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Macro MI: Using Motivational Interviewing to Address Socially-engineered Trauma

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ABSTRACT

Decades of social science data have illuminated how oppression and inequality on the macro levels of society can manifest as trauma and deprivation on the individual or micro level. However, clinical pedagogies within human services fields (social work, substance use disorder treatment, psychology, psychiatry) do not adequately reflect these advances. This creates barriers for service providers seeking to address socially-engineered trauma, i.e., trauma occurring in the context of oppressive macro structures such as white supremacist racism, neoliberal economic policies and cisgender-heteropatriarchy. Service provision that is structurally competent, on the other hand, exists at the intersection of macro and micro and offers both ethical and clinical advantages. Given its traditional focus on eliciting behavior change on the micro level, the therapeutic modality of motivational interviewing (MI) may not attract attention as a tool for addressing systemic social injustice. However, by integrating key elements of MI with SHARP – a framework for addressing oppression and inequality – new options for structural competence emerge. The resulting hybrid, Macro MI, offers tools to join with clients to assess the impact of structural oppression on individual problems, as well as to envision solutions that include macro systems change. Underpinning this approach is a belief that the collective work of tearing down and replacing the systems that create trauma is central to healing the wounds inflicted by oppression. Within Macro MI, activism, organizing and consciousness-raising are interventions to treat PTSD as well as tools for preventing trauma from occurring to other members of the community.

KEYWORDS

Motivational interviewing; trauma; structural competence; socially-engineered trauma

Introduction

Research over recent decades has documented how different forms of inequality and oppression on the macro level of social policies and social norms can manifest for individuals as physical deprivation and exposure to violence (Holmes et al., 2016; Prilleltensky & Gonick, 1996; Shaia et al., 2019). White supremacist racism, neoliberal economic policies and cisgender-heteropatriarchal rape culture, in particular, have been identified as macro-

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level engines of micro-level traumatic experiences (Shaia et al., 2019). As a result, psychologists, substance use disorder counselors, psychotherapists, social workers, psychiatrists and others who provide mental healthcare to women, racial/sexual/gender minorities and low-income individuals can use social science data and theory to understand how their clients' individual problems may reflect systemic inequities.

As a result of these scientific advances, a need has emerged to translate acquired knowledge about macro systems into micro-level clinical encounters. This search for tools reflects a broadening awareness among care providers that oppression and inequality exert significant influence over individual functioning and outcomes. Mental healthcare which includes an analysis of systems and uses it to enhance service delivery can be called *structurally competent*. This term describes clinical practice at "the intersection of individual and sociosystemic dynamics" (Gaztambide, 2019, p. 2028). Structurally competent approaches to therapy reflect the contributions of feminist therapy (e.g., Relational-Cultural Therapy), multicultural counseling, and theories of intersectionality.

There are four primary rationales for structural competence. First, it can enhance rapport between worker and client: by demonstrating an appreciation for how the social, cultural and historical contexts have contributed to the problem at hand, the provider reassures the client that she does not judge the client as exclusively to blame for experiencing the problem (Worthington & Atkinson, 1996). Second, macro frameworks can offer clinicians access to important areas of clinical inquiry. Third, helping clients to contextualize their individual experiences within macro systems can open the door for clients to join movements seeking to change those systems. Finally, structural competence allows service providers themselves to contribute to systems change by facilitating the entry of clients into social justice movements.

Intertwining macro and micro elements within clinical practice reflects the sociological theory of structuration (Turner, 1986), which proposes (in part) that macro systems or structures are reproduced on the micro level. In other words, patriarchy, racism and neoliberalism shape human experience and simultaneously depend on individual actors for reinforcement and replication. Changes to macro structures can therefore occur from the top down, e.g., when power holders enact new policies, or from the bottom up, when ordinary people change how they think, what they believe, and how they interact. Take for example civil rights activist Rosa Parks, whose individual refusal to reproduce one element of anti-Black racism changed American history.

Structuration theory offers a basis for understanding how traditional forms of mental healthcare, which focus on intrapsychic experiences rather than the systemic contexts of trauma (Burstow, 2003; Krawitz & Watson, 1997), can unintentionally reinforce oppressive systems by allowing them to remain invisible and blameless. Structurally competent clinical practice, on the other

hand, appreciates that psychotherapeutic interventions can and should have social implications. Simply put, unless and until oppressive, unequal social policies and norms are disrupted and transformed, the traumas engineered by the current systems will persist. Social justice activists, meanwhile, have long recognized that real systemic change requires broad-based grassroots political movements primarily composed of and led by individuals directly affected by the status quo (Mananzala & Spade, 2008).

Within this framework, how mental healthcare providers approach their work with marginalized clients can reflect their potential roles: contributors to systemic change or enablers of oppressive systems. In other words, to avoid propping up traumagenic systems, mental healthcare delivery should reflect the cumulation of data across multiple social science disciplines which, taken together, has demonstrated causality between social marginalization and trauma exposure (Shaia et al., 2019). Within an up-to-date scientific landscape, service delivery models which fail to reckon with the influence of macro structures on individual development and functioning now appear incomplete at best, and unethical at worst. The data speak too clearly: there is no longer any "neutral" space for clinicians to occupy.

This paper provides options for workers seeking to use the therapeutic modality of motivational interviewing (MI) with a structurally competent lens. First, a need for macro perspectives within micro-level client encounters is articulated. The second part describes SHARP (Shaia, 2019; Shaia et al., 2019), a framework for engaging clients in structural analysis. The section that follows proposes a theory of *Macro MI*, and the final parts integrate key MI techniques with the SHARP model to develop a fuller picture for how to deploy this familiar modality in new ways.

The need for macro intervention: Understanding socially-engineered trauma

Traditionally, research in health sciences and human services has understood trauma through an individualistic lens by focusing on healing the minds and bodies of trauma survivors (Burstow, 2003; Krawitz & Watson, 1997). Thanks to this work, disciplines including substance use disorder treatment, social work, nursing, psychology and medicine have expanded their skill-sets for responding to trauma at the individual or micro level. However, less attention has been paid to the root causes of some types of traumatic experiences: the social forces of oppression and inequality. These macro-level systems predispose certain social groups such as women (Fredrickson & Roberts, 1997), people of color (Carter, 2007), sexual and gender minorities (Bowers et al., 2005; Reisner et al., 2015) and low-income individuals (Cubbin et al., 2000) to certain forms of trauma exposure. *Socially-engineered traumas* (SET) have been defined as traumatic events rooted in the forces of oppression and

inequality (Shaia et al., 2019). SET should be contrasted with randomly-occurring traumatic events which do not unfold within political contexts such as racial and gender-based oppression and economic inequality.

