Guidelines for Psychological Practice with Women with Serious Mental Illness

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Introduction

Serious mental illness (SMI) refers to major mental health disorders that lead to serious impairment in at least one area of functioning, including social, academic/occupational, and daily living activities (Kessler et al., 2003; Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). SMI typically includes bipolar disorder, schizophrenia spectrum disorders, severe depression, and posttraumatic stress disorder (PTSD). There are many challenges that individuals may undergo due to their experience of SMI, including the impact of stigma and marginalization. In fact, the experience of SMI may be as much about the experience of oppression through stigma and marginalization, as it is about symptoms of mental illness itself (Anthony, 1993). In particular, women who experience SMI are prone to experience other challenges such as trauma, homelessness, poverty, and single parenting (Jonikas et al., 2003; Mowbray et al., 2003). According to the National Association of Mental Illness (NAMI, 2017), recent prevalence data indicated higher rates of SMI for women (21.7%) than for men (14.5%). Additionally, the intersectionality of social minority identities for women with SMI can multiply their oppressive experiences through the combined effects of racism, sexism, ableism, classism, and mental illness stigma (APA Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization, 2019; Carr, Greene, & Ponce, 2015; Mizock & Carr, 2016).

The mental health field has historically struggled with its oppression of women. Theories of gender differences have often reinforced a gender bias, as evidenced by the attribution of SMI to biology and the labeling of women as “mad” for not conforming to

gender norms (Gove, 1980; Mizock & Carr, 2016; Ussher, 2011). Even in more modern times there is evidence of discriminatory practices towards women in the mental health field, ranging from clinical bias, misdiagnosis, and mistreatment, (Eriksen & Kress, 2008; Mueser et al., 1998; Seeman, 2000; Usher, 2011). The general principles of the APA Code of Ethics (2002), the basic foundational principles that offer guidance for how psychologists are encouraged to aspire to the highest ethical ideals in the profession, include Principle D: Justice and Principle E: Respect for people's Rights and Dignity. These principles embody the ideals that all individuals are entitled to benefit from psychology and that there should be equitable process for them, including fairness and justice in the delivery of psychological services. Furthermore, psychologists shall respect the rights of people for self-determination and that there may need to be safeguards in place for the welfare of people that may be vulnerable, such as those who experience psychiatric disability. The APA Guidelines for Psychological Practice with Women and Girls have called attention to gendered oppression and the impact of such on mental health challenges in general (APA, 2018). This has been an important stride towards improved psychological practice with women and girls. However, guidelines for psychological practice are needed to address the specific, unique needs of women with SMI in particular, as there is a significant overarching guide for women with these concerns.

Purpose

The purpose of the *Guidelines for Psychological Practice with Women with Serious Mental Illness* is to aid psychologists in understanding aspirational tenets in providing clinical services to women with SMI. As seen in the literature (Jonikas et al.,

2003; Mowbray et al., 2003), women with SMI are likely to experience unique challenges and experiences, which has the capacity to inform the best methods of engagement in clinical practice. These practice guidelines can best direct professional behaviors and decisions of psychologists who work with women with SMI, as suggested by the criteria for practice guidelines set by the American Psychological Association (APA, 2015), and also provide a culturally responsive, trauma-informed approach to clinical engagement with a focus on offering both equity of access and equity of outcomes. Moreover, these guidelines strive to be informed by recovery-oriented care models. Recovery refers to not solely symptom elimination alone, but living a life of satisfaction, meaning, and self-determination in the face of a major mental health problem (SAMSHA, 2012).

Recovery

The term "recovery" is a shift away from traditional uses of the word, such as the absence of symptoms or substance use, but focuses on hope, self-determination, empowerment, and person-centered care (SAMSHA, 2012). The recovery-oriented care movement originates with the consumer movement in the 1960s and 1970s in which individuals in hospitals fought for their rights and the capacity to live autonomously in the community and to have a life that was more than just being a patient (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009). The experience of those with mental illness, then, was as much about the sociopolitical experience of stigma, marginalization, and discrimination as it was about mental illness. We strive to use the term "recovery" to refer to this lifelong process and healing, which recognizes the additive experiences of illness or trauma but we want to note the fact that these are different in some way due to such a life-changing event. Some individuals living with SMI also indicate that, after and

within a process of recovery and healing, they feel as if they have evolved into an even better form of themselves or positively altering their identity, though recovery does not negate or erase the experiences they have had in their life.

Documentation of Need

There are many factors that reflect a need for the development of practice guidelines for women with SMI. The Committee on Professional Practice and Standards (COPPS) has specifically noted three categories that suggest a need for practice guidelines: (1) legal and regulatory issues, (2) public benefit, and (3) professional guidance (APA, 2015). We will address these categories and rationale for the development of the *Guidelines for Psychological Practice with Women with Serious Mental Illness*. We will move on to this next, in detail, and review it in relation to the legal and regulatory issues, ways in which these guidelines can benefit the public, and offer professional guidance.

As this relates to legal and regulatory issues, there are no distinct and clear guidelines on the impact of specific practices that are part of the provision of mental health services, such as use of voluntary and involuntary medications, seclusion and restraint, and the resulting impact on women with serious mental illness. It is vital that there is some guidance due to the supporting literature indicating disparate and unique experiences of women. As for public benefit, these guidelines offer support for enhancing the treatment and efficacy of working with women with serious mental illness, who are particularly prone to the intersectionality of oppressive experiences and who are at disparate risk for marginalization and stigma. With the development of these guidelines the recovery process of women with serious mental illness can be advanced and the field

can also gain traction, with the literature that continues to grow. It is of note that as psychologists begin to use these guidelines, or as future revisions of the guidelines are developed, there may be additional reasons that document the critical need to inform clinical practice with women with SMI.

Legal and Regulatory Issues

APA indicates that where the legal and regulatory bodies are silent on assisting psychologists in recommended practices and there is a realized need due to the silence of these bodies, the development of guidelines may be enacted (APA, 2015). The notable gaps in the law and regulation of seclusion and restraints and its impact on those who experience such measures in the mental health system call for organizations and bodies, such as the APA, to help guide psychological practice. It is also important that though guidelines can help where there is silence by legal and regulatory bodies, the guidelines themselves do not supersede federal and state laws (APA, 2015).

Seclusion and restraints are still allowed in the United States in the delivery of psychiatric care despite the moral movement in the 1800s, which advocated for the elimination of this practice (American Psychiatric Nursing Association Position on the Use of Seclusion and Restraint, 2014). Many interested parties (National Association of Mental Illness [NAMI], National Association of State Mental Health Program Directors [NASMHPD], Substance Abuse and Mental Health Services Administration [SAMSHA]) have advocated for the elimination or reduction of the use of seclusion and restraint due to the traumatizing and potentially lethal impact they can have on those who experience its parameters, including both clients and staff (Boner, Lowe, Rawcliffe, & Wellman, 2002; Curie, 2005; Frueh et al., 2005; Glover, 2005; Mental Health America, 2015;

NAMI, 2001; Sailas & Fenton, 2001). In fact, SAMHSA has called for the federal government to develop a unified policy on the use of seclusion and restraint for those with mental illness (Curie, 2005). NAMI has developed guidelines for the protection of the rights of those with mental illness that include the right to protection from harm, least restrictive environments, and never subjecting individuals to seclusion and/or restraint unless it is absolutely necessary to prevent imminent or immediate harm from occurring to the individual or someone else (NAMI, 2001). Relatedly, the director of the NASMHPD has made it a priority to reduce seclusion and restraint in state mental health facilities and advocated for the ultimate elimination of such practices (Glover, 2005). Since the NASMHPD has made this a focus in many state facilities there has been a 16% reduction in the use of restraint and a 45% reduction in the use of seclusion in those targeted facilities (Glover, 2005; Mental Health America, 2015).

Though these nationally recognized efforts exist, there are no overriding federal mental health policies or laws that have banned the use of restraint and seclusion. The laws and/or policies that do dictate use of seclusion and restraint are silent on offering psychological practice that is trauma-informed and recovery-oriented, which may decrease the use of such traumatizing practices. However, SAMHSA, recently led a charge for reforming mental health care by integrating trauma-informed and recovery-oriented care in service delivery in order to reduce such punitive measures (SAMHSA, 2010). Therefore, given the high likelihood for retraumatization of women with SMI in our systems of care from such methods as seclusion and restraint, and the already incredibly high rates of trauma for women with SMI (Frueh et al., 2005; Goodman et al., 2001; Sailas & Fenton, 2001), psychological practice guidelines can alert psychologists

to these dynamics and subsequently attempt to decrease likelihood of retraumatization. Relatedly, the American Psychological Association greatly values human rights, as evidenced by its code of ethics (APA, 2002) which indicates that the discipline of psychology, and the academic, clinical, and other professional activities can and are encouraged to serve as a mechanism for securing and advocating for human rights. Such an approach is imperative when working with women with SMI as this is consistent with the values and virtues of the APA ethics code to do no harm and protect the human rights and dignity of all people (APA, 2015). APA's strategic plan (APA, 2018), also embraces centrally the goal of human rights for all and its innovative strategic plan is currently the guide for its goals, objectives, and action items as a whole organization and field, delivering global impact. Similarly, the World Health Organization (2017) has a strong focus on human rights and a mission to underscore the importance of understanding the disparate experiences of women with mental illness across the globe, as the medical field and different countries embark upon mechanisms to reduce these inequities.

Public Benefit

As with other guidelines, these professional practice guidelines for women with SMI also benefit the public in various ways (APA, 2015). It is believed that these guidelines can improve service delivery by targeting a diverse population that experiences unique challenges and the intersectionality of oppressive experiences (Carr et al., 2015; Mowbray et al., 2003). Understanding these nuances and the implications of such experiences of women and thus how to provide psychological practice with women with SMI can only aid in the ability of psychologists to provide an effective and culturally responsive experience in our mental health systems. Without guidelines that

call attention to the unique experiences of women with SMI, this group may be overlooked in the conceptualization of how service delivery is provided and thus the impact on this group that has particular concerns may go unaddressed.

APA's report on the need for development of guidelines (APA, 2015) suggests that guidelines are needed when there is evidence that discrimination or bias can occur in the inappropriate treatment process of a group of individuals. As a result, practice guidelines can shed light on appropriate practice methods that would help avoid harm. Relatedly, the literature indicates that women frequently encounter discrimination and bias from mental health professionals, including in the overdiagnosis of specific disorders that are more stigmatizing, while often ignoring the role of trauma on symptom development (Archer, Lau, & Sethi, 2016; Eriksen & Kress, 2008; Mueser et al., 1998; Seeman, 2000; Usher, 2011). The guidelines for psychological practice with women with SMI call attention to a unique group of women, as their needs and unique concerns warrant further attention and understanding for appropriate engagement in the mental health field due to particularly disparate risk for marginalization and oppression.

