Recommendations for Integrating a Social Justice Framework into Clinical Practice: A qualitative analysis with implications for psychology training programs

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Abstract

Social justice is a frequently used buzz word yet an abstract concept in clinical training. As a result, there is minimal guidance on how to implement social justice in clinical practice, which leads to training gaps, uncertainty, and discomfort among clinicians serving historically oppressed populations. This study examined how to integrate the social justice principles of community psychology into clinical psychology practice among doctoral students. The integration of the following social justice principles were analyzed: addressing oppression and social context, utilizing strength-based approaches, facilitating empowerment, acknowledging and managing privilege, and effective advocacy. We utilized qualitative methods to complete 26 one-on-one interviews and a focus group with 5 participants to understand student experiences and explore how they applied the above social justice principles to their clinical practice. Through an iterative process, doctoral student responses were synthesized into a list of recommendations on how to integrate a social justice framework into clinical work. The primary results from this study suggest that students in clinical-community psychology doctoral programs try to use client-centered strategies to understand their clients' experiences of oppression and incorporate social context and a strengths-based approach into multiple aspects of practice, such as treatment planning and advocacy to connect clients to resources. Students also reported managing their privilege through internal self-reflection and occasional self-disclosure during therapy with clients. However, despite the desire to use socially just practices, several training gaps and needs emerged. These gaps included the need to identify methods of measuring and confirming client empowerment as well as supervisory and institutional support for effective advocacy work. Thus, implications for integrating social justice principles into clinical-community psychology programs, clinical psychology, and related disciplines are discussed.

Keywords: Social Justice Framework; Clinical-Community Psychology; Clinical Practice; Social Context; Strength-based Approaches

Introduction

Dual-track doctoral programs in clinical and community psychology have the unique opportunity to inform and enhance each other given their focus on both individual and ecological levels of analysis and intervention. Despite this opportunity, there are several foundational contradictions between the principles and concepts of clinical and community psychology that make integration difficult and result in conflicting messages to graduate students in training. For instance, clinical psychology programs have historically conceptualized problems at the individual level and ultimately seek to identify and treat the pathologies that underlie individual distress (Tang, 2013; Witmer, 1907). In contrast, from a community psychology perspective, solely focusing on individual-level factors without addressing contextual and systemic factors perpetuates structural oppression and often results in 'victim blaming' (Nagayama Hall, 2005; Ryan, 1976). Notably, community psychology developed as a distinct field due, in part, to "discontent" with the lack of contextual application and the individual-level limitations of traditional clinical psychology (Dalton et al., 2013; Rappaport, 1977).

Community psychology has a stronger emphasis on multi-level interventions (micro, meso, macro, etc.) and social justice than clinical psychology. Indeed, a recent review of community mental health over time found that community psychology has moved away from mental health-focused interventions and towards social justice and advocacy for those who experience mental health concerns (Townley & Terry, 2018). Prilleltensky (2001) described social justice in a *distributive* capacity as, "the fair, equitable allocation[/distribution] of resources, opportunities, obligations, and power in society as a whole; promoting fair and equitable allocation of bargaining powers, resources, and obligations in society in consideration of people's differential power, needs, and abilities to express their wishes" (p. 754). In tandem, scholars include a *procedural* aspect of social justice, which include "fair, transparent, inclusive, respectful and participatory decision making processes[/procedures]" (Evans, Rosen, & Nelson, 2014, p. 5). This shift towards social justice in community psychology prioritizes outcomes that are equitably distributed, wherein those in need will receive what they need, as well as the process of equity, in which inclusive practices inform *how* those outcomes are attained.

In practice, community psychologists seek to combine a critical awareness of social justice with multi-level action to understand the socio-historical context and address the present practices of disparate access to resources based on the social group memberships of a given community (Dalton et al., 2013; Evans, Rosen, & Nelson, 2014). Similarly, modern clinical psychology training often suggests that it is important to *consider* social context in clinical practice (Clauss-Ehlers et al., 2019), but with few explicit didactics or emphasis on how to do so. When students *are* taught about social justice and environmental context in their clinical coursework, programs often de-emphasize or limit exposure to a single course. Thus, clinical psychology doctoral training tends to focus solely on diversity and raising awareness of differences across social identities, with little integration across courses, research and practical experiences (Green et al., 2009; Gregus et al., 2020). The term 'diversity' is a frequent proxy for social justice; however, awareness of diversity does not directly translate into using skills or taking action to dismantle opression, which are essential for social justice work. This lack of guidance leads to training gaps, uncertainty, and discomfort among clinicians serving historically oppressed populations. As a result, students are left with rudimentary or inadequate skills as practitioners and change agents for social justice (Green, McCollum, & Hays, 2008; Knutson et al., 2020; Sanabria & DeLorenzi, 2019).

In contrast to the limited emphasis on social justice in clinical psychology, counseling psychology programs often aim to promote social justice goals through multicultural education and advocacy training (Ali et al., 2008; Baranowski et al., 2016; Field et al., 2019; Sanabria & DeLorenzi, 2019). For example, Hays and colleagues (2007) explored counselors' experiences of privilege and oppression in the context of the therapeutic relationship to understand how to better provide multicultural education and training to students. They found that counselors were often aware that the counseling relationship could be affected by differing levels of cultural power, and that their responses and interactions with clients sometimes provided insight into their

own awareness of privilege and oppression. In a classroom setting, Brinkman and Hirsch (2019) created an advocacy proposal assignment for a multicultural counseling course that sought to increase students' perceived importance of and intentions to engage in advocacy work. However, their findings indicated that there were no significant differences between the students who completed the advocacy proposal assignment and a comparison group on the intent to or importance of advocacy. Despite the emphasis on multicultural education and advocacy in counseling psychology, there is little evidence that these strategies actually improve awareness and advocacy in practice. Furthermore, the community psychology social justice principles are composed of various multifaceted and overlapping components that include and span beyond multicultural awareness and advocacy alone (Dalton et al., 2013; Dalton & Wolfe, 2012; Evans, Rosen, & Nelson, 2014).