The term socially-engineered trauma describes the nonrandom distribution of trauma exposure within an unequal society. According to this model, multiple intersecting elements of an individual's identity – race, gender, sexual orientation, economic class, religious affiliation, disability status, immigration status, etc. – can influence one's likelihood of experiencing trauma. Specifically, membership within a marginalized identity group increases one's likelihood of exposure to certain forms of trauma; the likelihood increases further for holders of multiple marginalized identities (Cronholm et al., 2015; Voith et al., 2020) . In this way, group-level "vulnerability" is imposed by the social, political and economic environment, rather than arising from any intrinsic susceptibility. In the words of feminist scholar Bonnie Burstow, ours is "a world in which [marginalized groups] are routinely violated both in overt physical ways and in other ways inherent in systemic oppression and where the psychological effects of this violation are often passed down from generation to generation" (Burstow, 2003, p. 1294).

For example, research on the set of policies known as the War on Drugs has documented how, due to multiple intersecting forms of racism on micro, mezzo and macro levels, African Americans are more likely than members of other racial groups to be arrested, charged with drug-related crimes, denied bail, found guilty (or pressured into a guilty plea), given sentences of incarceration and denied opportunities for parole (M. Alexander, 2010). Individuals who are incarcerated, meanwhile, have higher rates of trauma exposure than those who are free (Anderson et al., 2016; Piper & Berle, 2019). (Specifically, incarcerated individuals face an elevated risk of physical violence and sexual victimization [Wolff et al., 2007]; an attachment framework would identify incarceration itself, and solitary confinement in particular, as inherently traumatic [Haney, 2018; Murray & Murray, 2010].) In this way, African Americans' disproportionate risk of exposure to the types of trauma that accompany incarceration can be described as socially engineered by the macro system of anti-Black racism. In other words, while individuals of any racial category may be incarcerated, within American society African American individuals have been specifically targeted for incarceration by means of policies such as the War on Drugs. In this way, racism imposes on African Americans the burden of an increased likelihood of trauma exposure. An intersectional view of this form of SET would identify the additional susceptibility of impoverished African Americans: for instance, how the system of cash bail in use in most states means that low-income defendants could face incarceration pre-trial (Appleman, 2016), further increasing the likelihood of incarceration-related trauma exposure.

Another example of SET is homelessness. Data has documented how the experience of homelessness is both traumatic in itself (Deck & Platt, 2015; Tsai et al., 2020) and also can increase one's risk of exposure to other forms of trauma (e.g., brain injury [Stubbs et al., 2020]). Street homelessness, as a form of trauma experienced almost exclusively by low-income individuals, can be described as socially engineered because America's neoliberal economic model fails to ensure universal access to safe, affordable housing (Rolnik, 2013). (Neoliberalism has been defined as an economic model that prioritizes fiscal austerity, privatization of public goods, financial and industrial deregulation, and the dismantling of the welfare state [Spolander et al., 2014].)

Looking deeper, an intersectional view of this form of SET could assess the particular susceptibility to homelessness-related trauma among transgender young people. This group is more likely than their cisgender peers to experience homelessness, and hence its attendant traumas, because of how the macro-level social norm of transphobia manifests on the micro level as family rejection of gender-nonconforming youth (Robinson, 2018). In other words, trans youth are not intrinsically more likely to end up on the streets – they are there because of social marginalization. For them, the trauma of homelessness is socially engineered.

Sexual violence represents another central example of socially-engineered trauma. With over 90% of rapes against women and men perpetrated by men (Black et al., 2011), sexual trauma can be understood as engineered by a system of patriarchal social norms which teach men that they are entitled to sex (Bouffard, 2010; Schwartz & DeKeseredy, 2008). This norm represents a central element of what feminist scholars and activists call rape culture (Buchwald et al., 1993; Harding, 2015). An intersectional view of this type of SET would assess the additional risk imposed on children with disabilities, whose rates of sexual victimization are higher than their non-disabled peers (McEachern, 2012; Wissink et al., 2015).

Because trauma has traditionally been studied in its individual/family as opposed to social/political contexts, many existing tools for responding to trauma do not account for the reality of SET. Providers across disciplines often attend carefully to the aftermath of trauma while ignoring the systemic conditions that helped to create it (Shaia, 2019). This imbalance reflects both the lack of tools for responding to trauma's social context as well as a reluctance on the part of many clinicians to engage in activities that feel "political." Ironically, a neutral stance places providers in the very situation they were avoiding – that of picking a side. By not pointing out when discriminatory contexts cause harm, clinicians may unintentionally reinforce a client's suspicion that the trauma exposure was her own fault. This is because experiencing "[p]ersistent, distorted cognitions about the cause of" trauma is both a symptom of posttraumatic stress disorder (American Psychiatric Association [APA], 2013, p. 272) and a natural consequence of the Western

cultural belief that individuals are fully responsible for their own situations (Rhodes & Langtiw, 2018). Hence, when working with marginalized groups, there is no politically neutral space for clinical service providers to occupy (Moreira, 2005; Shaia, 2019); the clinician is either reinforcing or disrupting a social culture that routinely blames clients for their problems.

Given that higher levels of shame have been associated with slower recovery from PTSD (Taylor, 2015), balancing micro skills with macro frames may represent an underexplored method for treating the cognitive distortions, self-blame and shame that often accompany trauma exposure (APA, 2013). An example would be exploring with a survivor the extent to which her experience of sexual trauma is connected to rape culture (social norms whereby men prioritize their sexual urges over the rights of others) vs. the decision to consume alcohol or her particular wardrobe choice. The term *socioeducation* (Shaia et al., 2019) describes this act of speaking factually with clients about macro systems such as white supremacist racism, neoliberal economic policies and cisgender-heteropatriarchal rape culture. Socioeducation is modeled on psychoeducation, whereby providers offer relevant information about diseases and symptoms as a way to assist clients to understand diagnoses and make informed treatment decisions (Colom, 2011).