These practice guidelines also serve the invaluable task of meeting the needs of an underserved and incredibly vulnerable population. As the literature indicates, women with SMI have to navigate the experience of gender oppression, which plays a role in the development and experience of SMI for women (Mizock & Carr, 2016). Additionally, women with SMI are more prone to trauma, homelessness, poverty, and stressors of single parenthood (Jonikas et al., 2003; Mowbray et al., 2003), not to mention the deleterious effects of the intersectionality of multiple oppressive experiences (Carr et al., 2015; Mizock & Carr, 2016). Conceptualization of all of these dynamics is crucial in

being able to offer psychological practice to women with SMI that is culturally responsive, ethical, trauma-informed, and recovery-oriented.

Professional Guidance

APA suggests that guidelines can also be developed to aid in new and diverse roles that psychologists fill in clinical practice or due to advances in theory and science (APA, 2015). The literature indicates that psychologists work in many diverse settings requiring organizational skills, as well as with individuals in public sector settings that treat people with complex concerns such as SMI (APA, 2009; Kohut, Li, & Wicherski, 2007). Though psychologists are serving in the public sector, working with this specialty population, and serving in roles requisite of organizational skills, there is limited literature and training experiences on leadership, clinical skill development, or organizational development (APA, 2009; Reddy, Spaulding, Jansen, Menditto, & Pickett, 2010). Moreover, many psychologists have not received specialized training in working with individuals with SMI, or women with SMI. Some groups are working on expanding the repertoire of training and specialization in the area of working with individuals with SMI such as Division 18 of APA, Psychologists in Public Service – Section on Serious Mental Illness/Severe Emotional Disturbance and the APA Task Force on Serious Mental Illness (APA, 2009; APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance, 2007). Yet, there is a need for more guidance on the psychological practice with women with SMI.

There have been some advancements at APA in the psychological practice with individuals with SMI, including such documents as the *Proficiency in Psychology – Assessment and Treatment of Serious Mental Illness* (APA, 2009), the *Catalog of Clinical*

Training Opportunities: Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness (APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance, 2007), and the *Recovery to Practice Curriculum* (American Psychological Association & Jansen, 2014). The new budding literature provides some evidence of the unique experiences of women with SMI and considerations for practice, but the development of these specific guidelines seeks to integrate the new literature and share that in a mechanism that can best inform psychological practice with women with SMI.

There has not been a specific, up-to-date, document that has addressed the unique needs of women and the role of sociocultural contexts in a manner that highlights the higher prevalence of SMI among women than their male counterparts, (NIMH, 2017). A greater focus on the cultural context of the experiences of women and the impact of trauma is needed to update the knowledge of providers as they work with women with SMI. These guidelines are especially important and critical given that women have disparate experiences and face intersecting oppressions from multiple levels when they also have an SMI, providing the impetus for the development of this document.

The scope of these guidelines includes some of the more disparate challenges that women with SMI face and the related challenges and intersectionality of experiences, as well as ways in which psychologists can be aware of these to better inform their modality of professional activities. Some issues beyond the scope of these guidelines, to name a few, include the unique challenges of men with SMI, the intersectionality of serious medical challenges, and biological and psychopharmacological considerations.

Audience

The intended audience for the *Guidelines for Psychological Practice with Women with Serious Mental Illness* includes psychologists, students, trainees, and experts that provide clinical care, engage in training and/or education, fill leadership positions in mental health organizations, and conduct research. There are many professional settings in which psychologists may work that are highly relevant including, but not limited to community mental health, the Veterans Health Administration, state psychiatric hospitals, private psychiatric hospitals, academic medical schools, graduate schools, counseling centers, and even in private practice. Given that 11% of women experience an SMI and SMI is higher among women than men, these guidelines have the potential to reach a considerable number of people in the general population that can benefit from such an addition to the field (National Institute of Mental Health, 2017; Substance Abuse and Mental Health Services Administration, 2003). Furthermore, an APA employment survey of 22,502 psychologists found 30% of psychologists practice in health care settings such as VA medical centers, community mental health centers, and general hospitals, which are settings where individuals with SMI engage in healthcare services (APA, 2009; Kohut, et al., 2007). Since there are so many psychologists in these settings it is important to be aware that psychologists are part of multi-disciplinary consultation and interprofessional collaborative teams, with the propensity to impact care within and across systems. Ultimately, this unique population is served in many settings, by psychologists and trainees with diverse career trajectories and, thus, there is substantial need for these guidelines.

Guidelines and Standards

It is important to clarify that guidelines are different than standards. In accordance with APA policy, guidelines are suggestions or recommended professional behavior and/or conduct for psychologists, whereas, standards are mandatory and can be enforced (APA, 2015). In essence, guidelines are not mandatory or exhaustive. Hence, these guidelines are written so that psychologists can strive to work towards aspirational goals of practice and are not meant to be mandatory, with the understanding that they may not pertain to all psychologists, dependent on their area of expertise and scope of practice. Guidelines are also developed to foster current advances in psychological practice. Similarly, guidelines do not take precedence over the professional judgments of psychologists founded on the knowledge base and scientific literature of the psychological field (APA, 2015).

Trajectory of Guideline Development

These guidelines developed as a product of the development of a Task Force on Women with Serious Mental Illness, which was developed in Division 35, the Society for the Psychology of Women of the American Psychological Association. The Task Force on Women with Serious Mental Illness was proposed in 2013 to the executive committee of Division 35 and accepted for development. Later, the Task Force became a committee and the guidelines originated as an action item from this working group. (For further history on the development of this task force then committee and the ensuing development of guidelines, see Appendix B.) As a result, this document contains 13 guidelines for psychological practice with women with SMI. Each guideline includes a rationale section and application of the literature to psychological practice. It is noted that these guidelines apply to women from diverse sexual, gender, and other minority

identities, and can be integrated alongside other guidelines such as the APA Guidelines for Psychological Practice with: Transgender and Gender Nonconforming People; Girls and Women; Lesbian, Gay & Bisexual Clients and the Multicultural Guidelines. There was no financial support for the development of these guidelines and no conflicts of interest. The authors of the guidelines extensively reviewed the background literature relevant to each guideline and included major findings that were relevant to each topic. Supporting literature for each guideline was further evaluated and augmented in the integration of suggested revisions from content experts. These experts specialized in APA guideline development and psychological practice with women and people with SMI.

Guideline expiration. The expiration date of these guidelines is scheduled for 10 years from their release, from the date by which they are approved by the Council of Representatives of APA. Therefore, these guidelines are to be reviewed and updated to reflect new literature and the development of the field.

Practice Guidelines

Guideline 1: Psychologists strive to provide recovery-oriented care to women with serious mental illness that acknowledges their right to self-determination.

Rationale. Gender is "a critical determinant of mental health and mental illness" (World Health Organization [WHO], 2017), influencing the differential power and control that women have in their lives. For example, the higher prevalence of sexual violence to which women are exposed and the subsequent trauma-related sequelae makes it imperative to address trauma in psychological care. In terms of professional biases, medical providers are more likely to diagnose depression in women compared to men (Nolen-Hoeksema, 2011), even when controlling for self-reported and presentation of

symptoms. According to a recent national survey, 23.8% of women compared to 15.6% of men have a mental illness (SAMHSA, 2009). Risk factors such as socioeconomic status, social position, and trauma exposure may lead to repeated experiences of disempowerment, domineering relationships, and differential health care in women with SMI.

Recovery began as a social justice movement in the 1960s and 1970s, led by consumers with SMI (Davidson et al., 2009). Across many eras and cultures, the prevailing professional model of responding to SMI has been the medical model, a patriarchal, pathologizing, and institutionalizing approach to working with individuals with SMI. More recently, recovery has begun to penetrate the field of psychology. As a result, SAMHSA has come up with an official definition of recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (2012). The four major dimensions that support a life in recovery are health (physical and emotional), home, purpose, and community. Moreover, recovery-oriented services are also guided by principles such as being respectful, being culturally responsive, addressing trauma, and involving strengths and responsibility of individual, family, and community.

Application. Providers are encouraged to provide recovery-oriented care to women with SMI. Again, the ten principles of recovery, as developed by SAMHSA, are useful tenets to use and guide the implementation of recovery-oriented care with women with SMI (SAMHSA, 2012). Those tenets of service delivery include, but are not limited to the following: providing hope, offering person-driven mental health services, holding respect for the individual, recognizing and amplifying strengths/responsibility, addressing

trauma, understanding and integrating the role of culture, providing a relational approach, offering peer support and holistic treatment, and understanding that recovery/healing occurs through many pathways. These goals for recovery-oriented care are guides for how psychologists can help provide services in a way that seeks to incorporate these tenets and abide by them as they seek to engage in the recovery process of the individual.

Practice applications. Analogously, from a recovery-oriented care perspective, person-first and non-stigmatizing language is encouraged (Titchkosky, 2001). One aspect of care which may require alteration is the traditional treatment plan. This is being replaced by the individualized recovery plan across major behavioral health care systems (Tondora, Miller, Slade, & Davidson, 2014). Individualized recovery plans are similar to person-centered care plans, which are becoming standard practice in health care across the globe (Tondora, Miller, Slade, & Davidson, 2014; Ekman, et al., 2011). Not only are individualized recovery plans strengths-based, personalized, and culturally-relevant, but they also continue to meet rigorous clinical documentation requirements by incorporating mental health and/or substance use issues that need to be addressed in recovery. Traits of recovery planning such as delineating the respective responsibilities of the consumer, provider, and her support network, focusing on the individual's personal goals and interests, and anticipating and preparing for a non-linear path of recovery, would communicate hope and strategies for a woman with SMI to overcome negative experiences of her illness, social position, and personal life history. The plan would also focus on the strengths and resilience of the individual as they seek community reintegration, recognizing this may occur via diverse pathways as each person seeks their own goals.

Systems application. Another aspect for psychologists to attend to is the context and environment in which women with SMI receive health care, and the gaps that may cause care to be rendered in an oppressive fashion. For example, inpatient psychiatry settings, which this population may present to, historically abide by the medical model, which may be characterized by: a problem focus, symptom reduction, medication compliance, and behavioral control (Slade, 2009). Health care provided within this framework is often incongruous to a recovery orientation, which, in contrast, promotes a holistic appraisal of the individual, believes in multiple mechanisms for a positive outcome, addresses trauma, and collaborates with the individual, family, and community (Davidson et al., 2009). Recovery also does not stop with symptom reduction but is a non-linear journey. Psychologists are encouraged to be aware of the role that they may play in facilitating feelings of personal safety with individuals (e.g., the orientation of office furniture and seating arrangement of parties). Furthermore, psychologists strive to recognize that they may bring to light the potentially harmful practices and policies that may undermine recovery. Examples of these include, but are not limited to: use of medications to control behavior, the side effects of medications, room sharing, use of seclusion and restraint, and the under-identification of traumatic stress, dual diagnoses, and co-morbid health problems (Frueh et al., 2005; Mueser et al., 1998; Davidson et al., 2009). Psychologists strive to identify and advocate alternative practices that promote recovery, such as respectful, collaborative provider-consumer communication, positive behavior supports (Hamlett, Carr, & Hillbrand, 2016), and adequate identification and intervention on relevant medical and mental health issues (Davidson et al., 2009).

