modernist framework of psychoanalysis?

The work of post-modernists helps readers to challenge assumptions and stereotypes, shift (or expand) perspectives, and follow the thread. As examples, the legacies of Stafford and White demonstrate that a receptive, sensitive, and nonauthoritarian male can lead and can effect change while maintaining strength. Ultimately, conviction plays a greater role in effecting change than gender. While the work of reauthorizing, revising, and healing can be fun, it is not for the faint of heart.

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Comorbidity of PTSD and OCD in Adults

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Abstract

Traumatic events, which may lead to posttraumatic stress disorder (PTSD), exacerbate the symptoms of obsessive-compulsive disorder (OCD). This correlation highlights the necessity for further research regarding the comorbidity of PTSD and OCD. The aim of this study was to compare the comorbidity of severity and symptoms in adults diagnosed with PTSD to those with a dual diagnosis of PTSD and OCD. We administered the CliniCom Psychiatric Assessment to adults ($N = 460$) who had a primary diagnosis of PTSD and collected data related to obsessions, compulsions, and trauma-related symptoms. Of the sample, 195 participants had a secondary diagnosis of OCD. We performed independent samples t -tests, multivariate ANOVA, and linear regression on the data. Adults who indicated higher scores of OCD severity also experienced an increase in PTSD severity. OCD severity demonstrated significant associations with intrusive memories of trauma in addition to avoiding thoughts and activities related to the trauma. Findings suggested that PTSD severity predicted compulsive behaviors. The increased severity for adults with PTSD and OCD indicated that the comorbidity among these disorders may contribute to an exacerbation of symptoms in both conditions. Understanding the associations between PTSD and OCD may inform the development of effective treatment interventions to improve the mental health of those affected by both disorders.

Keywords: posttraumatic stress disorder, obsessive-compulsive disorder, adult mental health, trauma

Comorbidity of PTSD and OCD in Adults

Literature on the comorbidity of posttraumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD) for adults is robust (Fontenelle et al., 2012; Nacasch et al., 2011). The comparable symptoms between PTSD and OCD include unwanted or intrusive memories, behaviors and actions oriented towards reducing distress, and avoidance (Dykshoorn, 2014). Gershuny et al. (2002) emphasized the importance of research on this topic because adults with comorbid PTSD and OCD who had heightened severity were not as responsive to therapeutic interventions. Assessment of the similar symptomatology of PTSD and OCD can assist clinicians in recognizing appropriate psychiatric interventions and treatment models.

Literature Review

Posttraumatic Stress Disorder

Responses to traumatic events differ as individuals cope in various ways (Kress & Paylo, 2019). PTSD is a severe and debilitating disorder that is characterized by persistent re-experiencing of the traumatic event, avoidance, and hyperarousal after a traumatic event (American Psychiatric Association [APA], 2013). Furthermore, PTSD is the only mental disorder besides acute stress disorder (ASD) that requires the experience of a traumatic event for a diagnosis (APA, 2013). One of the major differences between PTSD and ASD is the duration of symptoms; those with PTSD experience symptoms for longer than one month (APA, 2013).

Symptoms of PTSD include intrusive thoughts, which are spontaneous and reoccurring, and intrusive memories, which are autobiographical in nature and relate to a specific time and place (Brewin et al., 1996). Second, people with PTSD experience avoidance of negative internal events including cognitions, emotions, or sensations, which may prompt the re-experiencing of the trauma (APA, 2013). Hayes et al. (1996) noted that with avoidance and PTSD, individuals

attempt to modify, curtail, or control these unwanted experiences. Additionally, those with PTSD may experience hypervigilance, a continuous state of increased awareness and observation of one's surroundings, which is often a result of trauma (Dalglish et al., 2001). Other symptoms affiliated with PTSD include anxiety, insomnia or sleep disturbances, aggressive behaviors, and other somatic complaints (Kress & Paylo, 2019).

PTSD is characterized as a highly comorbid disorder (Qassem et al., 2021) with other disorders such as depression, anxiety, and substance abuse. A study conducted by Hawn et al. (2022) revealed that participants ($N = 1,179$) who had received a diagnosis of PTSD within the last year had also met the diagnostic criteria for another mental disorder. More specifically, trauma and PTSD are frequently associated with depression, which decreases quality of life and increases the risk of suicide (Cromer et al., 2007; Ojserkis et al., 2017). Furthermore, PTSD contributes to an increased risk of developing panic disorder with agoraphobia (PDA), generalized anxiety disorder (GAD), substance use disorder, and OCD (Brown et al., 2001).

With regard to severity, Knowles et al. (2109) suggested that veterans with at least one additional comorbid disorder and a diagnosis of PTSD reported significantly higher PTSD symptom severity. Understanding heightened PTSD severity with relation to comorbidity may provide further insight into the experiences of those impacted by a traumatic event. The aftermath of a traumatic event may include the exacerbation of prior symptoms or the onset of a mental disorder. Wadsworth et al. (2023) attributed the challenges of diagnosing and treating comorbid PTSD and OCD to PTSD symptoms such as hypervigilance, safety-related behaviors (e.g., scanning one's environment), and OCD rituals.

Obsessive-Compulsive Disorder

OCD is a lifelong disorder that is characterized by uncontrollable behaviors (compulsions) and reoccurring thoughts (obsessions), wherein the individual feels the urge to perform and repeat rituals (APA, 2013). Compulsive behaviors are actions an individual feels they must perform, compelled by obsessive feelings (Luigjes et al., 2019). The inability to perform the action can cause the individual to feel out of control. According to Kress and Paylo (2019), examples of compulsions include cleaning, counting, checking, balancing, asking for reassurance, repeating behaviors, and hoarding. Second, obsessions are persistent or repetitive cognitions that can be intrusive and unwanted and often are associated with distress (APA, 2013; Stein et al., 2019). For example, contamination, self-doubt, harm to self or others, religion, and sexual themes are classified as obsessions (Kress & Paylo, 2019). According to Gillan et al. (2014), individuals diagnosed with OCD experience an increase in avoidance habits. Although compulsions or the urge to perform an action is present, individuals with OCD implement increased avoidance compared to healthy controls.

OCD has demonstrated substantial comorbidity with other disorders. One study revealed that OCD is comorbid with anxiety disorders, impulse-control disorders, and substance use disorders (Ruscio et al., 2008). Moreover, a meta-analysis suggested that OCD occurred at a rate of 69% with major depressive disorder, GAD, and neurodevelopmental disorders (Sharma et al., 2021). Stein et al. (2019) recommended that practitioners question the duration of symptoms and assess functional impairment to reduce comorbidity with other disorders when considering an OCD diagnosis.

Comorbidity of PTSD and OCD

In the United States, between 3.4% and 26.9% of adults have been diagnosed with PTSD (Schein et al., 2021), whereas the lifetime prevalence rate of OCD is approximately 2.3% (Ruscio et al., 2008). A study completed by Pinciotti, Fontenelle, et al. (2022) reported that PTSD and OCD occurred simultaneously at a rate of 25%. Other findings suggested that posttraumatic and obsessive-compulsive symptoms had a positive correlation (Franklin & Raines, 2019). The high degree of co-occurrence of PTSD and OCD (Fletcher et al., 2020; Gershuny et al., 2008; Nacasch et al., 2011) warrants further investigation into understanding the impact of symptoms on one another.

Although the disorders are distinctively different according to their diagnostic criteria, PTSD and OCD share similar symptoms such as unwanted, intrusive thoughts, urges, or images (Pinciotti, Horvath, et al., 2022). Research on these symptomatic similarities suggested that these disorders are highly comorbid, and evidence suggests that the onset of OCD symptoms may occur as the result of a traumatic event (Fletcher et al., 2020; Imthon et al., 2020; Morina et al., 2016). Moreover, adults have reported the onset of OCD concurrent with or after they developed PTSD (Fontenelle et al., 2012).

For example, in one study, the symptoms of trauma-exposed veterans indicated that OCD was an outcome of a traumatic event with an exacerbation of symptoms related to unacceptable thoughts and feelings of responsibility for harm (Franklin & Raines, 2019). According to this study, 60% of the trauma-exposed veterans ($N = 117$) met symptom criteria for both PTSD and OCD (Franklin & Raines, 2019). Furthermore, Dykshoorn (2014) suggested that individuals experience psychological distress after a traumatic event as intrusive thoughts including nightmares, flashbacks, and hypervigilance. However, Ferrão et al. (2022) countered that the

psychological core symptoms or intrinsic characteristics are notably different when flashbacks are related to memory and obsessions are oriented toward cognition. Other findings emphasized the difficulty in differentiating between PTSD behaviors related to safety and avoidance and OCD-related rituals and avoidance (Wadsworth et al., 2023). The aftermath of trauma on individuals with OCD can have lasting effects such as increased symptom severity (Cromer et al., 2007; Ojserkis et al., 2017; Shavitt et al., 2010).

Fontenelle et al. (2012) proposed specific phenotypes of OCD and PTSD comorbidity after a traumatic event, ranging from pretraumatic OCD, posttraumatic OCD with previous obsessive-compulsive symptoms, and posttraumatic OCD without previous symptoms. The researchers reported that individuals who experienced posttraumatic OCD that was correlated with later onset OCD encountered issues with self-mutilation, plans for suicide, PDA, and compulsive buying. Pretraumatic OCD was correlated with an earlier onset OCD, as well as alcohol-related disorders, contamination-washing symptoms, and self-mutilation disorder. Participants with post-traumatic OCD who did not indicate a prior history of obsessive-compulsive symptoms were found to have higher rates of contamination-washing symptoms, lower education levels, and more severe miscellaneous symptoms (Fontenelle et al., 2012). The phenomenon of aftereffects of a traumatic event that induce symptoms of OCD reinforces the importance of understanding the nature of these disorders.

Disregarding the exact mechanism of co-occurrence or comorbidity of these two conditions, the assessment of PTSD is imperative at the time of diagnosis with consideration of OCD for treatment. Gershuny et al. (2008) conducted a series of case studies, which revealed that participants diagnosed with OCD and comorbid PTSD responded less favorably to therapy. In contrast, Shavitt et al. (2010) found that individuals diagnosed with OCD and PTSD presented

with a greater magnitude of therapeutic responses for specific symptoms (e.g., obsessions related to contamination and compulsions such as cleaning and hoarding) than those diagnosed only with OCD. Furthermore, Rossi et al. (2020) suggested that psychopharmacotherapy treatments for OCD and PTSD rely on antidepressant medications such as selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs). Yet another study suggested that treatment targeting OCD increased the symptom severity of PTSD (Van Kirk et al., 2018). Although an abundance of literature documents specific symptom comorbidity for PTSD and OCD, limited research addresses PTSD and OCD severity.