Socioeducation is an example of a macro component of a micro-level intervention. Usually, clients know a great deal about racism, rape culture and impoverishment from their own lived experiences. When providers exchange information with clients about SET, clients can connect narratives of their life events to these big-picture frameworks when it makes sense for them to do so. Making political sense of personal issues can help decentralize self-blame, and macro frameworks can help clients assess whether larger forces may have contributed to their problems. In this way, placing trauma within its political context could promote recovery from PTSD by mitigating shame. Such conversations can be initiated with the simple question, "Would it be alright with you if I offer another perspective on that experience?" Of course, clients must be able to consent to macro-level approaches, and clinicians should defer to clients' assessments of whether these avenues of inquiry feel useful. Not all clients will be open to socioeducation; some will. The same is true of many clinical interventions.

Another way to combine macro and micro interventions is to help clients connect with relevant social justice advocacy groups in the community. As with any referral, the client decides for herself whether or not to pursue it; the provider's role is to offer appropriate options and then respect the client's decisions. A third option is to connect clients with policy advocates who can deploy client testimony (in person or in writing) to help advance legislation relevant to clients' lives and policy priorities. Such legislation could be on the municipal, state, federal or international level. A fourth option is to generate opportunities for clients to connect with one another to explore their shared

struggles in community, in the lineage of peer-to-peer consciousness-raising models developed by feminists of the Second Wave (Norman, 2006; Weitz, 1982). When co-facilitated by a clinician, such spaces may become billable as a form of group psychotherapy. In these and other ways, clinicians can adopt a "macro attitude" toward individual client encounters.

These examples of macro strategies represent clinical responses to the sheer volume of social science data demonstrating the causal relationship between oppression and certain experiences of trauma. Given what is known about the influence of macro factors on micro experiences – the scope and consequences of inequality and discrimination, the deliberateness and pervasiveness of norms and policies which advantage certain social groups at the expense of others – remaining exclusively focused on the micro aspects of clients' experiences now means willfully ignoring the macro. In terms of clinical pedagogy, when faced with the reality of socially-engineered trauma, it now appears arbitrary and detrimental to prioritize data about micro-level evidence-based clinical practices over data documenting the effects of oppression and inequality on health and wellbeing. As such, withholding relevant structural information from clients (as well as peers, supervisees, students, etc.) could be contrary to ethical practice.

More clinical interventions are needed which reflect and incorporate these data. To this end, the SHARP framework (Shaia, 2019; Shaia et al., 2019) provides a template for service providers seeking to bring a macro lens to micro practice.

SHARP: A model for embracing context in clinical practice

Structurally competent clinical practice is responsive to the context within which clients live and operate. These contextual factors cannot be addressed if they are not identified and explored in partnership with the client. In the lineage of feminist approaches to psychotherapy (Enns, 2004), this approach represents a deliberate pivot from the individualistic focus of traditional clinical inquiry toward a more balanced model which accounts for structural and environmental elements. On the other hand, models of service provision which focus primarily on the client's intrapsychic experience and which fail to incorporate analysis of macro structures can be described as context-avoidant.

One method for intertwining macro with micro is the use of a framework designed to bring a deeper understanding of social context directly into the client encounter. The SHARP framework includes five core components:

(1) ***Structural oppression***: What are the issues in the person's physical and social environment, outside her control, that impact the person and her ability to be successful?

These types of issues may include: lack of affordable housing, inaccessibility of dignified employment, inadequate access to healthy food, poor public transportation, lack of health insurance and lack of childcare. Any of these can impact a service plan or derail a well-intentioned clinical intervention. When the clinician fails to name relevant structural issues, she may reinforce an implicit social message that clients who can't get ahead simply have not tried hard enough and/or possess some intrinsic deficiency. Naming such barriers explicitly, on the other hand, validates the client's struggles with structural oppression.

(2) ***Historical context***: Historical context often can explain present-day barriers. What historical events impacting the individual's environment/community/family might be relevant to the issues the person is experiencing right now?

For example, the federal policy of redlining urban neighborhoods led directly to the creation of racially segregated, resource-poor residential areas (McClure et al., 2019; Zenou & Boccard, 2000); further, race-based barriers to homeownership prevented the accumulation and intergenerational transfer of wealth within Black families (Kuebler, 2013), contributing significantly to disproportionate impoverishment among African Americans to this day. As another example, a historical context for transphobia would name that the violent enforcement of the idea of binary gender identity is rooted within hegemonic Christian colonialism (Lugones, 2007; O'Sullivan, 2021).

(3) ***Analysis of role***: What will be the clinician's role in this service relationship: maintainer or disrupter of the status quo?

Given the individualistic micro focus of traditional clinical service provision, the act of considering structural oppression and historical context itself represents a disruption of the status quo. Finding ways to incorporate this context directly into the relationship with the client is the crucial next step. On the other hand, clinicians who do not identify or address macro contexts are complicit in perpetuating the idea that the client is entirely responsible for her circumstances. Deliberately or passively, clinicians are either disrupting or maintaining the status quo. There is no neutral space.

(4) ***Reciprocity and mutuality***: What strengths and gifts can the person share with the provider and with their own community?

Regardless of circumstance, every person is endowed with internal assets which can benefit those around her. One of the clinician's responsibilities is to help clients identify their strengths and determine how to use these to further individual and collective goals. This represents a shift away from viewing the client as broken and toward a recognition that the client is a fully capable person, filled with both realized and unrealized gifts, who has been impacted by structural and individual issues. All clients hold wisdom that can benefit clinicians and others.

(5) ***Power*** – What can the person do, alone and/or with others, to change the ongoing impact of historical and structural oppression?

Providers must uproot their conscious and unconscious racism, ableism, bias against drug-users and other forms of discrimination that prevent them from recognizing their clients' political agency. One version of an integrated macro/micro service delivery model consists of connecting clients with each other to build consciousness around traumagenic

systems. Another consists of developing opportunities for clients to join social justice movements by offering referrals to relevant local groups. As with any referral, clients are free to make their own assessment of its relevance to their lives and priorities.