Thus, to effectively build social justice acumen and practical skills among developing psychologists, it is critical to integrate a social justice framework into all applied psychology training institutions, course work, and field experiences (practica) (Baranowski et al., 2016; Evans, Rosen, & Nelson, 2014; Green, McCollum, & Hays, 2008; Knutson et al., 2020; Sanabria & DeLorenzi, 2019). Currently, in both clinical and clinical-community psychology doctoral programs, there are few opportunities throughout clinical coursework and practica experiences to focus on social justice. One way to address the gap between social justice and clinical practice may be to integrate community psychology's social justice principles into the key components of clinical practice (i.e., intake processes, treatment planning, therapeutic alliance, advancing client wellness, measurements/testing, referrals, etc.). For example, it is possible to apply social justice principles to clinical work with the values and foundational competencies of community psychology practice. Community psychology values include: recognizing the strengths of individuals/communities, respecting and celebrating human diversity, making referrals to and equitably allocating resources, analyzing power and systemic issues (acknowledging many social problems are created by institutions rather than individuals), being proactive/preventative, and collaborating with individuals/communities in fair decision-making processes (Dalton et al., 2013; Evans, Rosen, & Nelson, 2014; Rappaport, 1977). Further, the foundational competencies in community psychology practice include the ability to articulate and apply multiple ecological perspectives in practice, empowerment through supporting marginalized communities to gain access to resources and contribute to community decision-making, sociocultural and cross-cultural competence, including valuing and integrating multiple worldviews and identities, community inclusion and partnership, and ethical and reflective practice for continuous professional ethical improvement (Dalton & Wolfe, 2012; Wolfe, 2019). Given the inherent overlap between the above community psychology values and competencies as they relate to the critical training opportunities for rising clinicians, we sought to understand students' experiences of integrating these guidelines into clinical practice.

The current study focuses on the perspectives of doctoral students as a "bottom-up approach" to understand how to integrate social justice into clinical practice (Larrison, 2000). This bottom-up approach can be an act of social justice within itself, as it de-centers field "experts" in power, such as faculty at the "top," and re-centers individuals who have less power and are experts in their own experiences, such as students at the "bottom" (Larrison, 2000; Lundy & McGovern, 2008; Prilleltensky, 2001). Although faculty and academic leadership in doctoral programs have more power than students to implement department-wide changes to intentionally integrate social justice into clinical training, an objective of these changes would be to support student development and, ultimately, competence in a given area. Thus, when departments make changes for students, students should have a say in what may be helpful based on their preliminary experiences. This aligns with the community psychology competency of community inclusion and partnership (Wolfe, 2019). Further, beginning with students in this bottom-up approach provides a critical, early intervention point for social justice integration and creates a knowledge base to inform doctoral training competencies, program gaps, and students' training needs. Thus, the current study explores how students in clinical and community psychology

doctoral programs incorporate a social justice framework into multiple aspects of clinical work. We sought to understand the relations among community psychology and social justice principles, and how these can be integrated into clinical psychology training. Specifically, our primary research question was *How do clinical-community psychology doctoral students integrate social justice into clinical practice?* Ultimately, the goal of this study is to improve doctoral training programs and better prepare clinicians to support the equitable wellness of diverse communities.

Methods

Data Collection Procedure

Recruitment

To identify potential participants, the research team reviewed the list of clinical and community psychology doctoral programs that were listed on the Society for Community Research and Action (SCRA) website (https://www.scra27.org/what-we-do/education/academic-programs/). SCRA is Division 27 of the American Psychological Association and represents community psychology. Initially, we identified nine doctoral programs that listed dual training in clinical and community psychology; however, after visiting the program websites, we removed two programs from our recruitment list because community psychology was a concentration rather than a dual emphasis of the PhD program. This resulted in seven doctoral programs that had dual clinical and community PhD programs: Bowling Green State University, DePaul University, Georgia State University, University of Alaska-Anchorage, University of Illinois Urbana Champaign, University of Maryland Baltimore County, and the University of South Carolina. All programs, because they were clinical and APA accredited, adhere to clinical psychology training requirements. However, although all programs had a focus on both clinical and community psychology, there was some variation in program models such that some programs described more integrated clinical-community training than others and there was variability in terms of required practica in the community (as noted in their online program descriptions). For example, the University of Maryland Baltimore County (UMBC) offers several single program tracks such as clinical psychology, community psychology, and behavioral medicine, and students may opt to take a single track or combine two tracks, such as clinical and community psychology. At UMBC, although there is nearly an equal amount of clinical and community psychology courses in the dual-track, there is no intentional integration between the two tracks in coursework or training, and students must take several years of clinical practicum, yet there is no required community-based practicum for dual-track students (UMBC, 2020). In contrast, the University of Alaska-Anchorage (UAA) has a unique location and focus on indigenous populations. According to its program description, UAA has a strong training emphasis on "community-based action" and indigenous cultural context, and it requires a community-based practicum, termed a "cultural experience". The cultural experience consists of "direct exposure to Alaska Native and other cultural worldviews, values and life experiences through contact with cultural elders and advisors" (UAA, 2020, p. 16). Further, the UAA program description specifies the required integration between clinical and community psychology. For further information on the various structural descriptions of clinical-community programs, you may visit the aforementioned [SCRA website]. However, it is important to note that while program descriptions vary, it is difficult to ascertain from these online descriptions how clinical-community and social justice integration actually occurs in training programs.