Purpose of the Study

Several studies have demonstrated the increases in the severity of symptoms experienced by individuals diagnosed with OCD and PTSD compared to those with only an OCD diagnosis (Fontenelle et al., 2012; Ojserkis et al., 2017; Shavitt et al., 2010). Consideration of exclusion criteria is necessary as other disorders or prior treatment interventions could influence severity and symptoms. The aim of this study was to address these concerns by excluding adults diagnosed with disorders other than PTSD and OCD while including adults who were treatment naïve (i.e., had not been prescribed psychiatric medications and/or received therapeutic services). The goal of this study was to clarify and assess the comorbidity and severity of symptoms of PTSD and OCD.

One objective of this study was to determine if adults diagnosed with PTSD and OCD experienced increased severity of symptoms compared to adults diagnosed with only PTSD. The second objective of this study was to determine if there were any significant associations between trauma-related symptoms, PTSD severity, OCD severity, and OCD symptoms. Lastly,

we wanted to further understand the extent to which PTSD severity and trauma-related symptoms can predict OCD symptoms.

Method

Design

This quantitative study relied on a retrospective, cross-sectional design format with a purposive sampling technique. Selection of participants was dependent on convenience of location. Adults who had a primary diagnosis of PTSD were selected for the study to test for comorbidity between PTSD and OCD. The purpose was to answer the following research questions: (a) Are there significant group differences in the severity and symptoms of PTSD and OCD in adults diagnosed with only PTSD (Group 1) compared to adults diagnosed with both disorders (Group 2)? (b) Is there a significant group difference between lower versus higher OCD severity on PTSD severity and trauma-related symptoms for Group 2? and (c) To what extent does PTSD severity and trauma-related symptoms explain variation in OCD symptoms for Group 2?

Sample

The sample in this study included adults ($N = 460$) between the ages of 18 and 64 at the time of data collection. Participants were self-referred to an outpatient mental health clinic located in the Southern United States. The participants in this sample had attended their first appointment between August 2017 and November 2022. All participants were current clients at the clinic during data collection. After we received IRB approval, we retrieved participant charts that reported diagnostic information.

The first part of data collection included a search for all participants who met the criteria for the study and had a primary diagnosis of PTSD. After this initial selection, the second part of

data collection included assessing the participants' information for a secondary diagnosis of OCD. Participants who had a secondary diagnosis other than OCD and those who had previously received treatment were omitted from the study. All participants granted informed consent that covered confidentiality. Participants did not receive reimbursement for contributing to this study.

The sample in this study included a total of 460 adults (359 women and 101 men), who reported an average age of 32.49 ($SD = 11.75$) and had a primary diagnosis of PTSD. Participants were categorized into two groups: the first group included those diagnosed with only PTSD (Group 1; $n = 265$, 57.6%) and the second group consisted of participants who had a diagnosis of PTSD and a secondary diagnosis of OCD (Group 2; $n = 195$, 42.4%). The mean score for the age of Group 1 was 32.24 ($SD = 11.43$) and 32.82 ($SD = 12.20$) for Group 2. In terms of ethnicity, 401 participants (87.2%) identified as White, 43 participants (9.3%) identified as African American or Black, 12 participants (2.6%) identified as Hispanic or Latino, 3 participants (0.7%) identified as Asian, and 1 participant (0.2%) identified as "Other."

Instrument

CliniCom™ Psychiatric Assessment Software

The CliniCom™ Psychiatric Assessment (hereafter referred to as CliniCom; Handal et al., 2018) is a self-report instrument that assesses mental health symptoms based on mental health research, clinical practice expertise, and the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5; APA, 2013)* criteria to formulate a clinical psychiatric diagnosis. CliniCom is composed of 2,795 questions; however, the total items posed to individuals is dependent on their prior responses, resulting in approximately 400 questions per administration (Handal et al., 2018). CliniCom assesses for over 80 mental health conditions and consists of 35 standardized assessments, including the Patient Health Questionnaire-9 (Spitzer et al., 1999).

CliniCom is concordant with the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) (Goodman et al., 1989; Handal et al., 2018). Additionally, CliniCom has demonstrated reliability as the assessment depicts reproducibility of results over multiple administrations with a psychometric investigation indicating that the assessment is 78% concordant in diagnosing the same disorder in test-retest analysis (Handal et al., 2018).

The CliniCom assessment gathers participant information including individual and family history, social history, responses to mental health questions, self-assessment of severity of symptoms, quality of life, and current and previous mental health treatments (Handal et al., 2018). CliniCom utilizes the *DSM-5* (APA, 2013) symptom criteria to determine the client's severity for each disorder. Symptom and severity scores range from zero to 10, with a rating of 10 indicating the highest intensity, four or above suggesting moderate to intense, and three or below suggesting minimal intensity. For the purpose of this study, the following severity and symptoms were collected from CliniCom for each participant: PTSD severity, OCD severity, intrusive memories of the trauma, avoidance of thoughts related to the trauma, avoidance of activities related to the trauma, obsessions, and compulsive behaviors. After participants completed the assessment, a board-certified psychiatrist reviewed the results and performed a semi-structured diagnostic interview with the participant. Specifically, the semi-structured diagnostic interviews consisted of an evaluation of the participant's onset, duration, frequency, and severity of symptoms to confirm an official diagnosis.

Analysis

We used IBM SPSS 29 software for data analysis. Analysis included data from all participants in the sample. Before performing the main analysis, we cleaned and screened the data to meet the assumptions of normality, linearity, and homoscedasticity. We calculated

descriptive statistics and correlational analysis for preliminary analysis. Pearson r correlations determined relationships among main study variables. We performed an independent samples t -tests to answer Research Question 1. To answer Research Question 2, we calculated a multivariate ANOVA. Linear regression was performed to assess whether PTSD severity and trauma-related symptoms could explain OCD symptoms. The acceptable statistical significance for this study was $p < .05$.

Results

An independent samples t -test supported comparison of the severity ratings and symptoms for Group 1 and Group 2. Different than in the preliminary analysis, a statistically significant difference in severity ratings was not present between Group 1 and Group 2. Results indicated that Group 2 experienced higher levels of compulsions ($M = 6.30, SD = 2.506$) than Group 1 ($M = 3.89, SD = 3.063$), $t(458) = -6.811, p < .001$. These findings suggested that participants diagnosed with PTSD and OCD reported increased numbers of compulsions compared to the participants diagnosed with only PTSD. This outcome was not surprising as it would be expected that participants diagnosed with both disorders would experience compulsions more frequently than those diagnosed with PTSD alone.

A multivariate ANOVA was performed to determine differences between group means for OCD severity (the independent variable) and the trauma-related symptoms and PTSD severity (the dependent variables) for participants in Group 2. The omnibus test yielded statistically significant results, $F(10, 448) = 8.6, p < .001$, indicating that participants with increased scores of OCD severity endorsed PTSD severity with a medium effect size ($\eta^2 = .16$). Statistically significant results for OCD severity and intrusive memories of the trauma, $F(10, 442) = 5.75, p < .001$, suggested that participants with higher scores of OCD severity had

increased scores of intrusive memories of the trauma. The effect size was medium ($\eta^2 = .11$). Additionally, participants with higher scores of OCD severity also had increased scores on avoiding thoughts related to the trauma, $F(10, 448) = 6.44, p < .001$ with a medium effect size ($\eta^2 = .12$). Last, participants who exhibited higher OCD severity had increased scores of avoiding activities related to the trauma, $F(10, 448) = 3.2, p < .001$ with a small effect size ($\eta^2 = .06$).

A simple linear regression did not indicate that PTSD severity and trauma-related symptoms were statistically significant predictors of obsessions. A second simple linear regression assessed whether PTSD severity and trauma-related symptoms could be predictors of compulsive behaviors. Results indicated that PTSD severity was a statistically significant predictor of compulsive behaviors, $F(4, 448) = 20.86, p < .001, R^2 = .16$. The unstandardized coefficient, *B*, for PTSD severity was equal to .39, suggesting that for each score increase of PTSD severity, there was a .39 score increase in compulsive behaviors.

Discussion

Understanding the implications of the presence of two or more disorders is necessary for accurate diagnosis and the conceptualization of effective treatment modalities, including psychotropic medications. The aim of this study was to determine if adults diagnosed with PTSD and OCD reported heightened symptom severity compared to adults diagnosed with PTSD alone. Second, this study addressed any significant associations between trauma-related symptoms and OCD symptoms.

Findings of this study suggested that adults with increased OCD severity also had heightened PTSD severity. The results of this study are similar to those that have suggested that individuals experienced higher severity of symptoms when diagnosed with PTSD and OCD

compared to those diagnosed solely with PTSD (Fontenelle et al., 2012; Pinciotti & Orcutt, 2020). Concerns about the comorbidity of PTSD and OCD are relevant as several studies have suggested a weakened response to therapeutic interventions when both disorders are present (Gershuny et al., 2002; Gershuny et al., 2008). Increases in severity of these co-occurring disorders should be considered by clinicians as the severity of one disorder may be exacerbating the severity of another.

The findings of this study suggested that OCD severity had significant associations with intrusive memories of the trauma in addition to avoiding thoughts and activities related to the trauma. Intrusive memories and thoughts contribute to distress; these intrusions are considered obsessions (Stein et al., 2019), which then result in compulsions. Wheaton et al. (2018) suggested that avoidant behaviors are common for individuals with OCD. Perhaps adults with increased OCD severity avoid trauma-related thoughts and activities to reduce the impact of other OCD symptoms. These findings corroborated the results of other studies that suggested individuals experiencing PTSD and OCD reported higher rates of symptoms compared to those diagnosed with only one of the disorders (Franklin & Raines, 2019; Morina et al., 2016; Ojserkis et al., 2017; Pinciotti & Orcutt, 2020).

Another major finding of this study was that PTSD severity serves as a predictor of compulsive behaviors. As PTSD severity increased, so did the occurrence of compulsive behaviors. These findings aligned with the work of Morina et al. (2016), who suggested that PTSD severity is a predictor of obsessive-compulsive symptoms. According to Gershuny et al. (2003) and Dykshoorn (2014), compulsive behaviors may serve as a coping strategy for those with PTSD. For example, individuals utilize compulsions as a method to alleviate distress associated with a traumatic event.

People with comorbid PTSD and OCD may exhibit a complicated clinical presentation to counselors. During the initial assessment, we suggest that counselors consider the comorbidity of these diagnoses to provide appropriate and effective therapeutic services. Counselors may use the findings in this study to validate and normalize their clients' experiences with PTSD and OCD. Although counselors do not prescribe psychotropic medications, having knowledge about the overlap in these disorders and common psychopharmacological interventions such as SSRIs and SNRIs (Rossi et al., 2020) might allow counselors to provide psychoeducation to their clients.