In general, the clinical tendency to prioritize individual and intrapsychic factors over relevant social, historical and political determinants of health reflects the origins of mental health within medicine (Boyle, 2006; Rhodes & Langtiw, 2018). The SHARP framework represents a desire to understand individual problems through the lens of relevant systemic factors and to envision solutions that include changing problematic systems.

As such, the SHARP model reiterates a truth articulated previously by feminist theorists and therapists: that mainstream constructions of trauma currently in use within American psychiatric culture are outdated and inadequate. Rather than promoting health, individualistic models cause harm when they reinforce the inaccurate cultural message that clients are responsible both for the origins of and responses to their problems. The SHARP framework proposes that the health of the individual and the health of the broader society are reciprocal and intertwined; hence, an individual cannot fully heal from socially-engineered trauma while unjust systems continue to pose risks to them and to other community members. For these reasons, recovery from SET must take place simultaneously on the micro and macro levels (Shaia et al., 2019).

The following sections will blend the SHARP framework with key elements of the psychotherapeutic modality of motivational interviewing. This hybrid represents one of many potential formula for moving away from context-avoidance and toward structural competence in clinical practice.

A macro take on motivational interviewing

Motivational interviewing is a time-tested, evidence-based practice for helping people make changes in their lives. It is currently defined as a "collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion" (WR Miller & Rollnick, 2013, p. 29). Rooted in the person-centered approach of Carl Rogers, MI is used widely in substance use disorder treatment, mental health and primary care settings to promote harm reduction and the adoption of healthy behaviors. Its strong research base, effectiveness in short-term therapies and emphasis on client/provider rapport have contributed to its popularity across practice sites (Madson et al., 2009). Given its focus on modifying behavior at

the individual level, MI may not attract attention as an obvious means of addressing social injustice; however, MI has a history of adaptation for specific ends or for work with certain populations. Myers and Houck (2011, p. 38) note a "tradition of pairing MI with other interventions" including Cognitive Therapy, Cognitive-Behavioral Therapy, Motivational Enhancement Therapy and 12-step treatment. These authors cite MI's "focus on collaboration to nurture inherent motivation" and "empathic and evoking style" (ibid.) to explain its compatibility with other modes of treatment. Motivational interviewing also can be adapted for use as a "prelude" to other forms of treatment as a way to elicit client motivation for engagement (Burke et al., 2003). This flexibility, as well as its documented effectiveness with racial minority populations (Hettema et al., 2005), render MI well-suited to macro adaptation. This new form of treatment can be called Macro MI.

Whereas traditional MI might seek to help a client decrease the amount of substances used or increase health-related behaviors such as exercise (W. R. Miller & Rose, 2009), within Macro MI the definition of "health-related behavior" is expanded to include activities such as social justice activism, community organizing, peer-to-peer consciousness-raising, policy advocacy and other forms of participation in macro-level systems change efforts. In addition to benefiting society by seeking to change traumagenic systems, these activities are understood to have a beneficial effect on individual mental health by decentering the shame and self-blame which commonly arise subsequent to trauma exposure. (Greater levels of community integration and participation also are correlated with positive effects on individual mental health [Baron, 2007; Pahwa & Kriegel, 2018) Macro-focused health-related behaviors need not eclipse traditional MI goals; there is room for both, as well as for clients to make their own assessments about which types of change feel right for them at a given time.

As in previous hybrids, within Macro MI certain aspects of the original protocol are emphasized and modified. The following section focuses on how the SHARP framework can bring structural competence to the MI technique of accurate empathy.

Accurate empathy during the assessment process

Within traditional MI, clinicians are encouraged to be curious about the client's experience of her problem as well as the client's theories for how the problem came to exist (WR Miller & Rollnick, 2013). This curiosity forms the basis of the MI skill known as accurate empathy. According to C. Rogers (1959), empathy means sensing "the hurt or the pleasure of another as he senses it and . . . the causes thereof as he perceives them." Following Rogers, Levounis et al. (2017, p. 17) define accurate empathy as "making an effort to

understand the world from the patient's perspective." In other words, within MI, a shared understanding of how a problem came to occur forms a basis for addressing that problem.

Macro analysis can (and should) be accessed at any point during the client/provider relationship; however, this need to make sense of the origins of problems means that the assessment process represents the first opportunity for structural competence to take root and unfold. Within the SHARP framework, a central assessment question would be: did this client's problem arise, at least in part, as a reaction or adaptation to social/historical conditions and/or socially-engineered trauma? In other words, is the client struggling to manage physical or psychological pain arising from traumatic experiences of impoverishment, economic exclusion, transphobia, homelessness, sexual violence, etc.?

In fact, it is reasonable to suspect that, among clients whose presenting problems are connected to prior experiences of trauma, some such traumas were socially engineered. For example, a clinician working with a client seeking to change her relationship with binge eating could be curious whether this "disorder" may represent a coping strategy that emerged subsequent to experiences of sexual trauma imposed by rape culture. Trauma scholar Felitti (originator of the ACE Study, which emerged from his failed attempts to treat binge eating disorders [Stevens, 2012]), notes that a client's problem often represents an "unconsciously chosen solution to unrecognized traumatic life experiences that were lost in time and further protected by shame, secrecy, and social taboos against exploring certain realms of human experience" Felitti (2019, p. 787). In fact, a significant positive association has been identified between childhood sexual abuse and binge eating disorder in adult women (Caslini et al., 2016). Should a client choose to disclose a history of childhood sexual abuse, the *Structural oppression, Historical context* and *Anlysis of role* elements of SHARP call upon the clinician to engage with the fact that this form of trauma did not occur spontaneously, in a vacuum; there is a social context (patriarchal rape culture) which may explain it.

Within Macro MI, ignoring relevant macro factors during the assessment process represents context-avoidance; alternatively, using SHARP to expand accurate empathy creates space for structural competence. During any clinical assessment it is useful to remember that trauma, as noted by Felitti and codified within the DSM-5 diagnostic criteria for PTSD, is often experienced subjectively as shameful. For this reason clinicians should not assume clients will volunteer relevant information about antecedent traumas that may have played a role in the development of the presenting problem (Carson et al., 2020). Once sufficient rapport is established and the client has provided consent, clinicians can inquire whether a history of trauma

underlies the presenting problem – learning about "the causes [of the client's hurt] as he perceives them." If the client chooses to disclose a history of trauma, the clinician can join with the client in assessing the extent to which the trauma was socially engineered. This is an essential intervention of Macro MI.