Training applications. Recovery-oriented care may be incorporated into training and implementation of interventions such as brief education on trauma and self-management skill-building, while also recognizing the potential limitations of inpatient psychiatry (e.g., treatment duration, crisis stabilization). Additionally, all staff could be trained in trauma-informed care practices, from the support staff to clinical staff, as well as senior administration. It is important to understand the literature on the use of inpatient hospitalization and the efficacy for its use, while remaining aware of the costs and risks of longer-term hospitalization such as the risk of retraumatization and institutionalization (Frueh et al., 2005).

Cultural applications. Across various care settings, psychologists are encouraged to take care to infuse cultural responsiveness and self-determination into their work with women with SMI. A culturally responsive approach may often be overlooked in the service of women with SMI, despite the reality that it can be particularly valuable and beneficial (APA, 2017). A culturally responsive approach aims to not only be sensitive or aware but also be responsive to the element of culture and unique experience of the client. Literature on culturally responsive therapeutic relationships makes suggestions including, but not limited to, being culturally-informed but the provision of person-specific assessment of the presenting issue, exploring a person's perspective on seeking treatment and of the therapeutic relationship, and using technique-specific cultural modifications as appropriate (Asnaani & Hofmann, 2012).

Understanding the unique needs of women with SMI and providing an empowerment approach could potentially allow women to tap into their strengths and capabilities as they embark on their recovery journey. An empowerment orientation

allows individuals, families, and communities to gain influence over sociopolitical factors that affect their health and well-being (Worrell & Remer, 2003). This approach focuses on the strengths and resilience of the individual in their capacity and ability to deal with past, current, and future stress and trauma.

Community and advocacy applications. Psychologists are also encouraged to be advocates for approaches in mental health service delivery that strive to offer social justice-informed interventions and services, such as access to adequate and evidence-based mental health care, housing, employment opportunities, and financial resources (Carr, Bhagwat, Miller, & Ponce, 2014). Similarly, psychologists are urged to recognize the potential need for care coordination and the importance of being familiar with other social services and natural supports, which seek to support women with SMI in their recovery journey. Relatedly, psychologists are encouraged to consider the use of technology-based interventions and the use of smartphones, text messaging, mobile apps, social media, and digital therapies to help women with SMI engage in the services that would be supportive of their recovery (Naslund, Aschbrenner, & Bartels, 2016).

Furthermore, psychologists are reminded to be aware of the complex process, slow timeline, and costs of inciting and advocating for systems change. Psychologists are encouraged to practice their own self-care, support network, and burnout potential, as it applies to being a change agent or a minority opinion in a multidisciplinary setting that may be characterized by limited resources, overburdened providers, and rigid public laws or policies.

Research applications. Psychologists that engage in research related to the experiences of those with SMI are encouraged to unearth more of an understanding of the

unique and intersecting experiences of women with SMI. They are also encouraged to do so from a culturally-informed and feminist approach, which takes in to account the multi-layered and intersecting oppressive experiences of women with SMI that contribute to a more complex and sociopolitical experience of their mental illness. Relatedly, researchers are encouraged to take caution to use assessment tools and instruments, which are applicable to women, including diverse women, so that their experiences may be best understood and highlighted from an ethically judicious framework.

Guideline 2: Psychologists strive to be aware of gender norms, expectations, bias and discrimination and how these factors impact women's mental health and sense of self-worth.

Rationale. Sexism impacts differences in the rates, development, and recovery from mental illness among women (Gove, 1980). Sexism and gender-based discrimination include imbalances in power and mistreatment related to gender, which occur in the form of stereotypes, attitudes, values, as well as interpersonal and institutional discrimination (Logie et al., 2011). As a result of sexism, women are held to gender ideals and expectations in the dominant culture to be subservient, dependent, noncompetitive, emotional, sensitive, thin, traditionally attractive, and focused on their appearance (Broverman et al., 1970; Erchull, 2015; Eriksen & Kress, 1970). When women do not conform to these gender expectations, they may be judged harshly by peers, family members, partners, providers, and others in their social network, adding to mental distress (Angermeyer, Matschinger, & Holszinger, 1998; Chrisler, 2012). From an early age, girls are socialized to direct their mental distress inward, resulting in a higher

expression of internalizing disorders such as depression, anxiety, and eating disorders (APA, 2018).

Women face daily experiences with sexism in a number of ways that add mental distress and worsen their mental health. These experiences with sexism tend to include stereotypic gender role expectations, rigid beauty ideals, disproportionate domestic labor responsibilities, barriers to attainment in education and employment, inequality in wages, higher rates of poverty, workplace stress due to sexism, imbalances in power in the family, as well as associated vulnerability to violence and sexual maltreatment (Buchanan & Fitzgerald, 2008; Carmen et al., 1981; Erchull, 2015; Eriksen & Kress, 2008; Sanderson & Thompson, 2002; Yoder, 2007). It has even been argued that the frequent experiences with sexism constitute a traumatic stress that increases the risk of poor workplace outcomes, psychological challenges, and the development of mental illness (Brown, 2000; Buchanan & Fitzgerald, 2008; Saunders, Scaturro, Guarino, & Kelly, 2017).

Application. It is important that psychologists are mindful of the impact of sexism, as well as other forms of oppression, on the experiences of women with SMI. Psychologists strive to raise women's awareness of the impact of the sociocultural context on the lives and mental health of these women. Increasing women's awareness of oppressive gender-role messages and of institutionalized sexism empowers them by reducing self-blame and increasing awareness of stigma. Psychologists strive to conduct gender-sensitive assessments that investigate the impact of sexism, rigid gender roles, and traditional gender socialization on women's mental health (Archer, Lau, & Sethi, 2015; Brown, 1990). Psychologists may help women target the sources of sexist

mistreatment through the involvement of family members in their mental health services (Eriksen & Kress, 2008), membership in women's empowerment groups, or connections to other resources in their community. Psychologists strive to support women with SMI to connect to these social supports and resources in order to bolster access to services, educational attainment, financial empowerment, and safety in order to reduce distress posed by inequities and sexism on their lives.

Guideline 3: Psychologists are encouraged to consider the intersectionality of identities among women with serious mental illness including, but not limited to, gender, race, ethnicity, class, sexuality, ability, and other identities in how they uniquely impact their experiences with serious mental illness.

Rationale. Intersectionality is important to culturally responsive psychotherapy and a vital issue for psychologists in promoting social change (Brown, 2009; Shields, 2008). Intersectionality theory may capture more accurately the intersecting experiences of marginalization and privilege across different social identities among women with SMI. Intersectionality (Crenshaw, 1993) is a theory that may enhance understanding how various social identities among women with SMI contributes to compounded levels of stigma, oppression, and privilege. Intersectionality demonstrates how constructs like race and class are not separate processes but intersecting social hierarchies that determine access to power (Collins, 2000) and may impact mental health (Lewis, Williams, Peppers, & Gadson, 2017). For example, instead of just focusing on issues of race for an Asian American woman with an SMI, we would take into account her identity as an Asian American, lesbian, upper class woman with an SMI.

Similarly, intersectional stigma refers to the overlapping, multiple levels of stigma and discrimination faced by women with SMI from diverse backgrounds with regard to race, ethnicity, immigration, disability, sexual orientation, and other social identities (Logie, James, Tharao, & Loutfy, 2011). Women with SMI may be confronted not only with the stigma of mental illness, but also sexism, racism, classism, ableism, or homophobia. These multiple aspects of stigma may pose added barriers and stressors to the lives of these women with SMI.

Application. Psychologists take into account the impact of double stigma or intersectionality of mental illness stigma and sexism or another area of oppression on women's sense of self, relationships, access to basic needs, community integration, and mental health experience. Psychologists are encouraged to facilitate treatment options that strive to reduce internalized stigma and help women realize that their experience is fraught with a sociopolitical context, rather than seen singularly through a pathological lens, where the problem is thought to only reside within the person (Worrell & Remer, 2003). Psychologists seek to inquire about the impact of intersectional oppression on women with SMI, and learn of any mistreatment in mental health services or otherwise that might add to multiple levels of stigma and affect the therapeutic alliance. Psychologists strive to explore community resources and opportunities that might enhance awareness of these aspects of intersectional oppression in the lives of these women, and provide resources for overcoming the effects of multiple experiences with stigma. For example, psychologists aspire to support women with mental illness in gaining agency and helping others by becoming advocates to their peers. Psychologists

may be agents of social change in raising awareness of the impact of oppression on the lives of women with mental illness.

There are subgroups of women with SMI, i.e., special populations, to consider using an intersectional lens. For example, there are women with SMI who interface with the criminal justice system, and have unique concerns in psychological practice. Women with SMI in the criminal justice system tend to report higher rates of trauma, more extensive histories in the criminal justice system, and higher risks of problems with substance use, assault, running away, as well as crimes related to drug dealing and property offenses (Lynch, DeHart, Belknap, & Green, 2012). Other special populations include immigrant and refugee women with SMI, who may develop the onset or worsened symptoms of SMI, as a result of trauma and stress in the migration process (Donnelly, Hwang, Este, Ewashen, Adair, & Clinton, 2011). Hence, we must take into account the unique needs of other special populations of women with SMI and inquire and understand the impact of these intersecting identities on their mental health needs.

Guideline 4: Psychologists are mindful of the history of professional bias and stigma that has been directed towards women with serious mental illness and reduced their social power.

Rationale. Historically there has been a challenging history in the psychiatric field with evidence of professional bias and stigma towards women (Archer, Lau, & Sethi, 2015; Eriksen & Kress, 2008; Reich, Nduaguba, & Yates, 1988; Seeman, 2000), and particularly women with SMI. Such experiences have marginalized women and disempowered them, reducing their social power and denying their right for respect, autonomy, and self-determination. This has been demonstrated in many ways though

some of the most apparent are in terms of disparities in the diagnosis and treatment of mental disorders (Eriksen & Kress, 2008; Reich, Nduaguba, & Yates, 1988; Seeman, 2000). Among medical providers, women are more likely to be diagnosed with many mental disorders than men, even when self-report and presentation of symptoms are controlled for in studies. Interestingly, female gender is also a significant predictor of being prescribed a psychotropic medication for mood (WHO, 2017).

Professional biases propagated during undergraduate training, graduate training, and clinical training may include assumptions, from a medical model, that psychologists are better suited to working with clients without serious mental illnesses, because of the nature of psychotherapy (Furnham & Bower, 1992). In addition, there are some biases that individuals with serious mental illness may not benefit from psychotherapy. This seems to reveal a stigma against SMI, despite the independence between having a SMI and having the insight, motivation, and/or skills to benefit from psychosocial interventions. Ironically, direct care psychologists are scarcely represented in public sector health systems, where individuals with SMI are most likely to receive services (Mueser, Silverstein, & Farkas, 2013).

Application. Psychologists are encouraged to be aware of the historical bases of bias towards women in the field of psychiatry and engage in their own process of intrapersonal examination of any such conscious and unconscious biases they experience, which may impact diagnosis, treatment, or ideas regarding capacity for recovery. As psychologists engage in this reflection process, they are also encouraged to seek out consultation or peer supervision with other psychologists to empower their own capacity to work with women with SMI from a culturally responsive and mindful model.