To recruit potential participants from the seven clinical-community psychology doctoral programs, we used a combination of convenience and snowball sampling methods. Research team members first emailed a letter to faculty at several institutions and asked those faculty members to forward the email to their doctoral students. The recruitment email advertised the "Social Justice in Clinical Training study," detailed participant

eligibility, and stated the purpose of the study: *to learn how community psychology social justice principles may be integrated into clinical psychology training and practice*. We were also able to obtain student email addresses through several program websites. When student email addresses were available, we sent the recruitment email with the study information directly to students.

The recruitment email provided a link to a short questionnaire that included the informed consent and asked for demographic information, program and clinical training experience, and contact information for scheduling an interview with a research team member. Eligibility criteria included any student who was enrolled in a dual track clinical and community psychology PhD program in the U.S. who had completed at least one year of clinical practicum, which may include supervised psychotherapy practice, assessment, or other clinical duties. Participants were informed that they would each be compensated $30 at the conclusion of a virtual 1-on-1 qualitative interview. Recruitment for the interviews concluded after 26 participants completed the study, with a minimum of three participants from each program.

After all interviews were completed, 6 students were asked to participate in a focus group to review the initial themes and provide recommendations for the study. More detail on the focus group is provided below.

Procedure

As noted above, the recruitment email included a link to an online Qualtrics form, which included an electronic informed consent and collected the participant's contact and demographic information. After providing consent and completing the Qualtrics form, the research team reached out to eligible participants to schedule a 1-on-1 interview via WebEx video conferencing technology. As participant data were collected, each was assigned a participant ID and any personally identifying information was stored separately from study data to protect confidentiality. All procedures were approved by the University Institutional Review Board.

All 26 participants who completed the Qualtrics form completed a virtual interview. All interviews were recorded and lasted an average of 61 minutes. After the interview was completed, participants were compensated with $30, which was paid through a free mobile payment app or cashier's check. Also after the interview, participants were emailed a brief Google document of resources to supplement their education on how to integrate social justice into clinical practice. These resources included videos, podcasts, blogs, and books surrounding active anti-racism and decolonizing mental health, and are available online here or upon request by emailing the first author. All interviews underwent human transcription by a verified Black-owned business, ThoroughScript.

Interview Questions

The research team developed a semi-structured interview guide that offered scripted probes, requests for examples, and options for clarification as needed. To understand how participants integrated social justice into clinical practice, the researchers narrowed the scope of theoretical social justice principles in a way that was relevant to students in doctoral training programs. The primary questions included: *In what ways, if at all, do you address oppression in your clinical practice? ...incorporate knowledge of social context in your clinical practice? ...work towards equity in your clinical practice? ...use a strengths-based approach in your clinical practice? ...facilitate empowerment in your clinical practice? In what ways, if at all, have you acknowledged and managed your privilege in your clinical practice?* And, *In what ways, if at all, do you advocate for your clients?*

Interview responses were analyzed and synthesized into a list of recommendations for integrating social justice into clinical practice.

Focus Group

After all 26 interviews were completed, the research team invited a sub-sample of participants to meet in a virtual focus group via WebEx video conferencing. Out of the 6 participants invited, 5 attended the

focus group meeting. The participants were randomly selected from the original sample using stratification to increase diversity in gender, race/ethnicity, and geographic area/institution. About 2 days prior to the focus group meeting, participants were provided the list of recommendations for integrating social justice into clinical practice so they could review and prepare their questions and thoughts. During the meeting, research team members asked the focus group to share their thoughts and suggestions to confirm or revise the recommendations. The focus group served as a reliability check to ensure that the research team's list of recommendations accurately reflected clinical-community students' experiences, concerns, and goals. At the conclusion of the meeting, focus group participants were compensated with an additional $30 via a free mobile payment app or cashier's check.

Researchers' Background Statement

Out of the 5 authors, the principal investigator identified as a Black woman in her 3rd year of doctoral training, 2 identified as Black men in their 2nd year of doctoral training, 1 identified as an Afro-Latino/Caribbean Hispanic woman in her 1st year of doctoral training, and the faculty advisor identified as a White woman. Four of the researchers, including the principal investigator, were current clinical-community doctoral students at the University of Maryland, Baltimore County (UMBC) and advised by the fifth researcher, a clinical-community faculty member at UMBC. All team members take a strong stance on the need to integrate social justice into all facets of research and practice on individual, community, and systemic levels. The researchers began this project because they experienced the effects of inadequate integration between clinical and community psychology doctoral training. These effects included an excessive and imbalanced workload, in which training opportunities and coursework prioritized clinical requirements while minimizing community perspectives and practice, especially in clinical training. Thus, the researchers sought to learn from other clinical-community doctoral students to understand and inform practice and training needs, with a long-term vision of supporting future student clinicians by creating a more clear and intentional integration between clinical and community psychology through a social justice framework.

Qualitative Data Analysis Plan

Phenomenological Approach

This study utilized a phenomenological approach to understand student experiences and describe how they applied social justice principles into their clinical practice. The focus group meeting last about 1 hour. Phenomenology was selected because researchers using this method often describe the essence of lived experiences across individuals who have all experienced a phenomenon (Cuthbertson, Robb, & Blair, 2020). As such, knowledge is co-constructed between the study participants and the researchers (Langdridge, 2007). This means that the researchers' choice to frame the interview questions around particular social justice applications aided in the data collection just as much as the recorded experiences of the study participants (Langdridge, 2007). Using a phenomenological approach, the research team developed themes, de-identified relevant examples, and inferred a list of recommendations from the common and unique experiences of participants. The inferences aim to add clarity and guidance on the phenomenon of integrating social justice into clinical practice.