This interaction should feel like a transparent and collaborative process, with clients fully aware of why providers are asking about traumatic experiences. Here, structural competence describes a clinical attitude of curiosity about a problem's context and contributing factors beyond the individual and family levels. This term also refers to a relational dynamic that emerges between provider and client when macro analysis is incorporated into discussions about how and why the client ended up experiencing a given problem. That is, structural competence is a co-constructed, intersubjective dynamic between workers and clients who join forces to make sense of how the world works. This act of building truth together speaks to the *Reciprocity & mutuality* element of SHARP: clinicians are not teachers, nor clients students; both are learners, seeking wisdom together. Commonly, structural competence unfolds through the MI process known as "information exchange" (see subsequent section).

Should a client choose to discuss antecedent trauma, providers can note whether systemic factors such as oppression and inequality are accounted for within the client's narrative. If oppressive macro social structures did contribute to trauma, individuals may or may not identify these experiences as SET. Indeed, due to the American cultural norm of individualism and the trauma response of self-blame, it is typical for trauma survivors to elevate individual or family-level explanations for problems over systemic theories (Lannamann & McNamee, 2020). Moreover, issues of transference also could cause a client to self-censor; for example, a client's fear of being judged negatively by the provider if she identifies discrimination as partly to blame for her situation (Shaia et al., 2019). The *Analysis of role* element of SHARP encourages the provider to respond to these tendencies by proactively offering structural frames when analyzing problems, and allowing clients to indicate their level of interest in such avenues of inquiry. In this way, the SHARP framework offers a roadmap for providers who are concerned that remaining silent about structural contributors to trauma may in fact reinforce a client's (spoken or unspoken) shame and self-blame.

For instance, a clinician working from the SHARP framework who is talking with an unhoused client about the pain of living on the streets could name that the trauma of homelessness is not the fault of the individual, given that access to safe, affordable housing is a universal human right (United Nations, 1948). Of course, the client is free to accept or reject this idea according to her own judgment; however, the essence of *Analysis of role* is

that if the clinician chooses not to mention that a human rights violation is occurring, she may unintentionally reinforce the client's self-blame over finding herself homeless. In this scenario, leaning into structural analysis serves two purposes. First, it honors clients' intrinsic political *Power* by opening up a conversation about the movement for housing as a human right. Second, it increases identification between clinician and client by demonstrating to the client that the clinician does not blame or judge the client for her housing status, but rather seeks a balanced accounting of contributory factors.

In these ways, Macro MI uses accurate empathy to assess whether a client's explanation for her situation accounts for structural influences. Within Macro MI, accurate empathy encourages the clinician to be curious about the source of the client's pain as she perceives it. That is, to what extent does the unhoused client believe this trauma to be her own fault vs. the fault of an economic model that is not based on respect for fundamental, universal human rights, such as housing?

Based on the client's responses, socioeducation about neoliberalism may be indicated for instance, that the price of rental housing in America has increased 15% between 2001 and 2019, while renters' wages increased just 3.4% over the same period (Gartland, 2020). Referrals to housing justice activism groups in the community may be offered. Such macro interventions can and should exist alongside traditional MI goals such as helping the client assess whether getting off the streets and into a safer situation makes sense for her at this time. In this example, by using the *Structural oppression* element of SHARP to explicitly name the impact of a neoliberal economic model on housing status, the provider destigmatizes a taboo topic. Naming the "elephant in the room" in this way can enhance rapport, especially given that the provider and client probably have different housing statuses.

Whether or not they choose to articulate it, clients typically know or suspect that macro structures including white supremacist racism, neoliberal economic policies and cisgender-heteropatriarchy have directly contributed to their experiences of trauma. But given the taboo nature of race, class and gender issues within American culture, clients may feel hesitant to bring up these ideas (Qureshi, 2007; Sanders & Mahalingam, 2012). This hesitancy can be exacerbated by differences in power that naturally exist between client and provider, including with respect to race, gender, social class, neurotype, education level, immigration status, etc. As such, the obligation to introduce structural topics rests with the provider. Clinicians should not expect clients from oppressed identity groups to bring up oppression without it having been first named as a valid conversation topic by the provider (Cardemil & Battle, 2003). This may be particularly true when working with Black people, who are frequently stereotyped/discredited as "angry" when they point out oppression

(Ashley, 2014; Sue et al., 2007). Such issues of transference and countertransference are natural and inevitable when macro strategies are deployed within micro clinical encounters (Comas-Díaz & Jacobsen, 1991; Shaia et al., 2019). Properly managed, these direct encounters with structural complexity can deepen and enhance the client/provider relationship.

Macro MI offers clients the option of contextualizing experiences of trauma as lived manifestations of oppressive macro systems; hence, the clinician must possess a working knowledge of structural oppression. In the same way that clinicians working in the field of substance use disorder treatment must learn about the effects of different psychoactive drugs, various theoretical models of substance misuse and recovery, etc., those who serve marginalized populations must understand how oppression and inequality can contribute to individual impairment. At this time, the absence of structural analysis as a general professional norm represents an ignorance or sidelining of key data across multiple clinical pedagogies. Fortunately, in both macro and micro approaches, encyclopedic knowledge is not required for an intervention to be successful.

Certainly, one place providers can start is with the expertise of the client: respecting a client's accumulated wisdom and asking to benefit from it (*Reciprocity & mutuality*). Accessing professional trainings and participating in personal or peer-led study also builds provider structural competence. Regardless of its source, the cultivation of new knowledge is understood to be an ongoing activity for clinical professionals (Congress, 2012).

Other key interventions

Accurate empathy during the assessment process represents a key locus of structural competence, but other aspects of MI – information exchange, providing feedback, asking open-ended questions, focusing on change talk and change-related behaviors and responding to ambivalence – also offer opportunities for clinicians using the SHARP framework.