Guided by the findings of this study, counselors should utilize interventions, such as exposure therapies and cognitive behavioral therapy (CBT), that target PTSD and OCD. Exposure and response prevention therapy and prolonged exposure have been proven as effective treatment modalities for individuals with co-occurring PTSD and OCD (Pinciotti, Post, et al., 2022). In these therapies, clients identify situations that induce fear and engage in exposure to manage their symptoms while enacting safety behaviors. A CBT framework has demonstrated effectiveness in alleviating symptoms of PTSD and OCD by integrating a meaning-making approach to thought appraisal in which the client shifts the negative perspective of thoughts to a neutral stance (Dykshoorn, 2014). We recommend that counselors consider these findings during the diagnostic assessment and treatment planning processes.

This study is the first, to our knowledge, to offer an analysis from a sample solely diagnosed with these disorders. Screening for treatment allowed the study to measure and analyze the comorbidity of PTSD and OCD for participants in their true states. A further strength of this study is that participants had not received treatment for their mental health disorders. This

condition further established that the sample is strongly representative of adults diagnosed with either PTSD or both disorders.

Limitations and Future Research

This study has a few limitations. First, the data derived from a self-report measure, which may contribute to an over- or under-reporting of symptoms. Second, we collected data at one point in time, limiting the information as to the severity of symptoms since the traumatic event. A third limitation was the inability to establish which disorder preceded the other. Fostik et al. (2012) suggested that increased OCD symptoms are a result of a biological connection with a traumatic event. To clarify this question, future researchers may collect measures of severity at multiple points after the onset of OCD symptoms.

An additional limitation of this study was the small sample size. Small sample sizes for those with PTSD and OCD are common in the literature (Fontenelle et al., 2012; Ojserkis et al., 2017). Future researchers should make efforts to incorporate a larger sample to increase generalizability and curb small effect sizes. Moreover, the demographic characteristics were limited as the sample was homogenous in terms of ethnicity and contained more females than males. Thus, it would be interesting for future studies to incorporate a more diverse sample to detect any impact on the comorbidity of these disorders.

Overall, the findings of this study contribute to the growing body of literature on the comorbidity of PTSD and OCD. Understanding the similarities in symptomatology and exacerbation of severity of mental disorders is necessary for clinicians to conceptualize effective treatment modalities. For example, treatment modalities that focus on resolving trauma may assist in the reduction of compulsive behaviors. The associations between OCD severity and trauma-related symptoms in addition to PTSD severity predicting the occurrence of compulsive

behaviors demonstrate the necessity of continuing research on the comorbidity of these disorders. Finally, these findings may encourage clinicians to assess for trauma before treating OCD.

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**Advancing Inclusivity: A Feminist Framework for
Women of Color in Academia**

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Abstract

Women of color in higher education face unique challenges shaped by gender bias, stereotypes, underrepresentation, and other complexities of intersectional identities. Grounded in the Black feminist lens, this conceptual framework highlights the critical importance of cultivating inclusive campus culture and promoting a strong sense of belonging. Establishing an equitable and inclusive campus culture is essential for advancing the academic success and psychosocial wellbeing of women of color in academia, as highlighted by the existing literature. In this paper, we propose a three-pronged approach to accomplish this goal: (a) generating awareness through education and training, (b) adopting inclusive and Black feminist pedagogy, and (c) implementing institutional changes.

Keywords: women of color, sense of belonging, inclusion, higher education, academia, Black feminist framework

Advancing Inclusivity: A Feminist Framework for Women of Color in Academia

Introduction

As a nation, the United States holds the burden of a long history and continued practices of racial, cultural, and social injustices and stereotypes perpetuated against women of color. Due to these factors and intersectional identities associated with race and gender, women of color often face greater amounts of stress, which may broadly impact their psychosocial wellbeing (Woods-Giscombé & Lobel, 2008). Continued experiences of racial discrimination often put students of color on psychological high alert, and the accompanying feelings of seclusion and hypervigilance impact their emotional wellbeing (Ancis et al., 2000). Over the years, despite a multitude of socio-cultural barriers, the number of women of color in academia, both in terms of admission and degree attainment, is on the rise (Bartman, 2015). Utilizing the Black feminist framework, this review of literature depicts the need to cultivate a sense of belonging for women of color as students in higher education and informs readers of three ways to create inclusive campus climate that foster inclusivity.

Discrimination based on race and gender is a phenomenon that may result in a wide range of detrimental psychological and physical health issues (Williams & Mohammed, 2009). In light of the fact that women of color find institutions to be unwelcoming, insensitive, and isolating, it is important to employ a framework that may highlight their viewpoints and confront concepts like normativity, neutrality, and meritocracy (Watt, 2006). Further, racial stereotyping diminishes performance and dampens aspirations when members of underrepresented groups

perceive that these unfavorable preconceptions provide a context for evaluating their academic capabilities (Spencer-Oatey et al., 2017).

Researchers have established these themes and other similar patterns, and overall, they indicate significant concerns for the wellness of women of color in higher education. Behavioral scientists assert that social support and emotional connection are prerequisites to wellbeing and can act as cushion for symptoms of depression (Marjorie, 2017). Participating in meaningful interactions with diverse communities positively influences individuals' sense of belonging. This effect is particularly pronounced in engagements with peers, faculty, and within an overall supportive campus environment (Johnson et al., 2007).

Utilizing a Black feminist framework, we will highlight the need to address the unwelcoming and isolating environments often encountered by women of color. By challenging concepts such as normativity, neutrality, and meritocracy, and proposing three strategies to create a more inclusive campus climate, the article emphasizes the importance of fostering a sense of belonging to enhance the academic achievement and psychosocial wellbeing of women of color.

Conceptual Framework

The Black feminist framework is one that acknowledges and offers understanding of the intersections of the multiple identities of race, gender, and class that women of color face (Howard-Hamilton, 2003). The experiences of women of color are uniquely different from those of other women as well as those of men. These differences are the result of a historical progression and ideology of Black people in the United States (Howard-Hamilton, 2003). The oppression that women of color face today derives from their subordinate status as enforced by the patriarchy, as well as by White women (Howard-Hamilton, 2003). Female educator Lucy

Slowe confirmed that Black women face multiple challenges when entering college (Howard-Hamilton, 2003).

Today, women of color continue to face anomalous challenges and difficulty as they learn to navigate non-inclusive spaces in higher education. Racial, gender, and class inequities continue to exist within institutions of higher education and therefore continue to create roadblocks for those who attempt to elevate educationally and economically in society. Women of color in higher education are becoming more visible in spaces previously occupied by dominant groups, and Howard-Hamilton (2003) explained that it is up to the faculty and administrators to work to improve these issues. It is the responsibility of the faculty, staff, and leaders of higher educational institutions to work together to create solutions that foster and develop a more inclusive campus climate for women of color, creating environments in which they feel a sense of belonging.

The presence of women of color who function in higher education without a sense of belonging aligns with the concept of the *outsider within*, as described by Collins (1986). This term refers to a form of marginality experienced by groups occupying spaces characterized by unequal power dynamics (Collins, 1986; Hardaway et al., 2022). Consequently, while women of color are increasingly gaining access to higher education, they may continue to perceive themselves as outsiders. As Howard-Hamilton (2003) noted, “A sense of belonging can never exist because there is no personal or cultural fit between the experiences of African American women and the dominant group” (p. 21). The Black feminist framework challenges the faculty and higher education institutions to critically examine systems of oppression that adversely affect the academic experiences and psychosocial well-being of women students of color. By fostering intentional collaboration, educators and institutional leaders can engage meaningfully with

students to explore and understand their challenges. And this process may be essential for cultivating a more inclusive and welcoming campus environment (Collins, 2000; Crenshaw, 1989).

Literature Review

Women of color are marginalized and underrepresented in academia and often face diverse socio-cultural impacts such as differential treatment due to race, gendered inequality, feelings of isolation, and imposter syndrome (Schwartz et al., 2003). Because they are under constant scrutiny, women of color in higher education face ongoing feelings of exhaustion and fatigue as they attempt to prove their worth as academics (King & Bruner, 2000). Women of color frequently experience biases stemming from the intersection of their racial and gender identities. In academic spaces, these biases manifest as unique challenges that significantly impact their sense of belonging (Johnson-Bailey et al., 2015). These challenges, including systemic racism, gender bias, stereotypes, underrepresentation, and intersectionality have a profound impact on their experiences (Davis Tribble et al., 2019).

Women of Color in Higher Education

It is crucial to understand how educators can best support women of color in higher education and create a space of cultural humility and acceptance. Whiteness as a privilege assumes that White people have exclusive rights to possibilities that have a favorable impact on their economic and political standing. This exclusivity also tends to center concepts of authority, riches, and domination (Harris, 1993).

Even though it is difficult to study racial prejudice as experienced by individual women of color in the United States (Spates et al., 2020), it is crucial in the current context to re-focus on the phenomenon to further create spaces of acceptance and diversity. A survey conducted by the

National Center for Education Statistics (Aud et al., 2010) indicated Black scholars constituted only 6.1% of doctoral degree earners. According to Johnson-Bailey et al. (2006), significant themes identified by women of color in academia included a sense of isolation and loneliness in their graduate life, experiences of discrimination in programs, emotional detachment from the institute, and self-reported feelings of being in a survival mode.

Sense of Belonging

When individuals feel marginalized or undervalued due to their race, ethnicity, or gender, they may interpret negative experiences in their surroundings as reinforcement of their lack of a sense of belonging. However, providing assurance and affirming the value of women of color may help counteract the negative impact of gender and racial bias and alleviate stereotype threat, a marginalized “person’s fear of substantiating negative generalizations about their group” (Godsil et al., 2016, p. 51).

The term sense of belonging typically refers to an individual’s perception and experience of being connected, accepted, and valued within a particular group or community (Baumeister & Leary, 1995). It involves the subjective feeling of being an integral part of a social network or environment (Jetten et al., 2017). Belonging is a fundamental human need, as it has profound implications for psychological wellbeing and functioning (Baumeister & Leary, 1995). When individuals feel a sense of belonging, they experience increased self-esteem, reduced stress levels, and improved overall mental health (Jetten et al., 2017; Walton & Cohen, 2011).

The significance of belonging is evident across various domains, including education, workplace, and community settings. For example, students who perceive a strong sense of belonging in their academic environment are more likely to engage in learning, persist in their studies, and achieve higher academic success (Strayhorn, 2012). African American women in

higher education face what is known as “double jeopardy” as they navigate the intersectionality of race and gender (Strayhorn, 2012). This intersectionality exposes them to multiple layers of discrimination and marginalization, which can negatively impact their sense of belonging in academic settings. Several other factors also contribute to the development of a sense of belonging, such as interpersonal relationships, shared values, and a sense of shared identity or purpose within a group (Walton & Cohen, 2011).