Psychologists are also urged to consider infusing their approach to working with women with SMI with a feminist theoretical orientation. On the other hand, some psychologists may work in settings whose practices and culture may run counter to a feminist approach of empowering clients with self-determination and attempting to disrupt the assumption that the client is "less than" the clinician. In such cases, psychologists are encouraged to play an active role in transforming mental health care and find mechanisms to bring recovery-oriented values to organizations that have hierarchical models. This may be achieved by using literature to support such shifts in care and by emphasizing the value of such approaches, which are more respectful and person-centered, as well as by highlighting the potential for better outcomes (Davidson et al., 2009). Along these lines, the training of psychologists could be revised to include more empirical and inclusive representations of SMI in coursework and clinical work, which may impact the level of stigma among providers. Training programs are also encouraged to put more emphasis in their overall training on clinical work with those with SMI, as well as the unique needs of women with SMI, which could increase the representation of psychologists in the public sector, where many with SMI are receiving services. Lastly, training programs are encouraged to evaluate their programs for discriminatory biases based on gender and SMI, as there are some programs that do not integrate psychotherapy into the treatment model, and may not provide adequate training and education in these specialty areas, causing more bias in the field.

Guideline 5: Psychologists endeavor to exercise diagnostic caution given that historically women have been disproportionately assigned diagnoses that incur greater stigma or pathologize gendered approaches to coping.

Rationale. There are known gender differences in the occurrence of mental disorders, including women's increased rates of depressive, anxiety, and eating disorders (Nolen-Hoeksema, 2001). Gender differences have also been found in diagnostic practices, with women often being negatively judged by mental health providers when not conforming to gender stereotypes (Eriksen & Kress, 2008). There is a profound history of labeling women as "mad" when not in compliance with gender stereotypic behavior (Ussher, 2001). Research on contemporary mental health practice has continued to find gender bias among diagnosticians, including overdiagnosis of affective and personality disorders and underdiagnosis of substance use problems (Eriksen & Kress, 2008; Seeman, 2000).

Women with SMI also are at greater risk of certain traumatic events, such as sexual abuse (Mueser et al.,1998), however, this is rarely diagnosed as PTSD or treated within psychiatric settings (Mueser et al., 2002). Furthermore, when such experiences of trauma present among women with borderline personality disorder (literature indicates as many as 86% of women with borderline personality disorder have experiences of childhood sexual trauma; Bryer et al., 1987), the trauma frequently goes untreated due to concerns for behaviors (Harned, 2013). Instead they may be met with disdain and resistance by providers as the clients' interpersonal styles may understandably be untrusting and complex, given their constellation of traumatic experiences. Ironically, this may set up a vicious cycle within mental health systems that resemble experiences of victim blame. This cycle may also impair and negatively bias the treatment that is provided in systems of care.

Clinicians tend to assign characterological diagnoses that stigmatize women's gender socialization of emotional expression, as well as the consequences of their elevated rates of trauma. This includes the overdiagnosis of histrionic, borderline, and dependent personality disorders among women (Eriksen & Kress, 2008; Reich, Nduaguba, & Yates, 1988). Such experiences are also frequently quite stigmatizing and may be an indication to providers that this person is seen as "untreatable" (Eriksen & Kress, 2008; Reich, Nduaguba, & Yates, 1988).

Even the term, *serious mental illness* raises challenges for many psychologists who are concerned with medical model language that might locate the pathology within the woman rather than the dominant culture in which she encounters gender bias that contributes to her mental distress. This quandary poses a *diagnostic dialectical tension* (Mizock & Kaschak, 2015), where psychologists must balance avoidance of stigma with the power of naming a mental health problem to enable awareness, communication, and quality and appropriate treatment.

Application. Psychologists may experience tension in assigning pathological diagnoses to women with mental illness due to diagnostic stigma and the history of labeling women as mad (Ussher, 2011). Psychologists strive to work with clients in a collaborative manner to find names for the problem in order to reduce power differentials in diagnosis and enhance empowerment in the diagnostic process. Relatedly, they may offer an egalitarian approach to psychotherapy so as to increase self-efficacy, enhance and embolden capabilities, and reduce oppressive experiences in mental health systems. Psychologists are urged to perform gender-sensitive diagnostic evaluations that maintain awareness of the history of gender bias in this area and other forms of bias. Psychologists

are encouraged to take into account the experiences of sexism on the development of a mental health disorder in their assessments to reduce gender bias in diagnostic practice, including incorporation of assessment of trauma, as trauma is strongly associated with SMI (Moradi & Huang, 2008; Mueser et al., 1998). It is important to note that it is valuable to be person-centered in each of these encounters and to use sound professional judgment in realizing these applications.

Guideline 6: Psychologists endeavor to employ trauma-informed practice and assessment of past or ongoing trauma in the lives of women with serious mental illness given their vulnerability to abuse.

Rationale. Women with SMI have a high likelihood of a history of trauma, with some statistics estimating that as many as 51-97% have a physical and/or sexual assault history (Goodman et al., 2001). Women in general experience high rates of physical and sexual violence and abuse (Chandy, Blum, & Resnick, 1996). Women who have encountered trauma are also at increased risk of developing a mental health problem (Herman, 1997; Jennings, 2009). Moreover, individuals with SMI have an elevated prevalence of trauma in general. According to a study by Mueser and colleagues (1998), 98% of individuals with SMI reported exposure to at least one traumatic event, and 43% met criteria for PTSD as result of trauma. In addition, the first episode of psychosis may be traumatic in nature in itself, and has been found to rise to the threshold of diagnosable PTSD (Mueser & Rosenberg, 2003).

Traumatized women as well as women with a SMI are vulnerable to retraumatization (Goodman et al., 2001; Herman, 1997). Retraumatization frequently occurs in care settings in which a new incident stirs up the original trauma (Jennings,

2009). These multiple exposures increase the duration, frequency, and intensity of distress reactions (Duckworth & Follette, 2012). The triggering incident might resemble the original trauma in terms of content or interpersonal dynamics (Jennings, 2009). The psychologist and woman might be unaware of the retraumatization response as it occurs, and potentially aggravate the symptoms or retraumatize the woman again.

Retraumatization may also occur on an inpatient unit or other residential treatment facility, referred to as sanctuary trauma (Mueser et al., 1998). People with SMI are likely to be hospitalized and vulnerable to violence, abuse, coercion, and force in these settings. One study found that among participants with SMI, 8% had been sexually assaulted in a treatment facility, 31% had been physically assaulted, and 63% had witnessed a trauma (Frueh et al, 2005). Sanctuary trauma is so common that it has been proposed that healing from its effects is central to the recovery process (Anthony, 1993).

Application. Women with SMI are at risk of trauma, both as individuals with SMI and as women. These women are uniquely vulnerable to sanctuary trauma as well, and may have histories of multiple traumas in mental health settings that may serve as barriers to care. Psychologists are encouraged to ensure their competence in treatment and communicate their experience to their clients to instill a sense of safety. Also, psychologists are reminded to use professional judgment as they navigate the complexity of addressing the results of trauma and the way it manifests. Psychologists are urged to be aware of the factors that mask symptoms of trauma or block access to help. Psychologists are encouraged to be aware of culturally responsive assessments for trauma experiences, which may be utilized. An empowerment-oriented approach to clinical work with women with SMI may enhance effective treatment and reduce retraumatization in mental health

care. The excessive use of force and restraints in mental health settings may traumatize and retraumatize women with SMI. Psychologists are encouraged to implement policies in their organizations to avoid retraumatization of women in mental health settings given the history of sanctuary trauma and vulnerability to retraumatization while receiving services.

Guideline 7: Psychologists strive to investigate and address the effects of sexual abuse, assault, and exploitation among women with serious mental illness.

Rationale. Sexual trauma appears to be a particular risk for women with SMI compared to their male counterparts. According to one study, 56% of chronically hospitalized women with psychosis had a history of childhood incest (Lipschitz et al., 1996). Another study found a rate of 55% of women receiving outpatient mental health services reported a history of childhood sexual abuse compared to 18% of men (Belk & van der Kolk, 1987). A third study found 53% of women who had been in an inpatient psychiatric inpatient unit reported a history of physical or sexual abuse compared to 23% of male participants (Carmen, Rieker, & Mills, 1987). Mueser and colleagues (1998) found that among a study of men and women with SMI, 26% of men reported sexual assault during their lifetime, whereas 64% of women reported sexual assault. Inherently, there is striking evidence that sexual abuse, assault, and exploitation among women with SMI is a serious health concern. In fact, sexual trauma may be a key contributing factor to the development of SMI (Belk & van der Kolk, 1987; Lipschitz et al., 1996).

A study that reviewed traumatic or harmful experiences in psychiatric settings revealed exposure to sexual exploitation may even happen within inpatient settings among individuals with SMI (Frueh et al., 2005), which calls attention to the need for

understanding this risk and putting into place measures that strive to ensure the safety of women with SMI in such settings. Obviously, our systems of care are meant to be places of safety and geared towards aiding people in their journey towards well-being; if the very places they are going for treatment actually are more harmful, this presents a serious concern.

Thus, there is overwhelming evidence for concern regarding the prevalence of experiences of sexual exploitation among women with SMI and additionally this is of even greater concern as we recognize that the literature highlights that there is also a high prevalence of posttraumatic stress disorder (PTSD) among people with SMI, compared to the general population (Mueser et al., 2002). Inherently, this has implications for understanding the potential consequences of sexual trauma among women with SMI. A review of studies indicates that between 29-43% of individuals with SMI experience PTSD, however, fewer than 5% of individuals have a PTSD diagnosis reflected in their chart (Mueser et al., 2002).

Application. Psychologists are encouraged to inquire and offer screenings for victimization among women with SMI generally, as well as about lifetime abuse, childhood abuse, and recent abuse (Goodman et al., 2001). Additionally, the value of doing so among women with childhood abuse histories, frequent psychiatric hospitalizations, experiences of homelessness, or substance use histories is essential, as the literature shows these factors predict recent victimization (Goodman et al., 2001). Similarly, intake assessments and regular ongoing assessments ideally explore specific and behaviorally anchored questions about coercive sexual experiences, assaults, and threats, helping highlight any concerns about safety (Goodman et al., 2001).

Given the high likelihood that significant trauma-related symptoms may go unrecognized or overlooked in the diagnosis or treatment of PTSD (Mueser et al., 2002) among women with SMI, psychologists are encouraged to carefully evaluate for PTSD and integrate this knowledge into treatment planning, clinical decision making, and choice of treatment interventions. Additionally, in light of the potential for women with SMI to experience even more sexual traumatization in psychiatric settings, psychologists who are in leadership positions are encouraged to bring to the forefront such concerns to administrators, supervisors, and clinicians (Frueh et al., 2005). Furthermore, psychologists are encouraged to create dialogues and enter into discussions about procedures, policies, and training efforts that aspire to ensure further sexual exploitation does not occur in our systems of care, affording us the ability to offer care that is humane and safe (Frueh et al., 2005).