Information exchange

Within Macro MI, socioeducation is one component of structural competence and represents one form of information exchange, which is a basic MI activity (WR Miller & Rollnick, 2013). Acknowledging differential access to information between client and provider, Miller and Rollnick (ibid., p. 132) recommend a model of "Elicit-Provide-Elicit," within which "whatever meaty information you provide is sandwiched between two slices of wholesome asking" (ibid., p. 139). Which is to say, to be consistent with motivational interviewing spirit and practice, socioeducation must respect client self-

determination. Providers should not approach socioeducation as a one-way transaction. Clients, for their part, always can decide for themselves whether they are interested in exchanging information about macro structures which the clinician perceives as relevant.

The recommended course of action for initiating socioeducation is to use language along the lines of, "Would it be alright with you if I offer another perspective on that?" This frame, which MI would call asking permission, centers client autonomy and agency. If a client consents, clinicians can share ideas via the *Structural oppression* and *Historical context* elements of SHARP. As socioeducation is being offered, providers should attend carefully to clients' verbal and nonverbal cues (body language and facial expressions) to assess client interest. A client's emotional response to the intervention can describe both her level of interest and her relational experience with the service provider.

In terms of countertransference, providers who are less experienced with macro interventions may find the prospect of discussing socially-engineered trauma with clients to be risky or transgressive. If so, this is likely because the clinician was not trained to talk with clients about oppression. This gap in clinical pedagogy arises from a misconception of psychotherapy as apolitical (McNamee & Gergen, 1992; Rossiter, 2000); the SHARP framework's *Analysis of role* component highlights the risk that comes from not talking about SET: failing to identify the structural origins of trauma may reinforce client self-blame and shame. In other words, while the SHARP framework is explicitly "political," avoiding conversations about structural context also is political in that doing so implicitly props up oppressive systems by allowing them to remain invisible and blameless.

Providing feedback

Within Macro MI, feedback can be used to tap into client *Power* as a way to counteract the feelings of overwhelm, despair and hopelessness that may arise when confronting the enormity of oppressive social structures. Some macro problems (e.g., white supremacy and cis-hetero-patriarchy) are deeply rooted in premodern ideologies; others (e.g., neoliberalism) are contemporary constructions with global implications. As such, meaningful reform can feel impossible. On the other hand, examples exist of American social movements which have secured real advances in human rights: the movement for African American civil rights (including abolitionism), the labor movement, the women's movement, the disability justice movement, the LGBT rights movement. Though their work remains incomplete, these examples demonstrate the viability and necessity of grassroots social change.

For clinicians, providing feedback in the form of naming historical and contemporary campaigns for human rights is a way to assist clients who may perceive macro barriers as unchangeable and/or themselves and their peers as politically powerless. Modern-day movements such as Black Lives Matter, Fight for 15, the new Poor People's Campaign, Red for Ed, #MeToo, Defund the Police, Medicare for All and the Green New Deal represent fronts in the ongoing struggle for human rights within the United States. History has demonstrated that ordinary people can and should seek to influence the course of social policy and social culture.

Open-ended questions

Open-ended questions are core to the traditional motivational interviewing skill-set (WR Miller & Rollnick, 2013). (Open-ended questions, affirmation, reflective listening and summary statements are known by the acronym OARS [ibid.] which guides clinician behavior in a typical MI session.) Open-ended questions allow for a broad range of client responses and allow clients to talk freely and identify relevant topics (Tollison et al., 2008). Typical open-ended questions within an MI session might include, "How can I help address the problem that brought you in today?," "How well does your current situation reflect where you'd like to be?," and "What do you think you need to take the next step?"

According to the *Analysis of role* component of SHARP, how clinicians understand the purpose of their job influences the types of open-ended questions that are posed. In Macro MI, open-ended questions provide a ready format for bridging micro and macro. Examples include, "You mentioned feeling targeted by the police; would you feel comfortable talking more about how discrimination has impacted your experience?," "You mentioned spending years on the Section 8 waiting list; why do you think there isn't enough affordable housing in this community?," and "You mentioned not liking any treatment programs; how might your experience in recovery be different if you were cisgender?"

Open-ended questions of this kind are useful in two ways: they introduce structural concepts (*Structural oppression*) while sending a message that the clinician is interested in these areas of clients' wisdom (*Reciprocity & mutuality*). While some clients may respond freely, others might not; for some, thinking in structural terms may feel unusual and hence uncomfortable. A diversity of responses to Macro MI is normal and to be expected. Some clients who are not open to structural analysis at a given point in time may become more interested in macro frameworks as the relationship with the clinician deepens across repeated encounters. Other clients may instinctually frame their problems as personal failings while simultaneously harboring suspicions that larger structural forces also played a role in their situation. This inherent push and pull between micro and macro speaks to the heart of

motivational interviewing, which recognizes ambivalence as a natural state of human experience. Assisting clients to explore and resolve their ambivalence is one of the main goals of MI (WR Miller & Rollnick, 2013).

Focusing on change

In practice, client ambivalence plays out in their patterns of speech, and MI trains clinicians to recognize the difference between "change talk," which promotes behavior modification, and "sustain talk," which is associated with maintenance of the status quo (ibid.; Moyers et al., 2009). Change talk is defined as "any self-expressed language that is an argument for change" (WR Miller & Rollnick, 2013, p. 159) and can be subcategorized into preparatory change talk (articulated rationales, desires, and needs for change) and mobilizing change talk (indicative that ambivalence about change is resolving) (ibid.).

The same model applies to Macro MI, but the target and substance of change talk is different. Within Macro MI, broader structural forces – e.g., income inequality, the lack of affordable housing, the lack of dignity-wage employment, police violence against People of Color, the normativity of harassment of women and sexual abuse of minors – may be appropriate targets for change. On the individual level where MI takes place, "change talk" around structural forces consists of clients working toward acknowledging the need for system change (preparatory change talk) and subsequently articulating a plan to become involved in activism (mobilizing change talk). These types of interactions reflect SHARP's focus on clients' *Power*.

The traditional MI focus on change-related behaviors also translates easily to Macro MI; the only difference is the expansion of what counts as a "change-related behavior." Within Macro MI, a client's participation in peer-to-peer consciousness-raising, community organizing, social justice activism and/or policy reform efforts represents positive individual change.