Thematic Analysis

The research team employed thematic analysis to identify participant patterns of perceptions, experiences and practices. Thematic analysis is a method of identifying, analyzing, and reporting themes from qualitative data (Braun & Clark, 2006). The research team employed Braun and Clark's (2006) six phases of thematic analysis: 1) familiarize with the data, 2) generate initial codes, 3) search for themes, 4) review themes, 5) define and name the themes, 6) and generate the report. Researchers reviewed, summarized, and analyzed

the interview transcripts to develop themes and identify relevant examples from participants on social justice in clinical practice. The research team met weekly to discuss and refine proposed themes and ultimately co-developed a list of recommendations, inferred from participant experiences and validated by the focus group, on how to integrate social justice into clinical practice.

Results

Participants

Twenty-six adult doctoral students who were currently enrolled in a dual track clinical and community psychology PhD program participated in this study. For demographic information, participants self-reported gender, and identified as female/women (76.9%; N = 20), male/men (19.2%; N = 5), and non-binary/gender non-conforming (3.8%; N = 1). More than half (57.6%) of participants identified their racial and ethnic backgrounds as non-Hispanic and White (N =15); while 15.4% identified as Asian (N = 4); 11.5% as Hispanic/ Latinx and White (N =3); 7.6% as Black (N = 2), and 7.6% as more than one race (N = 2). Importantly, 9 participants identified with more than one race and/or ethnicity (34.6%) as they wrote in their responses. On average, participants were 29 years of age (M = 28.92; SD = 3.06; range 23- 36). Participants had completed at least one year of clinical practicum through their PhD programs, and 57.7% (N = 15) were entering their 3rd through 5th years of their doctoral training program (M = 4.81; SD = 1.58; range 2-7).

The findings from the interviews demonstrate how clinical-community doctoral students attempt to integrate community psychology social justice principles into their clinical practice. The results below begin with the bolded social justice principle heading, followed by a description of common participant responses associated with applying the social justice principle to clinical practice, italicized participant quotes as examples, as well as bolded key phrases to reflect the overarching themes in each area.

Addressing Oppression and Social Context to work towards Equity

Participants reported overlapping examples for integrating knowledge of oppression and social context into their clinical practice, and these experiences were also often related to advocacy and privilege. When conceptualizing clinical work, participants often referred to the client's **context through an ecological framework**. For example, one participant stated:

...From an ecological approach, we like to think about a person who's sitting in a chair. There [are] four legs of a chair that keep it firm and standing right so you're not leaning on one side and not falling. And I like to think about a person sitting in that chair in a different context which supports that person. Where's the foundation? How are they being supported through those legs?

A few participants' diagnostic decisions were made cautiously to **avoid pathologizing clients who were experiencing oppressive systems and contexts**. These participants noted examples in which their clients would have been considered paranoid or diagnosed with a personality disorder if not for considering the clients' social contexts of growing up in an overpoliced neighborhood and experiencing racism and marginalization. However, participants also noted that they **rarely had the power to question the validity or use of the Diagnostic Statistical Manual of Mental Disorders (DSM)** in their clinical placements. Thus, some participants reported that they did not consider social context in their diagnosis decisions, which aligned with the standards and protocols of their clinical placements.

Participants also addressed social context as a means to build the therapeutic alliance. For example, participants **asked clients about what their life experiences were like** to **acknowledge clients as the experts on their lives** and gain a better understanding of their daily experiences:

I will say that to a client and give them the expert seat for a minute to tell me, this is what it's like being this

kind of person in America today. Or in this kind of neighborhood today. Or whatever context we're talking about.

Thus, participants frequently conceptualized or asked about social context through an ecological perspective by considering how social group identification, living conditions with housing, family or neighborhood safety, experiences of historical oppression due to group membership, and structural racism may all impact the individual. More nuanced contexts were also considered, such as therapy attendance and resource referrals, by inquiring about the client's needs for tangible resources, such as transportation for in-person therapy sessions and reliable internet access for online telehealth therapy.

Utilizing Strengths-based Approaches

When participants were asked about how they incorporate strengths-based approaches into their clinical work, several participants replied with **standard evidence-based treatment modalities.** Participants emphasized these modalities because they believed a strengths-based approach was encouraged and emphasized, as with Acceptance and Commitment Therapy (ACT), and Motivational Interviewing (MI):

…I think that ACT is totally strengths-based. I think it really puts the person in the center and really… yeah, it's just like it's an evidence-based practice. Which our program really values.

Other modalities and tools were named as being typically deficit-based, such as Cognitive Behavioral Therapy (CBT) that focuses on changing *cognitive distortions* and *maladaptive behaviors*, or standardized assessments that were normed on majority White populations.

Regardless of whether participants leaned on specific evidence-based treatment modalities, all participants valued **centering the client's strengths within therapy**. Strengths included the client's character, values, skills, resilience, hobbies/interests, and social supports. Participants **collaboratively explored and utilized client strengths to validate** the client, their treatment progress and support their self-esteem:

An example...with an individual who struggled with substance use...We explored the rationale about the drinking, and we found out that it's partially because of a maladaptive avoiding behavior [to avoid anxiety]. So we are trying to reframe that and find more adaptive coping skills to cope with his anxiety. And then the strengths-based comes in...His cultural coping such as fishing, hunting, berry picking, and drumming, we incorporated those into his coping mechanism, [so] he doesn't have to go to drinking to cope with his anxiety for example.

Naming and nurturing client strengths often became a key method of facilitating empowerment in which the client could build skills in therapy to improve and apply their strengths outside of therapy in order to sustain their own wellness. Thus, naming and nurturing client strengths were a common part of treatment goals as well as an intentional means of reaching treatment goals. In essence, participant's strengths-based approaches often explicitly overlapped with empowerment as well as advocacy, as seen later in the results.