Positionality

As fourth-year doctoral candidates in the Special Education, Rehabilitation, and Counseling (SERC) department at Auburn University, we bring a combined 15 years of professional experience, education, and dedication to serving marginalized communities. With backgrounds in psychology, sociology, social work, and clinical mental health counseling, our work has spanned across various settings, including substance-use rehabilitation facilities, shelter homes, residential treatment centers, college counseling services, and private counseling practice. Our professional identities are deeply rooted in upholding voices of underserved populations, particularly women of color, couples, and high-risk communities. We have worked extensively with issues such as gender identity, personality disorders, relationship distress, family conflict, sobriety, and chronic mental health disorders.

In addition to clinical practice, we have taught courses and supervised graduate students pursuing degrees in clinical mental health and school counseling, gaining valuable experience as primary instructors and clinical supervisors. Our research interests center on exploring the unique experiences of women and students of color in academia. As women of color in academia ourselves, we are committed to addressing the distinct needs of underrepresented communities. While our personal and professional experiences shape our perspectives, we also recognize the

importance of considering a wide range of perspectives to ensure a comprehensive understanding of multicultural issues in the field of counseling and counselor education. We are dedicated to ongoing learning, adaptation, and the development of counseling approaches that meet the evolving needs of diverse populations.

Implications for Counselor Educators

Just as gender does not exist in isolation, other identity characteristics, such as race, ethnicity, religion, and class intersect and shape people's experiences in complex ways. These intersections can create a diverse range of experiences and challenges for individuals, and they contribute to the social dynamics within various contexts, including media, workplaces, communities, schools, and homes (Godsil et. al., 2016). As delineated in the American Counseling Association's *Code of Ethics* (ACA, 2014), mental health professionals have an ethical responsibility to recognize the impact of their biases and privileges and to consider how they are shaped by their intersecting identities.

Counselor educators, therefore, should continue to engage in critical reflections on matters of race, ethnicity, oppression, power, and privilege in their personal lives (Constantine et al., 2007). Creating an inclusive academic environment for women of color is therefore a crucial task for educators and especially for counselor educators. As proponents of social justice and equity, counselor educators must play a crucial role in raising awareness of the intersectional experiences of women of color in academia. In this paper, we propose a three-pronged approach to further this concept: (a) generating awareness through education and training, (b) adopting inclusive and Black feminist pedagogy, and (c) implementing institutional changes.

Generating Awareness

Providing awareness, education, and training on issues related to gender, race, and ethnicity can help foster a deeper understanding among faculty and staff of the unique challenges women of color face (Smith & Doyle, 2022). According to specific social justice competencies (Constantine et al., 2007), multicultural awareness and training involve acquiring knowledge about the diverse ways oppression and social inequities may manifest at individual, cultural, or societal levels. Institutions may generate awareness through education and training by instituting formal professional development initiatives, such as workshops and seminars that emphasize the intersectional experiences of women of color, including the impact of microaggressions and systemic barriers.

Universities can further this effort by training faculty and staff to recognize and address implicit biases. Such training programs can be designed to enhance cultural competence, ensuring that educators are equipped with the skills to foster an inclusive and equitable classroom environment. This knowledge can be further extended to increase understanding of the unique ways different individuals, groups, organizations, and larger systems experience such inequities.

The United Nations Educational, Scientific and Cultural Organization (2017) and other international organizations advocate quality higher education that fosters an inclusive culture and recognizes and respects students as unique individuals with diverse learning needs and valuable experiences. Inclusive pedagogy is rooted in the belief that every student can offer valuable contributions within the learning environment (Moriña, 2022). Striving for inclusivity involves recognizing diversity as an opportunity to enhance the teaching and learning processes.

Adopting Black Feminist Pedagogy

Educators in the field of counseling should similarly work to create culturally responsive and inclusive pedagogical approaches. This process involves incorporating diverse perspectives and experiences into the curriculum, using inclusive language, developing diversity statements to promote equitable learning in classrooms, and addressing intersectionality in teaching materials (Dutt, 2019). Adopting these practices may ensure that the educational experiences of women of color are recognized, valued, and reflected within the academic setting. According to Moriña (2022), all participants in a study of inclusive pedagogy emphasized the importance of teachers' fostering a sense of trust and self-assurance in students' learning capabilities. Findings stressed the need for educators to establish high expectations and actively support students in recognizing their own potential (Moriña, 2022).

Additionally, implementation of Black feminist pedagogy creates a space for students to learn about and understand the experiences of women of color and fosters a sense of liberation and intellectual inclusion that challenges the Western educational tradition (Omolade, 1987). Black feminist thought critiques traditional educational practices that center a patriarchal lens (Quist, 2021). Further, a Black feminist framework in a classroom setting can act as a pedagogy of liberation, and any denial of its practices helps maintain America as a racist society (Joseph, 1988, as cited in Quist, 2021).

The adoption of inclusive pedagogy, particularly Black feminist pedagogy, thus necessitates a deliberate reconfiguration of curricula to include diverse perspectives and challenge dominant narratives. This change can also be operationalized by incorporating scholarly works authored by women of color and by facilitating critical classroom discussions about issues of race, gender, and intersectionality. By encouraging students to engage with these

materials and reflect on their own intersecting identities, educators can foster a more inclusive academic discourse. Additionally, mentorship programs can be established to support women of color by connecting them with faculty who share similar experiences or have expertise in navigating the complexities of academic spaces as women of color.

Implementing Institutional Changes

Furthermore, as advocates, educators can seek to change the narratives of institutional policies and practices to promote diversity, equity, and inclusion. This process may involve challenging biases in hiring practices, promoting diversity in leadership positions, and supporting initiatives that address systemic inequalities (Sue et al., 2019). By actively engaging in these efforts, counselor educators can contribute to creating a more inclusive and equitable academic environment for women of color.

Institutional change requires an ongoing commitment to revising existing policies and practices to prioritize diversity, equity, and inclusion. This may involve reassessing hiring practices to ensure that leadership positions are accessible to individuals from diverse backgrounds and that representation at all levels of the institution reflects this commitment. Additionally, institutions should implement policies that provide tailored support for women of color, such as mental health services that address their unique needs, affinity groups that foster community belonging, and scholarships or grants that reduce barriers to education. By embedding these approaches into institutional structures, universities can create a more equitable and supportive academic environment that recognizes and values the contributions and experiences of women of color.

Prioritizing mental health support and cultivating a sense of belonging for women of color in higher education is imperative, as their unique experiences and needs must be

understood within the broader context of intersectionality and systemic inequities. Addressing these complexities requires a comprehensive and culturally responsive approach that acknowledges the intersecting dimensions of race, gender, and other social identities, ensuring that institutional policies and practices align with the principles of equity and inclusion.

Conclusion

This article highlights the significant challenges and barriers faced by women of color in higher education. Additionally, it emphasizes the importance of creating an inclusive campus climate that fosters a strong sense of belonging for these students. Utilizing the Black feminist framework, we shed light on the intersectional experiences of women of color and the need for critical analysis and deconstruction of systems of oppression within educational institutions. The lack of belonging experienced by women of color in academia is rooted in historical and ongoing marginalization. These systems of oppression compound and perpetuate the detrimental effects on the psychosocial wellbeing and academic achievements of women of color. These effects emphasize the need for faculty, staff, and leaders in higher education to actively engage with the students of color, understand their unique challenges, and work to create a more welcoming and inclusive campus climate.

The three-pronged approach we have outlined includes raising awareness through education and training, adopting an inclusive Black feminist pedagogy, and making overdue institutional changes. Each strategy seeks to address the unique challenges faced by women of color, promote cultural humility and acceptance, and challenge biased policies and practices within educational institutions. This pedagogical and institutional approach promotes critical thinking and social justice while prioritizing the experiences and voices of marginalized groups. As counselor educators and advocates in the field, we call for a collective effort to dismantle

systems of oppression, foster a sense of belonging, and create a more equitable and inclusive educational environment for women of color to further promote both academic success and psychosocial wellbeing.

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Effective Suicide Postvention in Schools

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Abstract

Adolescent suicide rates have increased significantly in recent years, underscoring the need for effective postvention strategies in schools. This paper provides a comprehensive guide for schools to implement suicide postvention plans aimed at supporting students, faculty, and the wider community after the loss of a student to suicide. Using a framework built around crisis response, information sharing, intervention, and closure, this study emphasizes the role of school counselors, teachers, and administrators in fostering resilience, preventing suicide contagion, and promoting mental well-being. The discussion integrates social cognitive and interpersonal theories to explore the complex dynamics that affect students in the aftermath of a peer's suicide, including feelings of isolation and burden. Key strategies are outlined for school-based teams, focusing on crisis management, mental health awareness, and peer support. Challenges such as the stigma surrounding mental health, the "don't talk about it" mentality, and legislative gaps in school policies are addressed, along with recommendations for overcoming these barriers. This paper also highlights the importance of training and preparation, providing actionable steps for schools to create crisis response teams, conduct risk assessments, and ensure proper communication. Postvention efforts are positioned not only as an immediate response but also as a preventive measure to mitigate future crises, promote help-seeking behaviors, and encourage emotional healing. Finally, the paper calls for further research and policy development to support the sustainable implementation of postvention practices, advocating for schools to play a proactive role in addressing adolescent suicide.

Keywords: suicide postvention, adolescent mental health, school crisis management, suicide contagion, peer support, mental health awareness, school counseling

Effective Suicide Postvention in Schools

Introduction

Suicide among adolescents has increased at an alarming rate. It is the third leading cause of death for 10- to 14-year-olds and the second leading cause of mortality among 15- to 24-year-olds (Centers for Disease Control and Prevention [CDC], 2015). Between 2007 and 2015, the rate of suicide in adolescent boys increased by 30%. The rate in girls doubled during the same 8-year period (CDC, 2017). Due to these trends, it is crucial that schools begin to understand the significance of this threat.

Having a plan in place to implement following the suicide of a student is a highly beneficial practice for mitigating further damage to the survivors. Considering that the adolescent years can often be a time of increased stress, adding the stress of a peer's suicide could put many more students at risk. Such a plan should be based around the core goals of returning the focus of the school to education, facilitating natural coping responses of those affected, providing resources for those affected, preventing suicide contagion or imitative behaviors, and identifying ongoing needs of the school community (Hart, 2012). A variety of school personnel can fill important roles to support students.

School counselors are frontline advocates for students' emotional well-being. They are uniquely equipped to provide counseling services, conduct risk assessments, and intervene when students show signs of suicidal ideation. Regular training equips counselors with the skills needed for effective postvention strategies, which involve supporting students and staff after a suicide or other traumatic event (Çitak & Yazici, 2022).