Neoliberalism, white supremacist racism and cisgender-heteropatriarchy are three examples of macro-level engines that generate different types of traumatic experiences on the micro level. As such, uprooting these systems will prevent experiences as diverse as police violence, violence against trans people, homelessness and childhood sexual abuse from happening to other members of the client's community. Framing activism as altruism and community organizing as trauma prevention can be tools for engaging clients (and colleagues, students, etc.) in the work of systemic reform. The act of helping clients explore what they have to contribute to justice movements and learn about what others in the community are already doing to create change speaks to the *Reciprocity & mutuality* and *Power* components of SHARP.

Of course, in order to connect clients with systems change efforts, providers must themselves be connected to movements for social justice. The general absence of such connections between activists and organizers on the one hand and clinicians and service providers on the other represents another vulnerability across clinical pedagogies. This can be understood within the *Analysis of role*, which calls for reducing artificial boundaries between human service provision and movements for social change, and promoting connection and communication between healers and activists. According to SHARP, referral networks across the macro/micro spectrum ought to be cultivated as a matter of course during training programs. Often, providers entering clinical practice lack connections to grassroots social justice movements in their community and hence lack the ability to connect clients to those movements.

As such, a need exists to develop strategies for identifying local, viable social justice organizing opportunities; how to join clients in assessing whether these spaces are appropriate and accessible; and how to make the connections happen. This responsibility does not rest entirely with clinical service providers; activists and organizers also can build relationships with socially conscious clinicians who are ready and willing to assist them in growing their constituencies (i.e., base-building). Service providers can support activist movements to be trauma-informed and accommodating of individuals with diverse styles of functioning.

In regions or time periods where grassroots social justice movements are not active or accessible, and/or for clinicians who lack connections to such groups, therapeutic consciousness-raising remains a viable alternative. Derived from the pathbreaking work of second-wave feminist activists during the 1960s and 1970s, consciousness-raising (CR) relies on the experiences of individuals as a basis for generating knowledge about systems of oppression (Whittier, 2017). Clinicians who engage in CR-based techniques draw from critical pedagogy, an educational philosophy that "supports the empowerment of culturally marginalized and economically disenfranchised" participants (Darder et al., 2009). Interestingly, a foundational feminist text, the Redstockings Manifesto (Redstockings, 1969), explicitly states that "Consciousness-raising is not 'therapy.'" Likewise, the SHARP framework would name CR is not the end-goal of the clinical encounter itself, but may hold the potential for therapeutic impact. The *Power* element of SHARP argues that taking action to create change, rather than merely analyzing the nature of the problem, is an essential component of the clinical intervention. In SHARP, as in second-wave feminism, CR represents a tool for preparing to take collective action. CR can take place within individual sessions with clients as well as in group settings.

Participation in activism entails potential costs and risks which can be named and explored with clients who are interested in pursuing connections to movements. Activism can mean many things, ranging "from the mundane

to the extraordinary, from the protracted to the ephemeral" (Wiltfang & McAdam, 1991, p. 989). Writing letters, gathering signatures, recruiting other participants, organizing and attending demonstrations, and lobbying elected officials represent typical tasks; direct actions such as occupying buildings, blocking traffic, interfering with police activities and beyond may be deployed to disrupt business-as-usual (Della Porta & Fillieule, 2004). As there are typically no financial barriers associated with participating in grassroots activism, a chief measure of cost is time commitment. Risk – for example, of arrest or exposure to police violence – can be assessed based on the nature of the activity. Other risks include emotional burnout or feelings of despair when confronted with the complexity of systems change (see previous section, *Providing feedback*). Within this conversation, the clinician's role is to assist the client to explore her options, rather than to encourage a specific course of action.

Working with ambivalence

Responding to client ambivalence about change is the final motivational interviewing technique utilized by Macro MI. This skill embodies the fundamentally accepting and collaborative "MI spirit" (WR Miller & Rollnick, 2013). Given that ambivalence is regarded as normal, encountering uncertainty about change is an inevitable part of MI. When clients engage in sustain talk by expressing a commitment to the status quo rather than to changing, clinicians are typically encouraged to respond with OARS – open-ended questions, affirmations, reflective listening and summary statements – rather than attempts to persuade clients or talk them out of their positions.

This same approach applies in Macro MI, where there may be an ongoing tension between, on the one hand, a client's habitual shame and self-blame and, on the other, the clinician's drive (based on her *Analysis of role*) to balance micro with macro focus.

Renegotiating a position of self-blame, which for many survivors of trauma and abuse can feel instinctual, is not a quick or easy process (Au et al., 2017). Hence, in Macro MI as in traditional motivational interviewing, clinician willingness to encounter client ambivalence is necessary for change to occur.

Within Macro MI, one way to respond to ambivalence is to build structural competence, for example, by engaging in socioeducation. Consider for instance, a substance use disorder counselor who meets with an African-American client who is considering changing his heroin use. Through conversation it emerges that the client uses partly to manage his anxiety and depression due to living in a blighted Baltimore neighborhood overrun with violence perpetrated by the gangs that sell the narcotics he buys. He reports that some of his family members have died in shootings while others have joined the gangs.

The counselor, for her part, is aware that starting in the late 1930′s the federal policy of redlining contributed directly to the creation of resource-poor, racially segregated urban ghettos in major cities across the United States (Pietila, 2010). She interprets this as evidence that blight does not result from moral failure on the part of residents, but from deliberate, ongoing public and private sector divestment from redlined neighborhoods (Rothstein,) at all levels, from housing and public schools to trash collection. Coupled with an overinvestment in policing (Vera Institute of Justice, 2018), over recent decades Baltimore has seen a broad criminalization of poverty (Jobs Opportunities Task Force, 2018).

The counselor also is familiar with theories that understand addiction as a behavioral response to an intolerable lived environment (B. Alexander, 2008), one rife with chronic hopelessness (Malmberg et al., 2010), despair and a reasonable expectation of early death or extended incarceration. Gangs, though dangerous, provide needed income to individuals failed by the public educational system, excluded from the post-industrial job market and/or denied access to welfare benefits (Augustyn et al., 2019).