Facilitating Empowerment

When study participants were asked how they facilitate a client's empowerment, the majority of participants reported **connecting clients to local resources** and **advocating for equitable allocation of resources** based on a client's needs and social context. Some participants needed clarification on the term empowerment prior to answering. The interviewers clarified empowerment was an intentional shift of power and resources to the client. In response, participants often confirmed resource connection and further reported shifts of power occurring within their *client-centered* approaches to therapy, in which participants **collaborated with clients** in forming a treatment plan and encouraged clients to determine and amend treatment goals. **Psychoeducation** was also key in empowering clients to understand and choose their preferred

treatment option. Some participants, however, were not confident as to whether they facilitated empowerment in their clinical practice. When asked, one participant replied:

> *I think that my honest answer is, I have no idea. Again, talking with clients, asking how they're feeling about their own symptomology, their own coping skills, and stuff like that...working with clients to ensure that they do have the tools that they need to in order...to succeed or whatever. Again, it's all based on self-report. But I don't know. I have no idea if I'm empowering my clients or not.*

Another participant reflected on the **inherent client-clinician power imbalance** that may influence a client's self-report of empowerment:

> *...So that's what I try to do to empower the individual. But to say that they're empowered is a tricky thing, because there's a lot of power dynamics that will make it so that they might feel empowered…*

Thus, some participants expressed the concern that they were **unsure of how to best evaluate and confirm client empowerment**.

Acknowledging and Managing Privilege

When interacting with clients, the participants reflected on the multiple privileges they hold in the therapy room. This ranged from socioeconomic status, race, religion and the special advantage of their education alone. They discussed the **internal process** of acknowledging privilege as well as actively working on **gaining diverse perspectives**, and evaluating if any bias is impacting therapy:

> *That's a very clear educational thing for me to do. But then reading White Fragility also made me think, well, I'm reading a book written by a white woman. So maybe I should read something that is actually written by somebody in that oppressed group and see their perspective on how white privilege has continued to oppress them. And nobody was telling me to do that. I had to be internally motivated to do that and I will have to continue doing that…*

Personal evaluation of privilege was often a varied and **self-taught** experience among participants.

Effective Advocacy

Participants reported demonstrations of advocacy that involved both **voice and action** to promote what is best for their clients according to perceived and reported needs. Along with **connecting clients to community resources**, participants stated that they had **advocated for clinic procedural or structural changes.** For example, one participant was granted sound machines for their clinic's therapy rooms, upon noticing their absence, to protect client privacy. Another participant successfully advocated for a client's support animal to accompany them in the clinic to increase comfort and aid in therapy. Additionally, participants reported advocacy through **vocalizing client strengths** and **reframing client behaviors as adaptive** to clinical supervisors as well as community or institutional partners, including Child Protective Services and case managers. As noted by study participants, some community partners may not be as aware of a client's social context and may use deficit-based, rather than strengths-based, approaches or stigmatizing language when referring to the client. In this context, reframing normalizes the client's behavior or thought processes and facilitates empathy and understanding to protect the client's access to resources and equitable treatment. One participant discussed advocacy as:

> *…Really working with other people in the clients' lives to provide context and psychoeducation about the clients' presenting problems and what we were working on together. And I've used that as a way to try to involve others in treatment.*

Participants also reported **advocating for transparency** for their clients regarding diagnosis decisions and documentation:

> *That's asking if we can share symptom inventory reports with the client so that they can have that and see whatever data we're collecting. So a level of transparency there.*

However, study participants noted limitations of advocacy. **Advocacy frequency and quality can depend on the clinician's knowledge of and access to resources**, which can make traditional clinical contexts difficult settings for student clinicians to advocate in. For example, hospital placements for clinical practicum may restrict creative thinking and restrict resource access according to bureaucratic power hierarchies:

> *I think within a traditional clinical context, that work is a lot harder to do. Again, because you're not in direct communication with systems of power. You're **navigating within [systems of power]**."*

Study participants utilized a range of strategies to apply community psychology social justice principles to clinical practice. Many of their strategies (i.e., asking about the client's life experiences, naming and nurturing strengths, and reframing client behavior) as well as the social justice principles (i.e., strength-based approaches, empowerment, and advocacy) overlapped, as to be expected, with the primary goal of providing equitable treatment to clients.

Focus Group Feedback

After analyzing and summarizing the study themes, the research team developed a list of recommendations on how to integrate social justice into clinical practice to discuss with 5 focus group members, who were recruited from the original 26 clinical-community doctoral students. Focus group members asked key questions and requested more specific examples of how to implement social justice recommendations. The following list of recommendations were informed by study participant interviews and focus group feedback. Specific examples of how to integrate social justice into clinical practice are proposed in Table 1 below. Importantly, we note that these example conversations should be approached with sensitivity, as they reflect experiences of oppression and will be influenced by the power dynamics in the room, organization, and larger system.

Table 1: 10 Recommendations for Integrating a Social Justice Framework into Clinical Practice

Recommendations	Examples
1. Seek educational opportunities by Black, Indigenous, and People of Color (BIPOC).	• Educational opportunities include multicultural and policy classes, LGBTQ+ ally workshops, Black feminism and antiracism readings, social justice documentaries, racial equity webinars, decolonizing mental health podcasts and websites, and community-based practicum. • Contact the authors or review the following organizations/individuals for resources: artEquity for BIPOC navigating predominantly White institutions, Haymarket Books for social justice and equity, Dr. Jennifer Mullan and Shawna Murray-Browne on racial trauma and decolonizing mental health care.