Teachers and faculty members, as trusted figures in students' lives, can also play a pivotal role in early detection and intervention (Mueller & Abrutyn, 2023). Teachers should receive training to recognize warning signs and provide appropriate referrals to support services. Additionally, teachers may contribute to efforts to provide care and support to the affected students' peers, ensuring they have a safe space to express their emotions and receive support (Sonsteng-Person & Loomis, 2021).

Administrators, including principals and other school leaders, should prioritize student well-being by fostering a culture of support within the school community. They should ensure access to resources and facilitate staff training to enhance the overall response to mental health concerns, including the implementation of effective postvention strategies aimed at providing care and support to the school community. Well trained school counselors, teachers, and administrators can effectively address the complex emotional needs of students facing the stressors of adolescence, including the potential impact of peer suicide (Hart, 2012).

Responding to Suicide: Preparation in U.S. Schools

Following the suicide of a student, school personnel should provide timely and accurate information regarding the situation (Roberts et al., 1998). By doing so, schools can create a supportive environment that fosters open communication and active listening. Well trained educators may also model healthy mourning practices that demonstrate compassion, empathy, and resilience. The escalating trend of adolescent suicide rates is concerning, and by learning how to respond supportively, educators demonstrate they understand the significance of this threat (Roberts et al., 1998).

Assessing the risk of suicide is a complex and delicate skill. According to social cognitive theory, schools are an environment in which youths learn social skills (Bandura &

National Institute of Mental Health, 1986). However, risks are inherent in the dynamics of adolescents' interactions; feeling like a burden and being prevented from belonging are two of the most significant features of the interpersonal theory of suicide (Van Orden et al., 2010). The school environment generally consists of many cliques, and a student may not fit in with a group of friends. If a student does not have a friend group with whom they connect and then experiences a traumatic event such as a classmate's suicide, it is reasonable to consider them at higher risk for potential self-harm.

The suicide of a student can have a myriad of effects on the individual's peers and create different risk factors for each person. For instance, while those closest to the individual are generally deemed to be at the highest risk, acquaintances or distant friends are often more at risk, primarily because they do not receive as much support as close friends of the student who died (Gould et al., 2018). In addition to the risks at the individual level, it is of great importance to prevent a suicide contagion, which Insel and Gould (2008) defined as "the actual process of one suicide influencing the occurrence of subsequent suicides" (p. 296). Because of all these risk factors, schools need to enact postvention programs to mitigate the damage caused by a suicidal event. The student body can assist in postvention programs, as research has shown that the influence of their peers can positively impact students (Gould et al., 2018).

Currently, a paucity of research on the implementation of postvention leaves educators underinformed about suicide in schools. Many schools have an implicit "don't talk about it" mentality when it comes to suicide, which contributes to this problem. Ideally, postvention efforts will increase inclusion in every school plan following a suicide. Creating a plan with the goals of focusing on education, nurturing coping responses, providing grief resources, preventing suicide contagion, and anticipating ongoing needs (Hart, 2012) can produce a healthy reaction

from students and be easily integrated with practice. In addition, resource "toolkits" are available to facilitate the construction of comprehensive postvention plans. The American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Center (SPRC) authored one such toolkit in 2018.

As with any formation of a new program, school will encounter difficulties associated with its creation. Because of the unspoken mandate for silence in some schools, bringing in a postvention program can receive pushback merely due to the subject. According to the AFSP (2016), only 12 states and the District of Columbia required schools to have measures in place to prevent, intervene, and respond to suicide. The limited acceptance of these programs indicates that state legislatures might challenge the implementation of new programs. Therefore, it is crucial to ensure that schools are mandated to implement these programs and that they are appropriately regulated and monitored.

Robinson et al. (2013) called the lack of postvention practices and empirically based programs "disappointing" (p. 176) and asserted a need for more research and the creation of more postvention programs in U.S. schools to build a greater foundation from which to address this issue. During the development of postvention programs, Gould et al. (2018) sent out a questionnaire to determine the aftereffects of suicide on a school population and found that postvention programs can reinforce positive changes in adolescents' attitudes toward coping strategies and help-seeking behaviors.

These findings offer reasons to be optimistic about developing new postvention programs. It is essential to keep these and any future results in mind because suicide postvention in schools is very much in its infancy. Applying empirical data during development may lead to

the creation of better and more effective plans for suicide postvention and through them, better support for students in times of crisis.

Discussion

The detrimental practice of perpetuating a "don't talk about it" mentality regarding suicide has pervaded many schools. It is vital that each school creates an effective crisis response plan and organizes a crisis response team before a traumatic event occurs. Such proactive preparation may help their students if such an event does actualize. The team coordinator should be the school principal; the team should include five to six members (no more than 15) consisting of psychologists, school counselors, school nurses, social workers, school administrators, and school resource officers (AFSP & SPRC, 2018).

Teachers play an essential role in crisis response, serving as the front line of schools' suicide postvention response (Mueller & Abrutyn, 2023). Because teachers have the most face-to-face contact with students, they must be trained in the identification of students at risk for suicide. Training should also include how to provide immediate support and how to refer at-risk students to appropriate mental health professionals (Stickl Haugen et al., 2023).

Some resources are available to educators who wish to start a postvention program. An in-depth guide to suicide postventions in schools appears in "After a Suicide: A Toolkit for Schools," a resource published by AFSP and SPRC (2018). Roberts et al. (1998) developed a model called the TEAM approach to creating a comprehensive postvention plan to handle the crisis systematically and effectively. Four categories make up the TEAM approach: developing a team, establishing procedures, arranging support, and monitoring processes (Roberts et al., 1998). Mueller and Abrutyn (2023) urged school administrators, staff, crisis counselors, and

others who lead postvention to remember that their first and foremost role is to care for youth authentically.

The goal of this paper is to provide educators, specifically school counselors and teachers, with a practical, step-by-step, fundamental guide for suicide postvention. A common theme in this field of research is that many guidelines for how to implement a successful postvention are often overwhelming for a school counselor to attempt to use. Giving school counselors, administrators, and teachers a straightforward plan with a base from which to start can increase the likelihood of a successful postvention. The following four stages comprise that base: crisis response, sharing information, implementing intervention services, and closure. As these stages encompass broad topic areas, they must be tailored to each situation and matched to the exact circumstances of each event.

Stage 1: Crisis Response

The first stage of a beneficial suicide postvention involves the school's initial response to the crisis. According to the TEAM approach by Roberts et al. (1998), finding team members, designating leaders, identifying the strengths of members, assigning tasks, and training for implementation should all be addressed before a crisis happens. Then during Stage 1, the school should seek to immediately mobilize the crisis response team they have created and speak with the family/caretaker(s) of the student who died by suicide. While speaking to the family/caretaker(s), the school should obtain confirmation that the student died by suicide as well as gather as many objective facts about the suicide as possible. This information allows the school to modify its crisis response plan to address the present needs.

It is vital at this stage to ensure that the school does its best to help the family and offer condolences rather than treating them solely as a source of information. Most families never

anticipate losing a child—especially to suicide—so reaching out to the family with the resources the school has available can be a constructive step toward recovery for everyone involved (Lee et al., 2017). As the family provides as much information as they would like to the school, the school should ask how much information the family wants to be released to the public/student population. All members involved must be on the same page regarding confidentiality and releasing information.

Determining how long the crisis team will be available for students and teachers on campus is also essential. Administrators may consider bringing in extra volunteers, such as counselors from other schools, grief counselors, and clinical mental health counselors, to help with the initial shock. Both students and teachers need to feel supported during this time of crisis. Substitute teachers may need to be utilized as well to alleviate the pressure from the classroom teachers of the student who died by suicide.

Stage 2: Sharing Information

After the school has collected the appropriate and necessary information, the next step is to share that information. The TEAM approach by Roberts et al. (1998) addresses the processes for notifying the staff and students, including guidance on how the news will be shared, what information will be shared, and how the memorial activities will ensue. This step must be taken carefully to avoid conveyance of any judgmental attitudes, such as villainization of the student. Careful awareness must also be placed on the potential sensationalizing of information and romanticizing of the suicide. Some students may be at greater risk of suicide following the completed suicide of a peer, and romanticization of the suicide or inappropriate publicity surrounding it can potentially encourage the surviving peers to see the suicide as glamorous.

It is important to note that these four stages are also only a base from which to begin. Practically, infinite variables are present in each situation, making the responsible sharing of information difficult and complex. One byproduct of suicide is that rumors may arise afterward. A helpful tool administrators could provide for teachers is a prepared statement explaining how to inform students about the tragedy and suggesting ways to address and control rumors (Maples et al., 2005). If a rumor needs to be addressed, the school personnel should address it using the objective facts gathered from talking with the family and individuals involved. The school should not promulgate any potential rumors. It is best to tell students in smaller groups, such as their homerooms, rather than over a school intercom system or at a large school gathering (AFSP & SPRC, 2018).

Stage 3: Implementing Crisis Intervention Services

Following a suicide, different levels of needs will be present within the school. Some students who were close to the individual who committed suicide may be at a higher risk of attempting suicide themselves (Cipolletta et al., 2022). It is crucial to ensure that individuals who have been affected by a peer's suicide receive the necessary resources and support. According to Roberts et al. (1998), the TEAM approach for organizing support involves carefully considering several factors, including the structure of support groups, designated leaders and participants, duration of support, debriefing procedures, and communication with the family. The student body should be allowed to meet with a school counselor or mental health professional (from the crisis response team) in individual and small-group counseling sessions. For students to regulate their emotions and figure out what they need, safe spaces and calm, competent adults are essential (Mueller & Abrutyn, 2023).

When adults give information to students or answer questions regarding a peer's suicide, they should communicate the information as simply and efficiently as possible. Suicide, as a topic, should be addressed in general as the first step. Any blaming or scapegoating regarding the suicide or individuals involved/affected should be attended to and quelled. The method of the suicide should not be the focus of the conversation. Anger may be present, as well as the potential for peers to feel that they are somehow responsible for the suicide (Young et al., 2012). Both feelings and their related emotions should be addressed. In these conversations, adults should encourage help-seeking behaviors by students. Having a crisis response team member follow/monitor the deceased student's class schedule is one way to identify any individuals who need help (AFSP & SPRC, 2018). Creating a backup plan for the school day if a crisis happens is also crucial during this stage. Business as usual may not be able to happen on the first day of a crisis.

Stage 4: Closure

Carrying out this final stage requires critical tact. Following a completed suicide, there are often memorials, activities, and conversations that arise. Roberts et al.'s (1998) TEAM approach addresses how to determine how long the school should closely monitor at-risk students, how to maintain long-term community support, and how to assess the readiness of the school for potential suicide. The most critical potential byproduct that must be suppressed is the romanticizing of the suicide. It is possible that a student will see how much attention the deceased student's actions garnered and think of suicide as a way to increase their prominence. Acts of closure should never glorify, glamorize, or romanticize suicide in any form. Memorial activities may be conducted but should be appropriate. Students can be asked whether they would like the desk of the deceased student to remain in the classroom or be removed.