In considering treatment options for experiences of sexual exploitation among women with SMI, and specifically schizophrenia, psychologists are encouraged to think judiciously, using clinical judgment and consultation as needed, about the best intervention given the client's experiences with psychiatric symptoms. For example, the literature lacks clarity about whether exposure-based trauma treatment interventions are the best treatment for women with schizophrenia, as some women might experience retelling/recalling disturbing memories as highly distressing, which could lead to challenges with their psychiatric symptoms or symptom relapse (Goodman et al., 1997). Furthermore, many of the research studies exclude the experience of psychosis from treatment research studies so the evidence is not clear if such exposure-based treatments for sexual trauma are efficacious for women with schizophrenia. Researchers indicate

that some women with schizophrenia may benefit from a more gradual form of exposure-based treatment or a social-learning approach to treatment (Frueh et al., 1995; Penn & Mueser, 1996). Relatedly, a social skills training model that addresses interpersonal skills (social perception and labeling, self-assertion, self-protection, self-expression, relational mutuality), intrapersonal skills (self-soothing, self-esteem, self-trust, self-knowledge), and global skills (initiative taking, problem solving, identity formation) may be particularly helpful for women with SMI that have been sexually victimized (Harris, 1996, 1997; Goodman et al., 1997; Harris & Fallot, 1996). For those women who have self-injurious behavior and PTSD, a combination of DBT and prolonged exposure has been shown to be more beneficial than DBT alone, though this has not been researched among women with schizophrenia (Harned, Korslund, & Linehan, 2014). It is also worth noting that many well-known trauma treatments overlook the cultural and sociopolitical experiences context of trauma experienced by women of color or women with disabilities. Instead, many randomized clinical trials overlook these factors in the therapist and client, rather than examining whether the treatment specifically works for a woman of color with SMI and a physical disability (Goodheart, Kazdin, & Sternberg, 2006).

Guideline 8: Psychologists are encouraged to be mindful of the financial wellness of women with serious mental illness given that they are at higher risk of poverty, such as,, when possible, facilitating access to adequate resources including supported employment, housing, and education.

Rationale. Poverty means not having sufficient resources to support oneself, and has far-reaching implications for the capacity to meet basic needs and participate in

educational, social, leisure, and community activities (Perese, 2007; Wilton, 2004). There is a multitude of evidence that poverty is associated with the experience of having an SMI, creating barriers for recovery (Deegan, 1993; Hudson, 2005; Perese, 2007). The greater degree of poverty among individuals with SMI contributes to the greater number of unmet needs, and more unmet needs are associated with a poorer quality of life and poorer health (Wiersma, 2006). In fact, SMI has been shown to be associated with $193.2 billion dollars' worth in reduction in personal earnings for one year in the U.S. (Kessler et al., 2008). Beyond that, there is also evidence that women with SMI may experience poverty at a more disparate level than men with SMI, with one study indicating men with SMI have an average of earnings of $26,435 over a 12-month period and women with SMI earning an average of only $9,302 over a 12-month period, among individuals that had some type of earnings to evaluate (Kessler et al., 2008). This study also indicated that SMI significantly predicts reduced earnings in comparison to other psychological disorders, which do not share the same prediction.

Employment, interestingly, is also associated with a better prognosis among those with SMI, but the literature indicates the employment rate is poor among this group (Draine, Salzer, Culhane, & Hadley, 2002; Strauss & Carpenter, 1981). Furthermore, the lifetime work experiences of individuals with SMI is limited (Draine, Salzer, Culhane, & Hadley, 2002). Successful employment is also linked with educational level, but educational level may be interrupted or mitigated by the experience of SMI or associated other social barriers (Blank, 1995; Draine, Salzer, Culhane, & Hadley, 2002; Kessler et al., 1995). Interestingly, although one third of illness-related days out of work in the U.S. is related to mental disorders rather than physical illness, less attention and support is

given to the experience of mental illness (Merikangas et al., 2007). The extent of poverty may be demonstrated by findings that those individuals with SMI who are on a monthly Social Security Income check may only have approximately $120.00 left to cover personal items or recreational purchases after paying basic bills (Perese, 2007; Wilton, 2004).

Poverty contributes to the social issue of homelessness among individuals with SMI, with the literature indicating between one-fourth to one-third of all homeless individuals experiencing an SMI (Fischer & Breakey, 1991; Folsom & Jeste, 2002; Sullivan, Burnam, Koegel, & Holenberg, 2000). Individuals from some racial/ethnic groups are at even higher risk of homelessness, as evidenced by the literature indicating a higher risk of homelessness among African Americans (Caton et al., 1994; Caton et al., 1995). Additionally, being homeless and having an SMI is associated with poorer quality of life, increased risk of victimization, poorer access to health services but higher mental health treatment costs, a greater likelihood of inpatient psychiatric hospitalization versus outpatient treatment, and less capacity to make mental health needs a priority over the need to take care of primary survival needs (Folsom et al., 2005; Gelberg, Gallagher, Andersen, & Koegel, 1997; Hibbs et al., 1994; Lehman, Kernan, DeForge, & Dixon, 1995; North & Smith, 1992; Padgett, Struening, & Andrews, 1990; Rosenheck & Dennis, 2001; Rosenheck & Seibyl, 1998; Wenzel, Koegel, & Gelberg, 2000).

The risk or dangerousness of being homeless is well demonstrated in the literature. Findings from a large study of homeless individuals with SMI found that 44% of individuals had experienced violent victimization within the previous two months (Choe, Teplin, & Abram, 2008; Lam & Rosenheck, 1998). Furthermore, the impact of

poverty and the experience of homelessness is particularly difficult for women; the literature shows that one-third of women with SMI who are episodically homeless have been physically or sexually assaulted within the prior thirty days, and recent victimization is associated with increased symptom severity presentation (Goodman, Dutton, & Harris, 1997). As the authors of the Recovery to Practice Curriculum indicate (APA & Jansen, 2014) homeless women are more vulnerable than homeless men and they may have children they are trying to care for while facing the dangers of homelessness.

Application. Women with SMI face greater poverty than men with SMI, raising significant implications for how psychologists think about engaging women in mental health treatment and how we conceptualize their experience with poverty. Psychologists are encouraged to start with striving towards cultural awareness and competence by developing their own knowledge related to the social experience of poverty and its impact on well-being among women with SMI. Calling on Sue, Ivey, and Pederson's (1996) well-known model for engaging in cultural competence, also adopted by the *Multicultural Guidelines* (APA, 2017; Sue, 2006), psychologists are urged to strive to understand the experience of poverty by women with SMI by understanding their own personal biases or values of poverty. Engaging in personal reflection regarding biases or values and how that may impact their understanding and engagement with a client is fundamental for engaging in cultural awareness. Psychologists are encouraged to make efforts to increase their own knowledge of the client's experience of poverty, which intersects with other experiences, and work at having appropriate cultural skills to work with the client in a manner that is respectful of being culturally sensitive to the experience of poverty and its intersectionality.

As psychologists engage in working towards cultural competence with understanding poverty and its implications for women with SMI, they are encouraged to do so in a manner that is consistent with the use of scientific mindedness, culture-specific skills, and dynamic sizing (Sue, 1998). In this respect, psychologists aspire to avoid making conclusions or assumptions without data about the impact of poverty on a woman with SMI (Sue, 1998; Sue, 2006). To expand on the concept of dynamic sizing, psychologists are urged to individualize and generalize a client's concerns in the treatment process based on person-specific information, as the psychologist explores the intersection of the client's various cultural contexts and multiple identities (Ridley, Hill, Thompson, & Omerod, 2001; Roysircar, Dobbins, & Malloy, 2009; Sue 1998). Psychologists may integrate the use of dynamic sizing by understanding when to generalize and when to individualize the knowledge base on women's experience of SMI and poverty, which helps with problems that may occur by stereotyping. Without such a foundation, psychologists may fail to understand the experience of a woman facing poverty and how that may impact her mental health, recovery, and psychotherapy.

Psychologists are encouraged to work with the knowledge that women experience many disparities and negative life experiences due to poverty, therefore they are encouraged to strive to mitigate the experience of poverty and respective social problems such as homelessness, joblessness, and a lack of education. Working with such an understanding also calls for engaging from a social justice perspective with women with SMI, as the idea of social justice emphasizes the need to act for justice on the behalf of individuals who do not have equitable resources or power due to being marginalized, such as women with SMI (Constantine, Hage, Kindaichi, & Bryant, 2007). Relatedly, as

Vera and Speight (2003) point out, psychologists are recommended to take on diverse roles rather than staying fastidious to traditional roles. This translates into advocating for resources, such as financial assistance, housing, education, employment opportunities, and supported employment. By seeing oneself as a social change agent, psychologists have the opportunity to extend their reach into communities and affect the sociopolitical factors that play an impact on the experience of poverty among women with SMI.

Psychologists are encouraged to engage with women with SMI around their employment status, satisfaction with employment, and/or desire for employment. Psychologists are urged to advocate for and locate employment resources, if this is a desired goal of the individual. As the *Proficiency in Psychology in the Assessment and Treatment of Serious Mental Illness* (American Psychological Association, 2009) advocates, Supported Employment has substantial outcome data for its efficacy and is an approach to finding employment that includes a rapid job search, competitive wages for jobs, integrated vocational and mental health services, ongoing support once employed, and the honoring of client choice in occupation. Therefore, connection to opportunities for Supported Employment may offer important resources. The literature provides evidence for Supported Employment showing improved employment outcomes across diverse populations and settings (Becker & Drake, 2003; Bond, et al., 2001; Bond, Drake, & Becker, 2008; Twamley, Jeste, & Lehman, 2003), which is likely to have multiple effects on personal well-being.

Psychologists are urged to make efforts to understand the educational attainment of women with SMI, make efforts to support educational endeavors, and locate resources to engage in such agendas. Additionally, psychologists are encouraged to consider the

option of resource connection to such supportive services as supported education (Nuechterlein et al., 2008). The Recovery to Practice Curriculum (2014) recognizes that supported education is generally recognized as supportive and helpful. Supported education aids individuals with SMI in obtaining, continuing, or gaining extra education and is a collaborative process with a specialist or team. Such programs may help women with SMI achieve personal learning goals or become successfully employed.

Psychologists are encouraged to make efforts to aid in the prevention of homelessness, mitigate the negative impact of homelessness, and instigate opportunities that lead to housing when working with women with SMI. The consensus in the field is that having safe, reasonable housing is one of the best first steps towards recovery (Housing First), and that providing stable housing decreases homelessness (Recovery to Practice Curriculum, 2014). Supportive housing integrates case management, support, psychotherapy, and skills training, as well as other supports for treatment for mental illness and any dual diagnosis (Padgett, Stanhope, Henwood, & Stefancic, 2011). The literature also indicates that Housing First models rather than Treatment First models have better outcomes for reduced substance use, avoiding relapse, and increasing retention. Additionally, as the literature highlights, the high risk for women with SMI who experience homelessness, and the associated impact of homelessness, there are far-reaching implications for psychologists moving out of traditional comfort zones to aid with this essential need.

Guideline 9: Psychologists are encouraged to support women in managing family responsibilities to enhance empowerment within these roles.