These perspectives may be of use to the ambivalent client if they challenge his perception that his substance use problem is the result of personal weakness. In MI, the idea that one is too weak to stop using heroin represents an argument against making a change. On the other hand, by leaning into the *Structural oppression* and *Historical context* elements of the client's situation, the clinician can reframe substance use as a logical behavioral response to an intolerable environment, one deliberately shaped by public policies on the macro level. This avenue of inquiry opens up other ways to talk about the problem: for example, that using heroin represents merely one option for how best to cope with the pain of impoverishment and segregation – and that other options may also exist. An ethical way to initiate this encounter is by obtaining consent with the simple question, "Would it be alright with you if I offer another perspective on that experience?" Respecting *Reciprocity & mutuality*, it is essential to presume that clients already possess awareness of the influence of macro systems; information exchange should build upon existing client wisdom, and providers should expect to learn from clients as well as share their own knowledge.

Service providers can feel ambivalent too

Ambivalence on the part of the provider is the final consideration in Macro MI. This can occur for any number of valid reasons, including but not limited to: the provider is unaccustomed to talking openly about race, class, and gender; she fears she lacks sufficient knowledge or training to engage in structural interventions effectively; she worries about disrupting relationships with clients by broaching "risky" topics; she benefits directly from the status

quo which Macro MI seeks to disrupt and, consciously or unconsciously, feels ashamed of this privilege; and/or she judges her client as unready or incapable of participating in such conversations.

Awareness of these internal barriers through self-reflection is core to structural competence. These problems can generally be understood as forms of countertransference and may be productively addressed with the provider's supervisors, colleagues and mentors as well as through ongoing personal and professional development opportunities. Simultaneously, it is important to recognize that ignoring data about the consequences of structural oppression is contrary to ethical direct practice (Shaia et al., 2019). The SHARP model contends that the failure of current pedagogies to adequately prepare providers for engaging in macro interventions is insufficient reason to avoid doing so.

It would not be within the spirit of Macro MI for providers to reserve macro interventions for clients who have (in the provider's subjective opinion) demonstrated sufficient "progress" on the individual/intrapsychic level. This may be particularly true in treating substance use disorders: due to a monolithic construction of substance use and addiction-related behaviors – an attitude reinforced by the War on Drugs and the moral failure theory of addiction – individuals who use substances are frequently perceived by non addicted members of society as helpless, hopeless and unable to contribute (Dickson-Gomez, 2010). A clinician who has internalized this perception of drug users may limit herself to micro-level interventions. In reality, clients are always able to decide if they are interested in macro analysis and system change efforts. On the other hand, being denied the option to talk about an individual problem on the structural level may represent a form of gatekeeping of the clinician's privileged access to certain forms of knowledge. Indeed, rather than waiting until the client has made "enough" progress before including macro content, initial meetings and intake evaluations represent the ideal setting for a clinician to engage the SHARP framework. Doing so normalizes the act of talking about structural issues.

Finally, ambivalence about macro interventions also may emerge within the provider's professional context. This is because across clinical practice it is normative to focus on micro-level problem-solving while ignoring relevant macro and systemic factors. Depending on workplace culture, incorporating structural analysis into case formulation and treatment may be met with collegial and supervisory interest, support, confusion or displeasure. As such it will be necessary for service providers to advocate for updated norms of clinical practice at the mezzo level – within institutions, agencies and practice sites. Without such a shift, direct practice will not adequately reflect research-backed advances in theory and ethics. Clinicians will continue to endlessly treat the downstream effects of traumagenic social norms and policies while failing to address their root causes. Whereas some may resign themselves to coexist with the

consequences of oppression and inequality, others will feel motivated to join with clients to address society's core problems. SHARP and Macro MI are tools for this second group.

Conclusion

Much has been written about the "spirit" of MI – the idea that motivational interviewing is more than the sum of its techniques and actually reflects a specific way for service providers to connect with clients on a human level (WR Miller & Rollnick, 2013). Macro MI has its own spirit one which constructs health and wellbeing collectively and relationally. Using this lens, providers can join with clients to name the ways in which problems such as substance use disorders can arise in reaction to experiences of trauma which are themselves collective and socially engineered. Following C. R. Rogers (1980), this rebalancing of individualist and collectivist constructions of trauma represents not just a change in therapeutic technique but the adoption of a new "way of being" with a client. Changing our collective social conditions has the power to change the lived experience of individuals within that society; hence, within SHARP and Macro MI, healing the individual necessarily includes healing the broader society, and vice versa.

To avoid reproducing oppressive social structures in their work with clients, clinicians can openly acknowledge these structures and identify their consequences. This means naming and engaging with the "elephants in the room" of race, class, gender, etc. The alternative leaving systems of power unnamed and unexamined – normalizes socially-engineered trauma and reinforces clients' self-blame and shame. Alternatively, performing this type of micro-level systemic disruption has the potential to contribute to social movements for human rights.

This paper has described one therapeutic scenario in which limited or no structural information is provided to clients in the course of the clinical encounter; this represents one end of a spectrum. At the other end are referrals and connections to activist movements seeking to change oppressive systems. There are many points in between these poles, and many ways to build structural competence within a session.

Grassroots political agitation, through the lens of the SHARP framework, represents both a demand for the redistribution of power as well as a collective attempt to heal from socially-engineered traumas. Mollica (2006) has previously identified altruism – particularly in the form of helping to prevent one's experience of trauma from happening to another person – as a key element in PTSD recovery on the group level. In other words, the work of tearing down and replacing the systems that create trauma may hold the power to heal the wounds inflicted by those systems. This work can unfold within therapeutic relationships.

Of course, SHARP and Macro MI are not the only options for providers struggling with the professional burnout that results from ongoing exposure to the consequences of failed social policies and oppressive social norms (Johnson et al., 2018). These models merely offer tools for engaging with marginalized populations in ways that respond to the data. Fundamentally, clinical pedagogies and the institutionalized rules of engagement for how workers should serve their clients – the *Analysis of role* – should be updated in order to reflect recent social science data. Because of these data, we now know that oppression and inequality are to be regarded as pathogens which cause impairment, disease and death. Pretending otherwise by ignoring the science is contrary to ethics as well as common sense.

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