2. When possible, seek clinical placement sites that align with your social justice values and may support you in learning and implementing socially just practices.	• Consider the power structures/dynamics of the site. What is the character/style of leadership?
	• During formal/informational interviews or personal reviews of clinical sites, inquire: How do you think the community perceives this clinic and what it stands for? How does the clinic's culture and values align with that of the community it serves?
	• What treatment accommodations are provided for clients from different cultures/beliefs, physical/cognitive/developmental abilities, transportation access, and clients with life stressors that may interfere with clinic payments or attendance? How is accessibility and equity supported?
	• Does the clinic offer queer-affirming care?
	• What didactics are offered to train clinicians how to rely less on harmful systems (e.g., child protective services, involuntary hospitalizations, law enforcement) to support immigrant clients and clients from oppressed and marginalized backgrounds?
	• How do clinicians at this site apply knowledge of social context to multiple aspects of practice such as with diagnosis decisions and how to measure progress?
	• How do clinicians at this site typically advocate and shift power and resources to clients?
	• How does the administration/leadership support clinicians' efforts in advocacy and facilitating empowerment? When microaggressions or harmful behaviors are expressed by clients or by leadership, what procedures and support are offered to safely address these behaviors?
3. Gather social context information in sessions with clients using open-ended socio-ecological questions.	• Social context inquiries may include: How would you describe your sexual preferences? What gender (or race, etc.) do you identify with? What other identities do you hold (e.g., father, student, competitor, activist, etc.)? Which identities are the most important to you? Which are the most visible?
	• What has been your experience living with that identity at home (in your community, at school, at work, in this country, etc.)? What are the advantages and disadvantages of this identity for you?
	• How might others (in family, community, etc.) perceive you? How do you perceive yourself?
	• How have ___political and current events impacted you?
	• When/where do you feel safe/unsafe?

4. Apply knowledge of social context, including historical/ current oppression, to provide equitable services in all facets of clinical practice.	• During case conceptualization and diagnosis decisions, understand that a person's environment and experience of their environment may meet diagnostic criteria for "signs and symptoms of a disorder", but they may actually be normal and justified responses to a circumstance. For example, if a client identified as a racial/ethnic minority and has had interactions with or concerns about the local police; then the client's presenting paranoia/hypervigilance may make sense and be conceptualized as an adaptation vs a diagnosis. • Apply social context to how you collaboratively measure a client's progress. For example, for a client with a negative body-image, the clinician and client may consider treatment progress as the client trying less to fit in with aspects of mainstream culture. Progress can range from tolerating the sight or feel of a bodily feature, to accepting, and one day praising/validating the feature. Addressing each feature may be its own milestone for this client. Modify treatment to fit social context: • Modify metaphors in Acceptance Commitment Therapy to be relevant to a client's culture or environment. • Change wording of "homework" assignments for therapy to "wellness activities" and offer alternatives to writing/paperwork for diverse learners (e.g., a physical activity, thought exercise, client's choice). Consider adding psychotherapy activities. • Change wording in Cognitive Behavioral Therapy to be more culturally sensitive and strengths-based, such as substituting "adaptive vs maladaptive/distorted cognitions" for "helpful and less helpful/unhelpful thoughts".
5. Evaluate and employ tailored strength-based approaches. Connect strengths to therapy goals.	• Do not solely rely on intake forms or manualized treatments to do the strength-based work for you. Provide additional validation, genuine feedback, and instill hope. For example, a clinician may ask a client, "Can I share my experience of you?" And if they say yes…"My experience of you is that you are so thoughtful and compassionate. These are great strengths. What would it look like if you showed that thoughtfulness and compassion towards yourself?" • Inquire and prioritize the client's preferred treatment goals and collaboratively explore and often acknowledge clients' natural strengths (e.g., tendencies to adapt, think flexibly, care for others, care for self, survive, grow, etc.). Then, show and remind clients the connection between their strengths and progress towards their treatment goals.

6. Facilitate and measure empowerment. Collaboratively establish what empowerment can look like for each client considering their social context and goals.	• Inquire about and do your best to fulfill client preferences on therapy and therapist type. With knowledge of the clinic's capacity and staffing during intakes/phone screens, ask, "What kind of therapist would you prefer (e.g., race/ethnicity, age, gender, sexual orientation, religious affiliation, etc.)." Fulfilling client preferences is a shift in power.
	• Ask the client, "What are your goals for treatment? What is a small step towards that goal that we can do once a week? What can you do at home to work on that goal? How often are you willing to do that? We can modify our goals as you see fit...What would make you feel more empowered (e.g., resources, moral support, sense of community/belonging, self-awareness, education, etc.)? How would you know that you are empowered? What would it look like; feel like?"
	• Providing psychoeducation also empowers by shifting the power/resource of knowledge. Discussions comparing/contrasting treatment options, brief handouts, and frequent reminders of the chosen treatment's concepts and key terms supports transparent collaboration and informs the client's treatment decisions with you and future providers.
7. Analyze your intersectional identities; acknowledge and manage privilege in and outside of therapy sessions with clients.	• Address your privilege, without being prompted by the client, in initial sessions and when relevant by self-disclosing your visible and salient identities while verbally acknowledging that the client's experiences and perceptions may differ from your own. Verbally express that you cannot and should not assume to know what someone else is going through.
	• An example statement: "I want to acknowledge that although I am your clinician and I have certain skills and knowledge, I do not know your experience. I am a queer White woman. My queerness may be stigmatized in some places, but it is not always visible. Whereas my visible Whiteness carries many advantages in this country. So, I don't know what it's like to be another identity other than my own. But I want to listen and learn from you so we can work together on your wellness." -Then, initiate identity exploration activities with the client. Note that the client is not responsible to act as your sole educator or the spokesperson for their entire community/culture. Do your own work outside of the therapy session, in addition to listening to your client. Be careful not to take up too much space with self-disclosure. The point is to be transparent, make genuine connections, and create a safe space for the client to share.
	• We recognize that many of these conversations are sensitive. We suggest that student clinicians frame their presentation of any questions related to the clients' identity with full transparency about why the questions are asked and how they will be used. For example, *'I am going to ask you some personal questions about your background and experiences. I am asking these questions so that I can learn more about you and who you are, and what your experience is like outside of our therapy sessions. You can always choose not to answer these questions or we can come back to them at a later time.'*