Rationale. In the last 15-20 years there has been more attention in the literature highlighting the need to understand experiences of women with SMI who have important family responsibilities, such as parenting or motherhood. Mowbray, Oyserman, and Bybee (2000), notable scholars on the topic of women with SMI in parenting roles, have discussed the long-held bias in the mental health field that women with SMI cannot fill such important roles as mothering or parenting; they also highlight that their needs or concerns are different than other women who may experience challenges such as poverty or urban living. The desire to be in a parenting or mothering role by women with SMI is increasingly being recognized, though the literature indicates it historically has been seen as a problematic desire that is pathological, and professionals have held biases that these women are, as a rule, unfit to be mothers (Montgomery, Tompkins, Forchuk, & French, 2005; Walsh et all, 2002). It is important for mental health professionals to maintain awareness of any biased views in order to best support women with SMI in their recovery journey. There is a growing body of research that indicates there is evidence for the capabilities of these women to fill parenting roles with appropriate support (Nicholson & Biebel, 2002).

The literature indicates that women with SMI have normal fertility rates and have children at an average or even above average rate (Mowbray, Oysterman, & Bybee, 2000). There are also a significant number of women with SMI that serve as mothers or in parenting roles of children (approximately 10-65%). Interestingly, 10-15% of women develop a mental illness postpartum (Dipple et al., 2002; Downey, Coyne, 1990; Joseph et al., 1999; Mowbray, Oysterman, & Bybee, 2000; Nicholson & Biebel, 2002; Oates, 1988). Additionally, women with SMI are more likely to face parenting as single

963 mothers, experience lower socioeconomic status, begin having children at an earlier life
964 stage, and are more likely to face family problems and victimization (Belle, 1990;
965 Downey & Coyne, 1990; Mowbray, Oysermann, Bybee, McFarlane, & Rueda-Ridle,
966 2001; Nicholson, Sweeney, & Geller, 1998; Olson & Banyard, 1993; Wang &
967 Goldschmidt, 1994). Challenges that women with SMI face also include inadequate
968 living circumstances, the effects of mental health symptoms and medication side effects,
969 the challenges of dealing with stigma, and ever-present fears of having their children
970 taken away by child protective services (Montgomery, Tompkins, Forchuk, & French,
971 2005).

972 The fear of having their children taken away or losing custody is a realized
973 concern, as the literature indicates women with SMI are at increased risk of losing
974 responsibility for caring for or complete custody of their children, and therefore many
975 women mask their parenting struggles and mental health issues (Hollingsworth, 2004;
976 Nicholson, Biebel, Hinden, Henry, & Stier, 2001; Nicholson, Sweeney, & Geller, 1998).
977 Some studies have reported more African American women experiencing child custody
978 loss, while other studies indicate more white women lose their children (Lewis,
979 Giovannoni, & Leake, 1997; Sands, 1995; Zuravin & Greif, 1989). There is evidence of a
980 greater likelihood to experience child custody loss in the following circumstances: there
981 are problems with parenting skills, being younger at the birth of the first child, having a
982 greater number of children, experiencing single parenting, experiencing more personal
983 distress, unemployment or underemployment, experiencing homelessness, and having
984 less social support or less social services (Hollingsworth, 2004). Literature does indicate
985 that children of parents with SMI are more likely to experience foster care, behavior

problems, and psychiatric disorders themselves (Ghodsian, Zajicek, & Wolkind, 1984; Jacobsen, Miller, & Kirkwood, 1997; Mowbray, Oysermann, Bybee, McFarlane, & Rueda-Riedle, 2001; Oyserman, Benbishty, & Ben Rabi, 1992).

However, mothering can be a meaningful process for women with SMI, providing meaning and personal definition to life (Nicholson & Biebel, 2002; Nicholson, Sweeney, & Geller, 1998). A qualitative study gives life to this identity process, as the identity of being a mother is seen as signifying normalcy, security, and responsibility, which are empowering aspects of parenting and distinct from the experiences women may face with an SMI (Montgomery, Tompkins, Forchuk, & French, 2005). This study also highlights that rather than having a traditional, more negative biomedical outlook on the experience of parenting or motherhood among women with SMI, the mental health field may make mindful shifts to understand and appreciate the mothering efforts of women with SMI in the context of their challenges that are related to mental illness, which may aid in increased support and well-being.

The literature highlights some unique findings that have implications for empowerment among women with SMI in their chosen role of parenting or mothering. For example, Oyserman and colleagues (2002) found that social support, social stress, and financial stress have implications that affect parenting outcomes. These findings indicate that social support, adjusted income that is higher, and less stress have positive implications for maternal involvement in parenting roles among women with SMI. Furthermore, this study found current mental health functioning with fewer symptoms has implications for women with SMI being better apt to get social support, which in turn

can impact parenting. Thus, better psychiatric functioning also relates to experiencing less stress, both financial and social.

Application. Psychologists are encouraged to become more aware of the literature on the value of mothering or a parenting role among women with SMI and the implications for clinical practice. There is a significant and growing amount of literature on this topic that can inform our understanding, bring to light our own biases or misassumptions as a profession, and provide a guide to advanced clinical engagement. In this process, and as psychologists engage in their areas of expertise, they are encouraged to also conduct an intrapersonal process in which they examine their own biases or assumptions they have held about the capabilities of women with SMI to engage in mothering or a parenting role, while utilizing Sue, Ivey, and Pederson's (1996) model for cultural competence. Becoming more cognizant of our own biases or assumptions that we may have erroneously held can help psychologists to prevent treatment that is unjust, dismissive, marginalizing, stigmatizing, or paternalistic. With this increased awareness, psychologists may be better apt to provide clinical services that espouse the general principles of the APA Ethics Code (2002) of equality, fairness, and avoidance of biases instead of exacerbating experiences such as stigma and marginalization.

As psychologists engage in clinical services with their clients they are also encouraged to explore the personal meaning of the parenting or mothering role for each individual. Given that these roles might mean something very different per individual, it is important to understand the literature, but also interpret that within the context of the personal cultural experience and meaning for each woman with SMI. For example, one woman may embrace her role as a mother or parent and want to hold fast to those

meanings, build on this part of her life, and find personal value and empowerment from such an identity. Another woman may have only experienced more hardship from the role of mothering, and may not feel as negatively about the loss of custody. As researchers advocate (Mowbray, Oyserman, Bybee, & McFarlane, 2002; Oyserman, Bybee, Mowbray, & McFarlane, 2002), psychologists are encouraged to be careful to assess the status and current functioning of mothers with SMI, rather than assuming there are problems or intervention needs that may not be present.

For those women who fear they are at risk of losing custody of their children or have lost custody of their children and this is identified as a particularly challenging or painful process, psychologists are encouraged to aid their clients in being able to process the meaning of this experience, any difficult emotional reactions, and find appropriate social services to support such concerns. The literature highlights that family members may reinforce a sick role for mothers with mental illness, overlooking family members or women with SMI's own value for input or consultation regarding decision making about their children (Nicholson, Sweeney, & Geller, 1998). In this respect, family members may undermine the efforts of mothers to balance the demands of managing their mental illness and the roles of parenting, which can cause even more difficult dynamics (Nicholson, Sweeney, & Geller, 1998). Psychologists are encouraged to explore the dynamics between family members or those that may have roles in parenting the children of a client. Psychologists may strive to empower the client to serve in the role of mother in the capacity she can, and reinforce positive relational and healthy boundary dynamics with other parties involved. If a mother has lost custody of her children, but would still

like a role in her children's lives, psychologists are encouraged to explore how that can be done and what supports can be incorporated to make that possible.

Psychologists are encouraged to engage their clinical expertise in helping treat any mental health symptoms women with SMI are experiencing, as the literature indicates current mental health functioning plays a part in parenting capacity (Oyserman, Bybee, Mowbray, & McFarlane, 2002). Additionally, psychologists are encouraged to utilize the best evidence-based treatments and practices that can be beneficial for women with SMI, as suggested by the Recovery to Practice Curriculum (2014). Developing up-to-date training and skills in evidence-based practices has the potential to impact outcomes. This approach is also very meaningful from a social justice perspective as the literature indicates there is a science-to-service gap issue (Drake et al., 2001; Farkas, Jansen, & Penk, 2007), meaning that the literature shows there are many evidence-based practices for individuals with SMI, but few actually receive those services. It is also worth noting that many evidence-based treatments focus only internally and ignore the cultural context, which could make a significant difference in how women and diverse women experience a practice that is deemed evidence-based by a randomized clinical trial.

As the literature indicates women with SMI may be single parenting and experiencing less social support (Hollingsworth, 2004), psychologists are encouraged to partner with their clients to ascertain levels of social support, interest in increased social support, and appropriate avenues for social support. The literature indicates that it may be helpful to assess what support individuals do have from family and their capacity to parent and engage in treatment (Nicholson, Sweeney, & Geller, 1998). For example, is

there concrete support at times when a mother needs to attend a treatment appointment and needs childcare or is their support for actual treatment engagement from family members or loved ones in taking medications or for seeing a treating clinician? The literature also indicates it may be helpful to provide support to the family in the context of supporting parenting/mothering by an individual, while also trying to balance mental health needs (Nicholson, Sweeney, & Geller, 1998).

As women with SMI are more likely to experience challenges with housing, financial support, and employment (Draine, Salzer, Culhane, & Hadley, 2002; Folsom & Jeste, 2002; Perese, 2007), which has likely implications for the capacity for involvement in parenting roles, psychologists are encouraged to attend to these potential needs and engage in roles as community connectors, advocates, and social change agents to empower increased social resources and equity within the community. As the literature indicates, parenting under the stress of poverty and social challenges can impact the well-being of children and mothers, therefore intervening in this manner is imperative (Mowbray, Oyserman, & Bybee, 2000).

Guideline 10: Psychologists could work to enhance the peer support network of women with serious mental illness to overcome social barriers posed by stigma and mental health symptoms.

Rationale. Peer support is defined as when two or more people with similar experiences get together to share their experiences, to learn together how to move past the difficulties that these experiences have created in their lives, to give each other hope, and to support each other as they do the things they want to do and make their lives the way they want them to be (Copeland, 2015). The peer support National Practice

Guidelines entail providing peer support on a voluntary basis in a manner that is hope-inspiring, open-minded, empathetic, respectful, facilitative of change, honest and direct, mutual and reciprocal, equitable in power relations, strengths-based, transparent, and person-centered (International Peer Supporters, 2016).

Peer support is an alternative and/or complementary response to medical treatment of mental illness. Some posit that peer support in its purest form, solely led and received by those who have experienced mental illness, by definition cannot be co-located within traditional mental health agencies or systems (Valenstein, 2015). On the other hand, health care systems such as Medicaid and the Veterans Health Administration have supported the integration of peer support providers as an innovative and effective strategy to improve clinical and recovery outcomes for the populations they serve. One form of peer support, called Intentional Peer Support, stresses a new way of thinking about and inviting transformative relationships. Intentional Peer Support differentiates itself from traditional mental health and social services by viewing relationships as an equal partnership where both parties learn and grow, not assuming that there is a problem, promoting a trauma-informed way of communicating, situates one's life in the context of mutually accountable relationships and communities, and encouraging enacting what we want rather than focusing on what needs to be stopped or avoided (Intentional Peer Support, 2016).