As important as the rituals of closure are, with an event like a completed suicide, closure may never fully be obtained. Such a loss can often leave individuals with many questions that may never be answered. This topic can also be addressed when speaking with affected individuals to help them understand that their feelings are understandable and can be challenging to deal with as their solution is not always easily attainable. These feelings may subside but may arise again on the anniversary of the suicide. If any memorial event is held on the anniversary of the suicide, it could be helpful to refer to it as a “remembrance” to diminish any potential chance of glorifying the suicide itself.

It is important to develop a follow-up plan for students and teachers who seek help during a crisis to ensure that everyone feels supported. Additionally, it is necessary to provide external resources to help students, staff, and teachers cope with the tragic event. To maintain a state of preparedness, the school can implement a curriculum that includes topics such as suicide and mental health, which can be taught during the regular school year.

Implications for Practice

A structured postvention plan enhances crisis response capabilities within the school. With clear protocols and procedures in place, school staff are empowered to respond swiftly and effectively in the event of a suicide. This response includes providing immediate support to those directly impacted, coordinating with external resources such as mental health professionals or crisis hotlines, and communicating transparently with the broader school community to ensure accurate information and to dispel rumors or misinformation. In addition to crisis response, a postvention plan also focuses on prevention, specifically the prevention of contagion or the spread of suicidal behavior. By addressing the needs of those affected by a suicide loss and providing targeted interventions for at-risk individuals, schools can mitigate the risk of additional

suicides within the community. This proactive approach includes conducting risk assessments to identify students who may be vulnerable to self-harm or suicidal ideation and connect them with appropriate support services.

A well-designed postvention plan prioritizes the support and healing of grieving individuals. This includes offering counseling services, support groups, and other resources to help individuals navigate their grief and develop coping strategies for healing. By providing a supportive environment where individuals feel safe to express their emotions and seek help, schools facilitate the healing process and promote resilience within the community.

Barriers to Implementation

Implementation of postvention activities in schools may be hampered by various barriers. These obstacles may include a lack of resources, inadequate staff training or experience, or resistance from community members who may be hesitant to address the issue of suicide or mental health. It is essential to identify and address these barriers to provide effective support to those affected by a crisis. As with any formation of a new program, there will be difficulties associated with its creation.

The commonly long-held “don’t talk about it” mentality in schools may create pushback to any proposed postvention plan. According to the AFSP in 2016, only 12 states and the District of Columbia required schools to have measures in place to prevent, intervene, and respond to suicide. These circumstances indicate that school personnel should be aware of resistance at the local, district, and legislative levels, which significantly challenge the implementation of these programs. Therefore, it is crucial to ensure that schools are mandated to implement these programs and that they are appropriately regulated and monitored.

The scarcity of postvention practices and empirically based programs establishes a need for more research and the creation of more postvention programs in our schools to build a greater foundation from which to aid this issue. As schools develop postvention plans, it is essential to consider their implications, including mitigation of suicide contagion, support for grieving students and staff, restoration of educational focus, identification and support of high-risk individuals, education and awareness, policy and legislative change, research and development, and community involvement. The implementation of effective suicide postvention plans in schools is an imperative step toward addressing the increasing rates of adolescent suicide.

Recommendations for Future Research

Future researchers could examine the practical implementation of critical friends theory (CFT)-informed strategies within school settings in relation to school-age children and suicide prevention. This theory emphasizes the importance of peer support and collaboration in achieving goals (Carlson, 2019). By integrating CFT principles into school environments, educators could foster new supportive relationships vital for addressing mental health concerns. Specifically, a CFT model tailored to mental health in schools could facilitate knowledge sharing under the guidance of experienced mentors, potentially enhancing suicide prevention and postvention efforts.

Expanding upon the concept of CFT, its application within the context of suicide prevention and postvention warrants further investigation. Research endeavors could explore the efficacy of implementing CFT-based interventions to bolster mental health support systems within schools. For instance, exploring the dynamics of critical friends within student peer groups may unveil insights into how peer networks can be leveraged to promote mental well-being and prevent suicidal behavior. This exploration also could involve assessing the feasibility

and effectiveness of peer support programs rooted in CFT principles or evaluating the impact of integrating mental health education curricula informed by CFT. By elucidating the mechanisms through which CFT contributes to suicide prevention efforts, such research could inform evidence-based practices aimed at enhancing the overall mental health support infrastructure within schools.

Conclusion

A school that is prepared can play a crucial role in times of crisis. By providing accurate information, a supportive environment, and a model of healthy mourning, schools can help facilitate the expression of complex emotions by students, families, and the wider community. It is important to create a safe space where everyone can feel heard and understood during difficult times (Roberts et al., 1998).

Implementing a suicide postvention plan within a school community is a multifaceted endeavor with far-reaching implications for mental health support, crisis management, and community resilience. By systematically addressing the aftermath of a student suicide, schools not only provide immediate support to those directly affected but also lay the foundation for long-term healing and prevention efforts. A postvention plan signals a commitment to promoting mental health awareness within the school community. By openly acknowledging the reality of suicide and providing resources for support and healing, schools work to reduce the stigma surrounding mental health issues. A proactive approach fosters a culture of openness and understanding, encouraging individuals to seek help when needed and reducing the likelihood of future crises going unnoticed or unaddressed.

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Individual Placement and Support (IPS) Supported Employment Model:

Worth the Investment

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Abstract

Individual placement and support (IPS) is an evidence-based approach to supported employment that has been found to result in an increase in successful outcomes for people with serious mental illness. To confirm these results, we piloted the IPS model at three community mental health facilities in Alabama. We compared employment outcomes of people with serious mental illness, health care service utilization, and health care costs of those receiving IPS services and working and those not receiving IPS services and not working. We conducted a multivariable regression odds ratio to examine differences in medical services utilization and cost of medical services by employment status. Results identified a statistically significant relationship that supports the efficacy of the IPS model. Individuals with serious mental illness who were employed through IPS had lower general medical and mental health medical service utilization than those not employed. The implication is that funding for IPS services is a good investment for those wanting to manage medical and mental health service utilization and associated costs. IPS leads to employment, which reduces utilization of medical and mental health services, and therefore reduces costs.

Keywords: individual placement and support, supported employment, cost benefit analysis, employment, serious mental illness

Individual Placement and Support (IPS) Supported Employment Model: Worth the Investment

The Individual Placement and Support (IPS) model is the most researched and recognized evidence-based approach to supported employment (Bond et al., 2008). Supported employment services, including IPS, are typically implemented through collaborations among health agencies, community organizations, and state vocational rehabilitation (VR) programs. VR programs provide critical support in the implementation of supported employment, accommodating both physical and cognitive disabilities with individualized services. These services include job development, job coaching, skills training, and workplace accommodations, tailored to help individuals achieve and sustain employment (Fleming et al., 2019).

State VR programs play a pivotal role in supported employment by offering development services that assist clients in finding suitable employment opportunities and job coaching that provides continuous support after job placement. This support is essential for individuals with significant disabilities, including those with serious mental illness, as it helps them navigate workplace challenges and maintain employment over time. By working closely with IPS providers, VR programs enhance the employment outcomes of individuals with disabilities, making the supported employment services more accessible and effective (Bond & Drake, 2014; Karakus et al., 2011).

Characteristics of the IPS Supported Employment Model

Through the IPS model of supported employment, individuals with psychiatric disabilities receive integrated employment support services and mental health treatment. IPS is based on eight core principles (Bond, 2004; Bond et al., 2008):

1. The focus is on competitive integrated employment.
2. Eligibility for services is based on the consumer's choice (this principle is also known as zero exclusion); no one is excluded from participating in the IPS program based on diagnosis, symptoms, or history if they desire employment.
3. Rapid job search is utilized (i.e., place and train).
4. Employment and mental health services are provided simultaneously by an integrated treatment team.
5. Attention is given to consumer preference in the job search process.
6. Continuous, individualized job support is provided for as long as the person needs and wishes to receive support.
7. Develop relationships with employers to understand their business needs.
8. Personalized benefits counseling is provided; benefits planning and guidance helps consumers make informed decisions about changing or starting a job.

There are several other models of supported employment, such as customized employment and the clubhouse models. Customized employment focuses on the discovery of the unique needs, abilities, and interests of the job seeker. This information is then used in employer negotiations to develop a position and determine job duties (Elinson et al., 2008). The mutual benefits that result when job seekers with disabilities are matched to employers' needs has the potential to increase employment outcomes.

Clubhouse models emphasize a community-based approach wherein individuals participate in a shared work environment, but these models may not directly target competitive employment as an outcome. Research shows supported employment is a cost-effective service

that leads to positive competitive integrated employment outcomes for individuals with significant disabilities within the current VR system (Cimera, 2016). Although effective for some, these other models often lack the comprehensive, individualized, and integrated support of the IPS model, which focuses on rapid job placement, integration with mental health treatment team, and sustained job coaching in real-world competitive settings (Drake et al., 2016).

However, the IPS model is not without challenges. Barriers include inconsistent funding streams, variability in program fidelity, and difficulties in building sustained employer partnerships. VR services often have limited capacity to provide long-term support beyond their defined service duration, which can create gaps in ongoing job retention assistance. Furthermore, integrating mental health and employment services requires coordination that some systems may struggle to achieve, potentially limiting the model's full effectiveness (Karakus et al., 2011).

Evidence-based supported employment services like IPS are important for individuals with serious mental illness and the professionals working with them. Approximately two-thirds of individuals in the U.S. community mental health system have reported that employment is one of their goals (Bond & Drake, 2014). Even though individuals with serious mental illness have a desire to work, only about 15% are employed (Salkever et al., 2007). Previous research has proven that the utilization of IPS improves competitive employment outcomes when compared to other vocational services (Bond et al., 2008). Additionally, individuals who receive IPS services demonstrate substantial gains in employment rates for years following the end of services (Drake et al., 2016).

The IPS model avoids extensive assessments, pre-vocational training, and demonstrations of job readiness, focusing instead on rapid job placement in competitive integrated employment. IPS has demonstrated effectiveness across many populations, in different countries, and under

diverse economic conditions. The cost of IPS in the United States ranges from \$3,500 to \$5,000 per client in the first year after enrollment (Salkever, 2013). During the initial months, IPS employment specialists have weekly contacts with clients to help them find appropriate jobs, secure employment, and learn job tasks. Once clients have settled into their roles, typically after 9 months, support is gradually reduced to monthly check-ins (Bond & Kukla, 2011), which helps to substantially lower ongoing costs. While these cost savings are important, the true impact of IPS is often seen in the transformative successes of individuals with serious mental illness.