8. Advocate with voice and action in the clinic and in the community you serve.	• May reframe a client's behavior as a strength to supervisors or community partners (e.g., CPS, case managers, etc.) to normalize the behavior and facilitate empathy given the client's social context. Talk as if the client is in the room. Work towards the client's access to equitable care. • Leverage privilege and networks to acquire resources and structural/policy changes that benefit client wellness as well clinicians. • Advocate for yourself, too. Self-advocacy for self-care is just as important. As you accept new responsibilities, can you decline others? Reconsider maxing out your caseload too soon and multiple back-to-back clinical appointments. If possible, add 15-30min+ break in between some appointments. Intentionally make time for self-care, calling a friend, eating, walking, sleeping, and doing nothing.
9. Use education and compassion to safely confront oppressive behaviors (i.e., racist statements/ acts) with clients, staff, colleagues, etc.	• Consult with trusted colleagues and mentors to rehearse and review best practices on facilitating challenging conversations. Consider Dialectic Behavioral Therapy interpersonal communication techniques. Consider the objective and desired outcome of the conversation (i.e., mutual respect and understanding, treatment progress, personal growth vs. evoking guilt or shame, etc.). Then, consider what tailored phrases are appropriate to achieve the desired outcome while creating a safe space for both individuals to express respectful yet radical candor. Also consider possible consequences, likelihood of retaliation, and what safety precautions and allies may be necessary. • After weighing the risks and benefits, decide on your approach: to tolerate and deflect, ignore, document, explore the root of the oppressive behavior, educate, turn it into a treatment goal and work to substitute more helpful behaviors, clarify boundaries and definitions of respect, and/or to not tolerate; indicate at what point you may discontinue the professional relationship or file a formal complaint. • For clients, you may begin with curiosity, then education with defining the harmful words/behaviors and their impact. See examples of responding with curiosity and education below. • "When you say__, what is your goal; what impact do you want...expect?...and why? How does it make you feel when you say/do__? How do you think it makes others feel? Where might this behavior come from? Where else do you see/hear these behaviors/words (in childhood, home, community, TV, etc.)?" • "When you say__, I hear…" or "This is what ___may mean to others." If explicit harm continues, you may say, "I'm happy that you chose therapy as a safe space to grow. How are these words/behaviors adding to a sense of safety or growth?... Can we work together on alternative words/behaviors that allow you to still express yourself without harming others?...What helpful boundaries can we agree to so we can both feel respected (or welcomed) and listened to?"

10. Join local activism movements and organizations.	• Identify, join or collaborate with your institution's Diversity, Equity, and Inclusion committee or similar organizations to pressure your institution and community mental health structures to invest in antiracist-multicultural education and advocacy efforts of clinical trainees and supervisors to provide equitable services to clients.

Discussion

This study explored how doctoral students in dual clinical and community psychology training programs integrated social justice into their clinical practice. Our results suggest that integrating a social justice framework into clinical practice is a multi-layered, iterative process that requires critical reflection, on-going self-education, and action-oriented compassion for the equitable well-being of others. Our findings also confirm the need to expand social justice beyond multicultural education and advocacy training (Ali et al., 2008; Baranowski et al., 2016; Field et al., 2019; Sanabria & DeLorenzi, 2019). The 10 recommendations above are by no means a comprehensive protocol for how to incorporate social justice into clinical practice. They serve as a starting point and guide for student clinicians as well as training programs to develop a more socially just framework for clinical practice.

The integration of community psychology and clinical psychology through a social justice framework may not have been a conscious intention for all student clinicians in this study. This may be especially true for study participants who were enrolled in clinical and community psychology doctoral programs that were not fully integrated in their training models. However, participants employed a range of nuanced and overlapping clinical practice strategies that encompassed community psychology social justice principles. Such strategies included centering the client as the expert on their lives and inquiring about their life experiences with oppression and home/community life to understand their social context. As participants got to know their clients, many engaged in internal self-reflective practices as well as therapist self-disclosure of salient identities with clients as a means of acknowledging and managing their privilege. Acknowledging and managing privilege in therapy sessions coupled with gaining knowledge of a client's social context aided in building an authentic and trusting therapeutic alliance. Further, knowledge of a client's social context also informed ways in which participants facilitated empowerment and their work towards equity regarding what and *how* treatment services were delivered. Additionally, participants' use of strength-based approaches in treatment carried over into the client-centered language and strategies (i.e., vocalizing client strengths and reframing) used to advocate on behalf of clients to clinical supervisors and community resource partners. Many participants shared a critical awareness of the impact of systems on people's lives and a reflexive application of social context and other social justice principles. This may be indicative of standard community psychology values and training (Dalton et al., 2013; Evans, Rosen, & Nelson, 2014; Rappaport, 1977). Moreover, the frequent overlap of social justice principles and application strategies supports the feasibility of integrating community psychology social justice principles into clinical practice.

Challenges among Student Clinicians and Implications for Training Programs

Despite their valuable skills as student clinicians, participants highlighted several training gaps and challenges when applying social justice principles to their clinical practice. For example, some participants were uncertain about whether their empowerment facilitation was effective from the client's perspective, suggesting a need to identify methods of measuring and confirming client empowerment. In another example, participants noted that the standardized assessments and treatments that they were expected to administer on all clients were normed on majority White populations. Moreover, several participants listed standard evidence-based treatment modalities, such as ACT, as their primary method of using strengths-based approaches with

clients. This may indicate that there is a blanket reliance on Western evidence-based treatment modalities for diverse clients despite participant knowledge that these modalities are normed on majority White populations. Rather than relying solely on these Western tools, there may be a need to use Eastern and African therapeutic approaches as well as more tailored equitable approaches to integrate social justice into clinical practice. The recommendation list in Table 1 provides guidance on integrating social justice principles to work beyond Western clinical standards. For instance, a more equitable strength-based approach requires an in-depth understanding of historical and current oppression as it relates to the client and their strengths (i.e., resiliency, survival, compassion, etc.), the application of the client's socio-ecological context to diagnostic and treatment conceptualizations, and facilitating empowerment and collaboration to center client preferences and cultural perspectives during treatment planning.