Women with SMI may benefit from encounters with peer support, which aims to ameliorate and heal the typical limiting and/or harmful experiences that consumers have had with traditional mental health care. For example, these women may have experienced feeling inferior in the typical power dynamic between provider and patient. These

individuals may have experienced disempowering and retraumatizing experiences in various outpatient, inpatient, and residential treatment settings. Furthermore, women with SMI who embody one or more identity dimensions potentially subject to sexism, ableism, classism, and racism, may greatly benefit and feel at home in interacting with a peer or peers to mirror and empathize with their identity and their life experiences.

Application. Psychologists are encouraged to become knowledgeable about peer support organizations at the national, state, and community levels. They are also urged to become knowledgeable about resources and services offered by organizations, such as the National Alliance of Mental Illness (NAMI) and The Copeland Center. NAMI offers a 10 session course, called Peer-to-Peer; local availability of this is searchable through the NAMI website. The Copeland Center is an international training organization that certifies facilitators of a manualized approach to recovery called Wellness and Recovery Action Plan. States and local communities often have peer support services available at venues such as a respite centers, recovery centers, and Clubhouses.

Psychologists are also encouraged to consider systems barriers to women with SMI as they access healthcare, such as the ability to bring children to appointments at the clinic where they receive their care, financial support, or transportation support to get to appointments and/or take medications. Psychologists are encouraged to be change agents and help think of creative solutions for the delivery of care to support women in their diverse experiences. Also, psychologists aspire to become well-versed in the state of the research evidence for iterations of peer support, such as peer-to-peer, WRAP, and providers and programs geared toward specific issues. Finally, psychologists are encouraged to advocate for women with SMI to engage in and perhaps to become

providers of peer support. Given the possible accumulation of experiences that may erode the self-knowledge, self-concept, and self-confidence of women with SMI, it is especially important that psychologists be supportive in facilitating these individuals' mental health recovery and engagement in their communities, as self-defined.

Rogers (2017) reviewed the current evidence base on peer specialists, and found that this service appears to be especially useful in enhancing social support and mental health and coping, and reducing reliance on traditional mental health providers. Peer support appears to offer a unique opportunity for self-disclosure on the part of the peer specialist that is instrumental to fomenting the therapeutic alliance via shared lived experience. However, Rogers recommended more rigorous research to be conducted in this area and more research is needed as to the potential applications to the specific needs of women with SMI.

Guideline 11: Psychologists strive to address the relationship goals and interests of women with serious mental illness to ensure safety and fulfillment.

Rationale. Though the majority of people in the U.S. report engagement in a significant dating or partner relationship in their adult lives, individuals with SMI have greater difficulty having or maintaining sexual partnerships and/or marital relationships (Laumman et al., 1994; Wright, Wright, Perry, & Foote-Ardah, 2007). The literature indicates that 30-70% of individuals with SMI report being sexually active, with fewer reporting a marital or long-term relationship. There are many theoretical explanations for this that point to the impact of discrimination, which is associated with stigma from mental illness or from physical side effects of medication (Agerbo et al., 2004; Buckley et al., 1999; Carey et al., 1999; Carey et al., 2001; Dickerson et al., 2004; Wright, Wright,

Perry, & Foote-Ardah, 2007). Related to societal stigma of mental illness and pulling from modified labeling theory (Link, 1987), the literature indicates many people devalue individuals with SMI as potential spouses or partners due to the stigma of mental illness, with the most potent negative reactions drawn from the idea of entering a marital relationship with someone with mental illness (Link et al., 2004).

As Deegan (2001) relates, individuals with SMI experience the need for love, intimacy, and companionship just like the general population. However, they may fear rejection, withdraw from others in efforts to protect themselves, lack social skills needed to attract others, and ultimately choose to avoid relationships or withdraw to avoid rejection, which may reduce the likelihood of intimate relationships (Wright, Wright, Perry, & Foote-Ardah, 2007).

Wright and colleagues (2007) found that women with SMI are more likely than men with SMI to be sexually active, in contrast to the general population, and are also more likely to engage in unprotected, higher risk sexual encounters. Those authors also found that women with SMI are more likely than men to have concurrent sexual relationships. The unique challenges that women with SMI may face are also highlighted by the research that indicates 79.4% of these women have experienced physical assault by a partner or relative within the previous year (Cascardi, Mueser, DeGiralomo, & Murrin, 1996), and are particularly prone to experiencing abuse in sexual relationships (Dickerson et al., 2004; Goodman et al., 1997).

Application. Psychologists are encouraged to explore the relational interests of the women with whom they work, who have SMI, and identify what value partner, marital, or sexual relationships serve for the individual. Psychologists strive to explore

the supports women have to foster the maintenance of healthy relationships, initiation of new relationships that are desired, and ability to have healthy boundaries within relationships and/or make empowering choices in relationships that may be abusive. As identified needs may come up in the area of requisite supports to pursue personal relational goals psychologists are encouraged to provide appropriate psychosocial supports or connect individuals to advantageous resources. These could include avenues for exploring dating relationships, social skills training, therapeutic interventions or resources for intimate partner violence, and referrals to appropriate healthcare, which may address goals related to sexual activity and protection. Furthermore, psychologists are encouraged to explore in therapy the role of stigma on the relational goals of women with SMI and introduce mechanisms to mitigate the impact of stigma. For example, a psychologist may explore the impact of internalized oppression on a woman's belief that others may not be interested in her as a romantic or sexual partner due to the fact that she has an SMI.

From an advocacy perspective, psychologists are encouraged to advocate for women with SMI that may be experiencing challenges within our mental health systems due to policies that marginalize the right to have romantic and/or sexual relationships. For instance, psychologists are encouraged to explore what policies inpatient psychiatric units have on the rights for sexual expression and offer support to foster romantic and/or sexual partnerships (Deegan, 2001). Psychologists are encouraged to look at this issue from a social justice perspective as many mental health systems ignore or deny the right for individuals with SMI to pursue such relationships. Additionally, psychologists strive to explore how community – or outpatient programs are organized to be inclusive of women

who identify with different sexual orientations, gender identities, and gender expressions. Along these lines, psychologists are encouraged to integrate and educate themselves with other guidelines, such as the transgender guidelines, which may further advance practice. Psychologists are also encouraged to educate medical personnel, public service professionals in law enforcement and criminal justice, and other community members about socially just ways to work with women with SMI.

Psychologists aspire to provide a crucially safe therapeutic space to psychologically process dissatisfaction or challenges in relationships and especially in the realm of experiences of violence/abuse. They are encouraged to assess issues of safety and empower women with SMI with tools that may enhance their feeling of safety, autonomy, self-determination, and choice. Additionally, in the face of experiences of sexual and/or physical abuse psychologists aspire to acknowledge the impact of trauma on the lives of women with SMI and either provide, or refer to, appropriate psychological treatment for these concerns, if indicated.

Guideline 12: Psychologists may conceptualize substance use treatment as an equal component of the mental health care of women with serious mental illness, and provide treatment for dual diagnoses.

Rationale. The literature indicates that substance use disorders are the most common and significant co-occurring experience for people with SMI (Drake, Mueser, Brunette, & McHugo, 2004), with lifetime prevalence rates approximated at 50% among all individuals with the experience of a SMI (from a study of over 20,000 people in the U.S.) (Regier et al., 1990). Many other studies report similarly high rates of the co-occurrence of substance use and SMI (Drake & Wallach, 2000; Mueser et al., 2000). The

importance of this concern is multi-fold, as the co-occurrence of SMI and substance use disorders is associated with many significant challenges including, but not limited to higher rates of homelessness (Caton et al., 1994), victimization (Goodman, Rosenberg, Mueser, & Drake, 1997), worsening symptoms of depression and increased risk of suicide (Meyer, Baborm & Hesselrock, 1988; Torrey, Drake, & Bartels, 1996), and increased family burden, interpersonal conflict, and financial problems (Mueser, Noordsy, Drake, Fox, 2003).

There is also research that indicates that women who experience mental illness are more vulnerable than men to the intoxicating and addictive components of drugs, which may have biological origins (Gearon & Bellack, 1999). Furthermore, based on evidence indicating that women become more easily intoxicated than men, they also develop substance use disorders sooner than men, making them particularly vulnerable (Lex, 1995; Shuckit et al., 1995). A study on gender difference in the experience of schizophrenia provided evidence that the more benign course and presentation of illness typically seen in women with schizophrenia, as compared to men, disappears when women abuse substances (Gearon & Bellack, 2000). The combination of having these co-occurring challenges also significantly raises the risk for trauma exposure and resultant negative outcomes for women (Gearon, Kaltman, Brown, & Bellack, 2003). In fact, large scale studies indicate that the rates of physical and sexual abuse in women with SMI that are abusing drugs are notably higher than the rates seen among women in the general population that are not abusing drugs and/or experiencing a SMI (Dansky et al., 1996; Cottler, Nishith, & Compton, 2001). One such study indicates a very high rate of physical abuse (81%) and revictimization in women with a co-occurring SMI and substance use

disorder (Gearon, Kaltman, Brown, & Bellack, 2003). Additionally, this same study provided evidence that prevalence rates of current PTSD (46%) are much higher than previously reported for women with co-occurring SMI and substance use disorders (Gearon, Kaltman, Brown, & Bellack, 2003). Clearly, this has serious implications for the impact of the dual experience of these two challenging issues among women.

Application. Psychologists are encouraged to fully assess women with SMI for the presence or warning signs of a substance use disorder, given the vulnerability to developing substance use problems and the impact of the co-occurring SMI. The literature indicates that women with some SMI diagnoses, such as schizophrenia and schizoaffective disorder, are less represented than men in substance use treatment programs. Access to care and advocacy for the right to evidence-based substance use prevention and intervention may be seen as a social justice issue (Alexander, 1996; Gearon & Bellack, 1999). Along these lines, a thorough review of the best modalities of treatment for the co-occurrence of substance use disorders and SMI recommends that effective treatments are integrated dual diagnosis treatment (IDDT), which address both concerns simultaneously, rather than offering treatment in silos (Dixon et al., 2009; Drake, Mueser, Brunette, & McHugo, 2004). In addition to access to evidence-based practices, women with SMI and substance use disorders ideally may be afforded the opportunity to have effective components of treatment, such as individualized treatment that addresses personal factors, engagement in treatment, relapse prevention, stages of motivation, and the ability to develop skills and supports (Dixon et al., 2009; Drake, Mueser, Brunnette, & McHugo, 2004). Consideration for integrated residential treatment, especially long–term, of one year or more, may be considered for those women who do

not respond to outpatient treatment, as the evidence is better for such treatment modalities (Drake, Mueser, Brunette, & McHugo, 2004).

Given the multitude of more significant problems with the duality of the experience of SMI and substance use disorders, and the particular vulnerability for women for increased trauma exposure and PTSD (Gearon, Kaltman, Brown, & Bellack, 2003), psychologists are encouraged to regularly screen for recent victimization among women with SMI and substance use disorders (Goodman et al., 2001). This investigation is recommended to be part of the intake assessment and be done in an ongoing manner, including specific and behaviorally anchored questions that may elucidate whether women are experiencing coercive sexual or physical experiences or threats, which impinge on their feeling of safety (Goodman et al., 2001). If there is an experience of trauma psychologists are encouraged to also treat that aspect of their current presentation and need for safety, while simultaneously addressing the concerns of their experience of SMI and substance use. For women with past or current histories of trauma, the treatments offered preferably are trauma-informed, as well as the systems in which they are offered.