Employment gives people hope, a sense of purpose, and builds self-worth, which leads to a decrease in symptoms and increased motivation to continue working (Fleming et al., 2019). As Jessica Hales, Alabama Department of Mental Health's Coordinator of Adult Mental Illness Services said, "Time and again, the success stories for those we serve provide testimony for the transformative power employment has on the lives of people...work is recovery!" (State of Alabama, 2018, para.7). Although IPS delivers substantial benefits for individuals with serious mental illness, the program faces several barriers including funding constraints and program variability. IPS require a commitment from multiple agencies, including VR programs and mental health agencies, to provide the comprehensive support necessary for sustainable employment outcomes. These partnerships enhance the likelihood of successful employment, which reduces medical and mental health service utilization and associated costs (Luciano et al., 2014).

Research Problem: Is IPS Worth the Investment?

Individuals with serious mental illness are employed at much lower rates than the general population (Gühne et al., 2021). This lower rate does not reflect the capacity or desire of people with serious mental illness to be employed, nor does it demonstrate an inability to work. In truth,

employment has been widely recognized as a fundamental part of recovery and community integration. The problem is the lack of funding for IPS services people with serious mental illness need to secure and maintain employment. Previous researchers identified the most significant barrier to IPS program implementation and service delivery to be administering the funding mechanism from more than just one payee (Karakus et al., 2011). For IPS programs to be successful, funds must be combined from Medicaid, VR, state mental health general funds, and other federal, state, and local programs (Luciano et al., 2014).

Convincing legislators and other key decision-makers to invest in IPS services and similar employment programs increasingly relies on demonstrating the cost benefits. The primary research problem for this study was the insufficient evidence regarding the cost benefits of IPS, which is crucial for justifying the additional funding needed to provide IPS services to people with serious mental illness. To provide this evidence, we set out to determine whether helping people with serious mental illness find and maintain employment using IPS saved money for the state's Medicaid agency.

Systems change and leadership is needed to facilitate positive employment outcomes for people with the most significant disabilities, including those with serious mental illness. Interagency collaboration is critical in this employment process as individuals with significant mental health issues often need on-going support for an extended period of time. Initially, strategic partners may expect VR to provide long-term supports. However, VR services are time limited; hence, another funding source must be secured to provide supports for the life of the job.

Most states, including Alabama, lack model programs with an effective IPS employment philosophy and strategy that could serve as a resource to people with severe and persistent mental illness. Because of this deficit, grant funding was sought to bring representatives from

VR and mental health services and the authors together to enhance consumer employment within the state. Alabama was one of seven states selected to receive the Substance Abuse and Mental Health Services Administration's (SAMHSA) *Transforming Lives through Supported Employment* grant (2014-2019). The Department of Mental Health (DMH), in partnership with the Department of Rehabilitation Services (DRS), used these grant funds to enhance state-level and community capacity to implement the IPS model of supported employment for adults with serious mental illness and those with co-occurring mental and substance use disorders. We, the authors, proposed that consumers with the necessary supports can manage disabling conditions, achieve the highest degree of independent living possible, be meaningfully employed, and be actively involved in social interactions with friends and family. These outcomes can also lead to a cost savings initiative for the state's Medicaid agency, the DMH, and the DRS.

The purpose of this examination was to show the potential for the IPS model of supported employment to save money for the state's Medicaid agency. This study was a comparison of health care service utilization and the costs of those medical services for people with serious mental illness who were working because of IPS to those who did not receive IPS services and were not working. To make the business case for IPS, the following research questions guided the study:

Research Question 1: Did IPS consumers with serious mental illness who work have lower medical service use related to their mental health than those not working?

Research Question 2: Did those who work have lower mental health service costs than those not working?

Research Question 3: Did helping people with serious mental illness find and maintain employment using IPS save money for the state's Medicaid agency?

Methods

This study was designed in consultation with Judith Cook, PhD, from the Center for Mental Health Services Research and Policy at the University of Illinois at Chicago. Dr. Cook was the project evaluator for the IPS/Supported Employment Project in Illinois. Survey data from Alabama's DMH and publicly available data from the Centers for Medicare & Medicaid Services were used in the analysis. In this group comparison design study, we compared those individuals with serious mental illness who became employed after receiving IPS services to those who did not receive IPS services and were not employed.

Instrument

Based on a similar analysis conducted by Cook et al. (2018), we developed questions for an IPS Employment and Healthcare Survey (Appendix). The research team conducted a content validity analysis to ensure the questions aligned with the purpose of the study; the DMH provided additional vetting. The survey contained 23 forced choice questions that assessed IPS consumers' demographics, disability status, health insurance, residential status, IPS services received, employment status, and medical services received. Examples of the forced choice questions included "Are you currently working?" with options like *Yes, for 29 days or less*, *Yes, for 30 days or more*, and *No*. Another question assessed clients' perception of their mental health status; this item used a 5-point Likert scale of responses ranging from *poor* to *excellent*. This structure allowed participants to select predefined responses, providing standardized data that facilitated the analysis related to IPS service engagement and health outcomes.

Procedure and Setting

To ensure the confidentiality and privacy of the data, we obtained permission from the Institutional Review Board (IRB) at Auburn University to conduct the study. Collected data were recorded in a spreadsheet for statistical analysis in the Statistical Package for the Social Sciences (SPSS). We provided the IPS Supervisor and the IPS Peer Support Specialist with a review of the survey instrument and training regarding administration. The IPS Peer Support Specialist administered the survey in person or by phone; the instrument assessed service utilization, disability status, employment, self-perceived mental and physical health status of the IPS participants and a control group. Using a convenience sampling method, the survey was administered to 68 individuals with serious mental illness in April 2019 at two sites in Alabama.

Participants

Procedures involving experiments on human subjects were performed in accordance with the ethical standards of the Committee on Human Experimentation of the institution in which the experiments were conducted and/or in accord with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. This study received approval from the Auburn University Institutional Review Board on May 21, 2018 (Protocol Nos. 15-113 MR1505 and 15-114EP1504). We secured informed consent was obtained from each participant before collecting any data.

We collected the following demographic information from both sites: IPS participants' gender, age range, race, highest education level achieved, top five primary mental health diagnoses, health insurance benefits, Supplemental Security Income recipient, Social Security Disability Insurance recipient, and residential status. Participants included individuals who

were actively receiving mental health services at the time of the survey with employment as a component of their recovery.

To aid in the analysis of the disability category data, we recoded the categories into smaller subgroups using the International Statistical Classification of Diseases and Related Health Problems (ICD) 10 Classification of Mental and Behavioral Disorders. These smaller subgroupings reduced the complexity in the analysis of the data without adversely impacting the interpretation. We determined the subgroups by examining the primary disability reported. These subgroupings were then matched to the appropriate ICD 10 header. Final disability demographics codes included the following: (a) schizoaffective disorder, (b) schizophrenia, (c) bipolar disorder, (d) major depressive disorder, and (e) all other diagnoses combined. Table 1 summarizes all demographic information.

Table 1

Participants' Demographic Characteristics

Characteristics	<i>n</i>	%
Gender	68	100%
Male	37	54%
Female	30	44%
Choose to not identify	1	2%
Age	68	100%
20–34 years	17	15%
35–44 years	15	22%
45–64 years	30	44%
65 years or older	5	7%
Choose to not answer	1	2%
Race	68	100%
White	38	56%
Black or African American	26	38%
Asian	1	2%
More than one race	3	4%

Table 1*Participants' Demographic Characteristics (cont.)*

Characteristics	<i>n</i>	%
Educational level	68	100%
Less than high school	22	32%
Certificate of Attendance	1	2%
Certificate of Completion	5	7%
General Educational Development (GED)	14	21%
Vocational/Technical Diploma	2	3%
Some college	15	22%
Associate degree	4	6%
Bachelor's degree	3	4%
Choose to not answer	2	3%
Primary mental health diagnosis	68	100%
Schizoaffective disorder	18	27%
Schizophrenia	16	24%
Bipolar disorder	6	9%
Major depressive disorder	4	6%
All other diagnoses combined	24	35%
Insurance benefits	68	100%
Medicaid		
Yes	42	62%
No	26	38%
Medicare		
Yes	29	43%
No	39	57%
Medicaid and Medicare		
Yes	16	24%
No	52	76%
Private Insurance		
Yes	11	16%
No	57	84%
Supplemental Security Income		
Yes	44	65%
No	24	35%
Social Security Disability Insurance		
Yes	37	54%
No	30	44%
Residential status	68	100%
Independent	24	35%
Family/friends	22	32%
Group home	21	31%
Choose to not answer	1	2%

Gender representation was evenly distributed with 44% of the survey population identifying as female, 54% identifying as male, and 2% choosing to not identify. Forty-four percent of the IPS participants fell in the 45-64 age group. Fifty-six percent of the IPS participants were White, and 38% were Black or African American. Twenty-one percent of the IPS participants reported that they had a GED, 32% had less than a high school education, and 22% reported having some college. IPS participants reported schizoaffective disorder as their primary mental health diagnosis at 27%, closely followed by schizophrenia at 24%. All other diagnoses combined represented the highest percentage at 35%. Regarding insurance benefits of IPS participants: a majority, 62%, received Medicaid; 43% received Medicare; 24% received Medicaid and Medicare combined, and only 16% had private insurance. Sixty-five percent of IPS participants received SSI, and 54% received SSDI. Residential status was approximately equally divided among IPS participants: 35% reported living independently, 31% reported living in a group home, 32% reported living with friends and family, and 2% chose to not answer.

Data Analysis

Of the 68 individuals surveyed, 54% ($n = 37$) received IPS services. Seventy-five percent ($n = 51$) were not currently employed; and 25% ($n = 17$) were currently employed. We used a multivariable regression odds ratio to examine differences in medical service utilization by employment status. Medical costs were examined using the CMS Medicare-Medicaid Linked Enrollee Analytic Data Sources (MMLEADS) Public Use File. The MMLEADS suite of files includes beneficiary-level Medicare and Medicaid enrollment and claims data for Medicare-only, Medicare-Medicaid dually enrollment, and Medicaid-only blind and disabled beneficiaries.

These files include information about: (a) eligibility and enrollment variables, (b) aggregated cost and use for Medicare and Medicaid, and (c) prescription drug service utilization. The following four files are released for approved MMLEADS data requests: beneficiary file, Medicare services file, Medicaid services file, and conditions file. The MMLEADS data source estimates were utilized because actual state Medicaid data was unavailable to the researchers. Therefore, medical cost estimates and mental health cost estimates were examined using the CMS MMLEADS Public Use File and based on Medicaid, Medicare, and dually enrolled Medicaid/Medicare fee-for-service costs for Alabama in 2012 among adult enrollees with a mental health disability. The 2012 CMS MMLEADS Public Use File was the most current data file available at the time this research was conducted.