Another challenge participants reported involved their capacity for effective advocacy. Specifically, some participants said that there were not always established routes to advocate for their clients and incorporate client-centered changes. Therefore, participants often had to think creatively or take calculated risks in confronting supervisors and community partners to do more for clients and to acknowledge client strengths rather than solely their deficits. According to participants, the effectiveness and extent of their advocacy for clients was dependent upon their knowledge of and access to local resources, as well as on the clinical setting and population. For example, it was often easier for participants to name advocacy when working with children and community schools compared to adults. In contrast, participants reported challenges within medical settings attuned for fast-paced/shorter-term interactions and a high-volume of clients. The structure of such settings may not allow the time and flexibility for clinicians to gather adequate social context to tailor advocacy and client care.

To address challenges in advocacy, focus group members emphasized the need for additional support from clinical supervisors and doctoral training programs in order to increase clinician knowledge of, access to, and the skilled use of resources to equitably shift power and resources to clients. Specifically, focus group members suggested that student clinicians should be granted financial and educational support for social justice efforts. Focus group members also expressed that student clinicians should be allotted "protected time" to focus on advocacy and empowerment work to properly invest in equitable client care.

Ultimately, the resulting recommendation list, as informed by participant interviews and the focus group, attempted to provide a guide for student clinicians' best practices. However, both study participants and the research team recognize the power limitations of student clinicians who may encounter negative consequences to their academic/professional careers and relationships for advocating too passionately or confronting oppressive behaviors, particularly in those with more power. Student clinicians may serve on the front-end of client care; however, the support of supervisors, training programs and greater systems of power are needed to actualize advocacy efforts, model what strength-based approaches and confronting oppression looks like, and collaborate with students to work towards equity in student training and clinical practice.

Clinical supervisors and training programs are called to question their traditional Western procedures, practices, and expectations. Consider the following: How might clinic procedures support or hinder equity for some students or clients? How often is student feedback solicited and incorporated to fill training gaps, particularly as it relates to socially just practices? How can facilitating empowerment and applying social context in clinical practice be better demonstrated for students? How can the principles of social justice be modeled within supervision relationships, meetings, class structures and training opportunities?

It is the explicit *how* of socially just practices that is often missing in clinical training. Although there is often not one right way, modeling and discussing examples along with proactive support will provide a deeper understanding of the *how,* which will result in more personally and professionally prepared future clinicians.

Study Limitations

This study had limitations that should be addressed in future research. First, the current study's sample was composed of primarily White women. Although White people do make up the majority of psychologists, as only 4% of psychologists in the workforce are Black (American Psychological Association, 2018), the authors expected more diversity among clinical-community psychology students. However, given our convenience and snowball sampling methods, as well as limited public program level data on demographic information, we do not know how well the sample reflects the social identities of students in dual clinical-community psychology doctoral programs. Second, because this study captured a cross-section of self-reported doctoral student experiences, there may be recall errors in participant's reports. However, we believe that asking for specific examples from participants may have alleviated this challenge. To address the current study's limitations, future research on this topic should expand the size and diversity of the sample to capture more diverse experiences. Finally, a longitudinal study may capture more recent reflections and examples of socially just practices. Longitudinal studies may also capture the progression and contributing factors of students' professional, clinical development as they learn how to navigate systems of power and integrate social justice into clinical practice.

Future Directions

The current research study illuminates the need for social justice integration beyond the individual level of clinicians, to expand to supervisors, faculty, and institutions with more power. As such, doctoral programs should actively work to integrate clinical and community psychology through a social justice framework within courses and training. Such integration can address training gaps regarding the incorporation of social context in diagnoses and assessments, effective advocacy, and measurements of empowerment. Even for purely clinical track programs, a social justice framework is necessary to create explicit praxis for providing equitable care to diverse clients. To inform these efforts, further research is needed to gather insights from individuals and institutions in power to create structural changes beyond the individual level. For example, future research should incorporate the feedback of licensed clinicians, clinical supervisors, faculty, university system leadership and even accrediting bodies to provide a more comprehensive framework for integrating social justice into clinical training and practice.

Future research and practice must also acknowledge the broader systems of harm and how clinicians can avoid reinforcing harm and maintaining the power of these systems. For instance, for several study participants who interacted with Child Protective Services (CPS) on behalf of youth clients, there was no discussion of the potential harms of CPS and other systems. Although the researchers did not ask directly, no participant spoke of the harms of systems that are commonly present in clinical work, such as CPS, schools, police, involuntary hospitalizations, and the unnecessary, ineffective or over-medication of clients. Such welfare, legal, and healthcare systems disproportionately harm people of color and should be addressed with caution, rather than with reliance on these systems. Future studies should explore best practices to understand alternatives to systems that can cause harm to clients and communities.

In closing, the fields of clinical and community psychology can and should enhance one another with the intentional integration of a social justice framework into doctoral training programs. This social justice integrative approach may also enhance the profession and training of single-track clinical psychologists as well as researchers and practitioners in diverse fields including, but not limited to: healthcare, social work, human resources, non-profit or organizational management, public administration, and public policy. Specifically, we provide an interdisciplinary tool that shows *how* to center the perspectives of students, clients, and social groups with less power; address oppression and social context for equity and decision-making; utilize strength-based approaches; facilitate empowerment; analyze and manage one's privilege; advocate for others with less power; and, overall, develop an applied social justice framework to inform and evaluate practices. Implementing these components ensures that social justice is more than just an abstract construct worthy of *consideration* in *some*

fields. Instead, social justice is an *interdisciplinary* and *action-oriented* framework through which to process and enact transformative change and equitable wellness for all.

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