Guideline 13: Psychologists strive to focus on the safety of women with serious mental illness to reduce the risk of suicidality and enhance coping strategies.

Among those with SMI, risk of suicide varies from 8.5 (schizophrenia) to 15 (bipolar disorders) to 20 (major depression) times the expected rate, calculated by a standardized mortality ratio (Harris & Barraclough, 1997). Moreover, the presence of eating disorders, which are generally not considered a SMI, but which increase suicide risk, may be a pertinent consideration during provision of clinical care, given their

prevalence among women. The risk of suicide for eating disorders has been found to be 23 times the expected rate (Harris & Barraclough, 1997).

There are some additional issues to consider with regard to suicide and women with SMI. One is the co-morbidity between SMI and Borderline Personality Disorder (BPD). Between 40% and 65% of individuals who commit suicide meet criteria for a personality disorder, the most common of which is BPD. A Borderline Personality Disorder diagnosis co-occurs in 46-56% of women diagnosed with PTSD, and in 10-20% of women diagnosed with bipolar disorder (McGlashan, 2000). BPD is more commonly diagnosed and treated in women versus men (approximately 70% versus 30%, respectively) (Lieb, Zanarini, Schmahl, Linehan, Bohus, 2004). Estimates of the mortality rate from suicide of those with BPD are as high as 10% (Paris & Zweig-Frank, 2001). For individuals with BPD and suicidality who enter treatment, it is suggested that the first priority is to decrease suicidal behaviors by increasing behavioral control, during which the severity of suicidality may be actively and consistently monitored.

There is little data that pharmacotherapy reduces risk of suicide or attempted suicide, and pharmacotherapy or hospitalization may not be effective for women with BPD (Soloff, 2000). Rather, results from randomized controlled trials of Dialectical Behavioral Therapy (DBT), a form of structured outpatient psychotherapy that includes skill building in emotion regulation, mindfulness, interpersonal effectiveness, and distress tolerance, as well as intensive psychotherapy with coaching calls, indicate that an aggressive, outpatient treatment, which rarely hospitalizes, shows lower rates of suicide attempts than standard treatment (i.e., emergency services and inpatient treatment) (for a review, Linehan, 2010). Thus, DBT reduces risk of suicidal and self-harm behaviors.

Another relevant issue for women with SMI is perinatal suicide in mothers. Female suicide, versus male suicide, is less associated with unemployment, adversity, single status, and divorce (Oates, 2003). Suicide is the leading cause of maternal death based on a national U.K. report (Oates, 2003). Maternal deaths due to psychiatric causes such as suicide, substance use, and homicide have been measured at 12%, with suicide accounting for the majority, at 10%. Among these deaths by suicide, 68% were related to an SMI such as psychosis or severe depression. That epidemiological report indicated that the majority of maternal suicides were by violent means, such as by hanging or jumping, rather than from medication overdose. However, in contrast to previous studies on gender differences, regarding the method of suicide, women were more likely to die by non-violent means such as overdose.

Remarkably, in the cases of maternal suicide, it was rare that mental health or maternity professionals knew of the risk of suicide, and to an even lesser extent had implemented behavioral management plans, despite a previous history of SMI or post-partum depression among these mothers. Of the maternal deaths by suicide, 46% had documented mental health problems and were in contact with mental health services (Oates, 2003). Furthermore, oftentimes even when previous postpartum psychiatric history was recorded, postpartum depression was the diagnosis on record even when postpartum psychosis may have been more accurate and indicative that more intensive interventions may have been warranted.

Application. Psychologists are encouraged to know the higher rates of suicide among clinical disorders such as major depression, bipolar disorder, schizophrenia, and eating disorders. Furthermore, particular attention could be paid to outpatient outreach,

evidence-based interventions, and psychiatric screening and behavioral management for BPD, PTSD, and maternal postpartum depression and psychosis. It is vital to integrate sound professional judgment with gender-specific knowledge into decision-making regarding suicidality. Increasing this awareness could potentially help many individuals to get the appropriate level of services to meet their needs. Additionally, as the experience of pregnancy is a potentially distressing and at-risk time in life, psychologists and others providing psychological services to women with SMI could try to connect expectant mothers to appropriate supports which could potentially mitigate the likelihood of postpartum depression and psychosis, and offer resources that could promote engagement in parenting, while also receiving supports that more directly facilitates women's own mental health recovery.

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Appendix A

Definitions

There are many terms used throughout these guidelines, which may be used often in specialized work with women with SMI but there may be some who read the guidelines that may not understand the terms. Therefore, the following definitions are offered as a way to ensure that those reading the document understand the use of the terms that are being conveyed.

Culturally Responsive: an approach that aims to not only be sensitive or aware but be responsive to the element of culture and the unique experience of the client. From this perspective a few goals from the literature share that a culturally responsive approach attempts to engage in some of the following ways: not only be culturally-informed but provide person-specific assessment of the presenting issue, engage in education regarding specific cultural norms and consult the literature for culture-specific treatment techniques, ensure adequate and effective training has occurred for cross-cultural competency, explore client's perspective on seeking treatment and of the therapeutic relationship, incorporate client's strengths and resources into treatment, and use technique-specific cultural modifications as appropriate (Asnaani & Hofmann, 2012).

Dynamic Sizing: understanding when to generalize and when to individualize a client's particular experiences based on various cultural contexts and multiple identities (Sue, 1998).

Empowerment Approach: an approach, which allows individuals, families, and communities to gain influence over sociopolitical factors that affect their health and well-being (Worell & Remer, 2003).

Intersectionality: is a theory that may enhance understanding how various social identities contribute to compounded levels of stigma, oppression, and privilege (Crenshaw, 1993). Intersectionality demonstrates how constructs like race and class are not separate processes but intersecting social hierarchies that determine access to power (Collins, 2000).

People-first Language: use of language that shows respect by referring to an individual first by their name and then by their disability when needed such as "person with serious mental illness." This approach demonstrates respect for the individual and that they are inherently a person first with capabilities, rather than naming them by what they are perceived to have as a disability (Blaska, 1993).

Recovery: is a shift away from traditional uses of the word "recovery", such as the absence of symptoms or substance use, but focuses on hope, self-determination, empowerment, and person-centered care (SAMSHA, 2012). The recovery-oriented care movement came out of the consumer movement in the 1960s and 1970s in which individuals in hospitals fought for their rights and the capacity to live autonomously in the community and to have a life that was more than just being a patient (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009). It means recovery occurs despite symptoms recurring or being in the hospital again. This perspective focuses on the rights of those with mental illness to be empowered, have a voice in their mental health experience, and ultimately live lives of meaning beyond the effects of mental illness. This

perspective calls awareness to the reality that the experience of those with mental illness was as much about the sociopolitical experience of stigma, marginalization, and discrimination as it was about mental illness.

Recovery-oriented Care: a systems approach to mental health care that looks at how to implement recovery oriented values and transformation so that mental health systems can partner with those in their recovery journey (Davidson et al., 2009).

Serious Mental Illness (SMI): refers to major mental health disorders that lead to serious impairment in at least one area of functioning, including social, academic/occupational, and daily living activities (Kessler et al., 2003; Substance Abuse and Mental Health Services Administration (SAMHSA), 2017). SMI typically includes bipolar disorder, schizophrenia spectrum disorders, severe depression, and posttraumatic stress disorder (PTSD).

Stigma: "the threats of diminished self-esteem and of public identification when labeled "mentally ill"" (Corrigan, p. 614, 2004).

Trauma-informed Care: the provision of mental health services that take in to account the understanding of the impact of the interpersonal violence and victimization on an individual's life and development (Fallot & Harris, 2001). This perspective has multiple goals but they include such perspectives as offering choice, trustworthiness, empowerment, maximizing control, and providing a recovery process.

Appendix B

History of the Development of the Guidelines

The aims of the Task Force on Women with Serious Mental Illness in Division 35 were to represent and advocate for the needs of women who experience SMI from a multicultural feminist perspective. The task force was compiled of several feminist psychologists specializing in working with individuals with SMI who were concerned about the dearth of formal attention and activism that was being pursued to represent this group of women.

The feminist rationale for developing the task force was multifold. First, the group reflected on the fact that there is a significant amount of women that experience SMI (SAMHSA, 2003). Secondly, women with SMI frequently experience other oppressive experiences putting them at disproportionate risk of unique challenges (American Psychological Association, 2009; Bassuk, Weinreb, Buckner, Brown, Saloman, & Bassuk, 1996; Goodman, Dutton, & Harris, 1995; Roberton, 1996). Furthermore, this group was concerned that women of other minority social identities who experience SMI may endure an even greater experience of oppression and marginalization (Carr, Greene, & Ponce, 2015; Szymanski & Moffitt, 2012). As Division 35 seeks to be a leader in the field of psychology in advocacy for the rights of all women, the Task Force suggested that the multicultural feminist movement needed to become stronger in representing and advocating for the needs and rights of all women who experience SMI. Initiatives of the group included presentations at national psychological meetings to represent the unique needs of women with SMI, larger efforts to make contributions to the psychological literature on women with SMI, and the development of these *Guidelines for*

Psychological Practice with Women with Serious Mental Illness. Division 35 was supportive of these initiatives and voted to transition the Task Force into a Committee on Women with Serious Mental Illness in January 2016 at their Mid-Winter Annual Meeting of the Executive Committee of Division 35, in order to provide a mechanism to continue the work of the original Task Force.

The core group began its initial focus on the development of Guidelines in 2015, including discussions with representatives from APA regarding guideline development and a review of the literature. The co-chairs of the Committee and Task Force, Erika Carr (Lead Co-Chair) and Lauren Mizock, led the charge to develop guidelines joined by group member Shihwe Wang. Other psychologists were later assembled to provide additional edits and review of the initial draft that the core group developed. The second tier of psychologists, that joined the working group, at the end of 2017 and beginning of 2018, to edit the draft were included due to the following specializations: psychological guideline development, women's mental health, SMI, women with SMI, and multicultural feminism. The core group initially met quarterly over conference calls in order to begin to develop the guidelines. The core group began to meet monthly over conference calls during 2016, and specific writing deadlines were assigned and feedback shared on the writing process. After an initial rough draft of the guidelines were developed the Lead co-chair, Erika Carr, provided a thorough edit and then next the other co-chair, Lauren Mizock, made an edit of the guidelines, and then the draft was edited a second time by Erika Carr, as well as reviewed by Shihwe Wang. Congruently the core group next provided another edit and discussion to address any outlying issues that remained. Other stakeholders and experts in psychological practice with women with

SMI and in women's mental health then provided additional edits to the guidelines. These psychologists included: (Marcia Hunt, Stephanie Lynam, Meaghan Stacy, Pamela Remer, and Viviana Padilla-Martinez). After their edit, the core group went back and provided additional revisions based on the suggestions of those who edited the core group's draft of the guidelines.