Results

Research Question 1

The first research question was “Did IPS consumers with serious mental illness who are working have lower medical service use related to their mental health than those not working?” When comparing those individuals with serious mental illness who received IPS services to those who did not receive IPS services, results indicated mental health medical care use was less likely among employed individuals than those who were not employed. A summary of the analysis revealed that consumers receiving IPS services had a 21% chance of receiving hospital emergency care associated with their mental health, whereas their not-employed counterparts had a 79% chance. Table 2 details the mental health medical care utilization.

Table 2

Mental Health Medical Care Utilization

Facility	Consumers			Analysis		
	Employed <i>n</i> = 17	Not Employed <i>n</i> = 51	Total <i>N</i> = 68	Odds Ratio - 95% Confidence	Upper/Lower Bounds	Probability %
Hospital ER	1 (5.8%)	10 (19.6%)	11 (16.2%)	0.26	.03 - 2.17	21%
Primary Care	3 (17.6%)	9 (17.6%)	12 (17.6%)	0.93	.22 - 3.91	48%
Other (Don't Know)	1 (5.8%)	6 (11.8%)	7 (10.3%)	0.47	.05 - 4.20	32%
No Medical Services	12 (71%)	26 (51%)	38 (56%)	0.40	.12 - 1.3	29%

Hospital ER

The odds of an employed consumer needing hospital ER services was approximately 1 in 4 [Odds Ratio (OR) = 0.26] as compared to consumers who were not employed. In other words, four not-employed consumers would receive hospital ER services for each employed consumer. This result suggests a 21% chance that a hospital ER service would be provided to an employed consumer and a 79% chance that a hospital ER service would be provided to a not-employed consumer. Findings may be slightly inflated due to small sample size.

Primary Care

The odds of an employed consumer needing primary care services was approximately 1 in 4 (OR = 0.26) as compared to consumers who were not employed. Thus, four not-employed consumers would receive primary care services for each employed consumer, a 21% chance that a primary care service would be provided to an employed consumer and a 79% chance that a primary care service would be provided to a not-employed consumer. Findings may be slightly inflated due to small sample size.

Other (Don't Know)

Of the 68 total consumers, seven consumers were unable to recall if the services they received were provided by hospital ER, primary care, or some other medical service provider. Without knowing the specific type of service provided, it was difficult to predict the probability of occurrence for this group. The data permits only the analysis of the probability for the provision of medical services compared to no provision of medical services. However, the data suggests that the odds of some type of medical service being provided to an employed consumer is 1 in 2 (OR = .47) as compared to consumers who are not employed.

Research Question 2

The second research question was “Did those who work have lower mental health service costs versus those not working?” We compared individuals with serious mental illness who received IPS services to those who did not receive IPS services, and results indicated mental health fee-for-service estimated costs were significantly lower among employed participants. A summary of the analysis revealed that consumers who were not employed had an average annual mental health fee-for-service cost of \$1,172.64. Consumers who were employed had an average annual mental health fee-for-service cost of \$781.71, a difference of \$390.93 per consumer.

Research Question 3

RQ3 asked, “Does helping people with serious mental illness find and maintain employment using IPS save money for the state’s Medicaid agency?” Historically, most individuals with serious mental illness remain unemployed and underemployed. According to the data analyzed here, individuals with serious mental illness who find and maintain employment through IPS offer a cost savings for the state’s Medicaid program, as they report lower utilization of mental health medical care and mental health services. These results generally confirmed that

IPS is worth the investment. Ultimately, specific information about cost effectiveness can be verified only with a true experimental study using recent, individual Medicaid data, which was unavailable for this study.

Discussion

This study focused on individuals with serious mental illness who received IPS services; we examined whether employment was associated with differences in general medical care, mental health care utilization, and associated costs. Results indicated that individuals with serious mental illness who were employed tended to have lower general and mental health medical services utilization than those who were not employed. These findings suggested that the implementation of IPS could decrease service utilization and provide cost savings for consumers with serious mental illness; however, this study compared costs of employed and not-employed participants rather than establishing direct causal effects of IPS implementation.

These outcomes are significant for agencies and organizations serving this population when considering supported employment options. Previous results, such as those reported by Cimeria (2016), documented the cost efficiency and cost effectiveness of supported employment compared to facility-based programs. In this study, we examined the utilization of IPS, a supported employment service that leads to competitive integrated employment, and demonstrated that employed individuals with serious mental illness generally had lower estimated medical costs than those not employed.

Most individuals with serious mental illness remain unemployed and underemployed, so that the broader application of these cost savings is limited. However, mental health professionals' perceptions can significantly impact the employment prospects of people with serious mental illness (Fleming et al., 2019). Changing these perceptions and adjusting state funding allocations

have the potential to increase employment opportunities for this population. Providing IPS services not only promotes sustained employment for clients but also may be a good investment for payors seeking to control medical service use and costs.

Limitations

We were not able to obtain the actual Medicaid costs for the individuals in the study; instead, we had to analyze the CMS MMLEADS public-use files. To further explore and verify the actual costs, and to better understand the cost savings, we would need to analyze current Medicaid expenditures for both medical and mental health services. Another limitation of this study was the use of a convenience sampling method, which may have affected the representativeness of the sample. Convenience samples can impact selection bias as participants are not randomly selected and may not reflect the broader population of individuals with serious mental illness. This limitation impacted our ability to generalize the results to all individuals receiving IPS services and highlighted the need for future studies to employ random sampling methods to strengthen the validity of the findings. Additionally, we had to rely on the consistency of the peer support specialist who administered the survey to participants and the memories of the participants; these conditions could have affected the accuracy of responses recorded.

Conclusions

Results indicated that people with serious mental illness who were employed were less likely to use medical services and mental health services than those who were not employed. Additionally, employed individuals with serious mental illness had lower estimated medical costs than those not employed. These findings indicated that employed consumers sought and used fewer medical and mental health services and had lower associated costs than those

consumers who were not employed. Therefore, results indicated that offering IPS services for consumers with serious mental illness may be a good investment for entities wanting to manage medical and mental health services utilization and associated costs.

Although people with serious mental illness want to go to work and benefit from going to work, employment services have typically not been available through public mental health systems (Burke-Miller et al., 2006). One of the biggest obstacles facing continued IPS service provision is funding (Karakus et al., 2011). The cost of IPS implementation, while justified by long-term employment and healthcare savings, can also be a barrier, especially in underfunded mental health systems. Addressing these challenges requires robust interagency collaboration, strategic funding alignment, and commitment to maintaining fidelity to the IPS principles (Salkever, 2013). Despite these challenges, IPS continues to stand out as a critical evidence-based model, offering significant benefits that make it essential for supporting individuals with serious mental illness. One possible solution is long-term braided funding and aligning other sources of funding to support individuals currently participating in IPS; however, waiver funding for supports is not available in all states.

This examination focused on cost savings for Medicaid to encourage the utilization of braided funding, an arrangement in which multiple agencies share funding responsibilities so no one agency must shoulder the entire financial obligation. The employment of people with significant disabilities requires wrap-around supports and weaving together funds from multiple sources including Medicaid, VR, state mental health general funds, and other federal, state, and local programs (Luciano et al., 2014). We conducted this study to provide more evidence of the cost benefits of IPS; results may serve to justify additional funding to deliver IPS services to people with serious mental illness.

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Appendix. IPS Employment and Healthcare Survey

Client research number_____

Demographics (Answers to the following demographic questions are to be provided by the consumer at the time of the survey)

1. Gender?
 - Male
 - Female
 - Choose to not identify

2. Age?
 - Birth - 19
 - 20 – 34 years
 - 35 – 44 years
 - 45 – 64 years
 - 65 – older
 - Choose to not answer

3. Race?
 - American Indian or Alaska Native
 - Asian
 - Black or African American
 - Native Hawaiian or Other Pacific Islander
 - White
 - More than one race
 - Choose to not answer

4. Highest education level achieved?
 - No education
 - Less than high school
 - Certificate of Attendance
 - Certificate of Completion
 - Diploma - Occupational
 - Diploma – Vocational Tech
 - GED
 - Some college

- Associate degree
- Bachelor's Degree
- Master's Degree
- Doctorate

5. A. Primary Mental Health Diagnosis? _____

6. Secondary Medical/Physical Diagnosis? _____
(primary mental health and secondary medical/physical) (ICD 10 code number and name for MH diagnosis. Example: F25.9 Schizoaffective disorder, unspecified)

7. Medicaid?

- Yes
- No

8. Medicare?

- Yes
- No

9. Medicaid and Medicare?

- Yes
- No

10. SSI?

- Yes
- No

11. SSDI?

- Yes
- No

12. Private Insurance?

- Yes
- No

13. Residential status

- Independent
- Friends/Family
- Group Home
- Homeless
- Hospital

Consumer Questions

(Answers to the following questions are to be provided by the consumer at the time of the survey)

14. Have you received IPS Services?

- Yes – Within the past 12 months
- Yes – Within the past 5 years
- No

15. Are you currently working?

- Yes – For 29 days or less
- Yes – For 30 days or more
- No

16. How many hours a week are you currently working?

- 5 – 19
- 20 – 31
- 32 – 40
- Over 40
- 0 – Not currently working

17. In the past 12 months, have you received medical services related to your mental health?

- Yes
- No

18. If the answer to question 17 is “Yes”, where did you receive the services?

- Hospital ER
- Primary Care Physician
- Urgent Care
- Free Clinic
- Other (or do not know)
- Not applicable (Select this option only if the answer to question 17 is “No”)

19. If the answer to question 17 is “Yes”, did it result in admittance to a hospital for an overnight stay to receive additional mental health services?

- Yes
- No
- Don't know
- Not Applicable (Select this option only if the answer to question 17 is “No”)

20. In the last 12 months how would you rate your overall mental health?

Poor
 Fair
 Good
 Very Good
 Excellent

Practitioner’s Perspective

Questions for Case Manager (Answers to the following questions are to be provided by the case manager - post survey)

21. In the past 12 months how would you rate this consumer’s overall mental health?

Poor
 Fair
 Good
 Very Good
 Excellent

22. From your professional perspective, what is your level of confidence that this consumer can either maintain their current employment (if currently employed) or obtain gainful employment (if not currently employed)?

Extremely unconfident
 Somewhat unconfident
 Neither confident nor unconfident
 Somewhat confident
 Extremely confident

23. From your professional perspective, would this consumer benefit from either starting or continuing IPS services?

Strongly disagree
 Somewhat disagree
 Neither agree nor disagree
 Somewhat agree
 Strongly agree

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