Evidence-Based Practice in Psychology: The Effective Counseling and Psychotherapy

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SCHOOL OF EDUCATION

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About the presenter

- Education (Counseling Psychology)
  - Ph.D. at Indiana University (IU; Enroute)
    - Minor in Inquiry Methodology
  - M.A. at University of Denver (DU)
  - B.S.S. at Hong Kong Shue Yan University (HKSYU)
- Associate Instructor
  - Undergraduate courses taught:
    - Intro to Counseling Psychology & Positive Psychology (2017-2018)
    - Positive Psychology & Multicultural Counseling (2018-2019)
- Scholarships and Awards
  - Outstanding Achievement in Research Award – Awarded by DU
  - Counseling Psychology Research and Scholarship Award – Awarded by DU
  - Morgridge College of Education Dean's Scholarship USD $20,000 – Awarded by DU
- Research interests
  - Positive psychology and positive therapies
  - International populations
  - Suicide prevention

About the presenter

- Counseling Experience

  B.S.S. at Hong Kong Shue Yan University

  - Pok Oi Hospital Ng Ma Choi Kiu Memorial Family Multiple Intelligences Center, H.K.
  - Hong Kong Federation of Youth Groups
  - Hong Kong Association for Specific Learning Disabilities
  - Hong Kong Music Therapy and Counseling Association
  - Serve Shine Care Education Center

  M.A at University of Denver

  - Devereux Advanced Behavioral Health,
  - Counseling and Educational Services Clinic of University of Denver
  - Salvation Army Denver Harbor Light Center

  Ph.D. at Indiana University

  - Center for Human Growth (CHG; 2017-2018)
  - Community Conversations: Diversity Dialogue Initiative (2017-2018)
  - IU Health Charis Center for Eating Disorders (2018-2019)
  - From Cancer to Health Training Institute (2018-2019)

Today's agenda

- Thoughts on effective psychotherapies
- Relevant APA ethical principles
- Evidence-based practice in psychology
  - Myths and my stance
- The great psychotherapy debate
- Best available evidence
- Introducing some clinical measures
- Implications and applications

Is there any proof that psychotherapy works?

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Are there negative clinical outcomes?

- Hadley and Strupp (1976) reported on the responses of 70 well-known psychotherapy clinicians, theoreticians, and researchers **all** agreed negative outcomes occur.
- Buckley, Karasu, and Charles (1981) found that **21%** of the psychotherapists questioned who had received personal therapy reported their treatment was harmful in some way.
- Smith et al. (1980) reported that in their review of 475 psychotherapy outcome studies, **9%** of the effect-size measurements were negative.

(Mohr, 1995)

The practical situation

- *Dr. Brown, the director of an outpatient mental health clinic, is staying late to prepare for tomorrow's annual staff retreat. She is faced with multiple challenges including a growing demand for psychotherapy services and a reduced budget, and because the clinic was recently approved as an* ***APA-accredited internship site****, she also faces the challenge of how to train the next generation of psychologists in "evidence-based practice (EBP)." She decides to pose this question to her staff:* ***What does the research evidence say about providing effective psychotherapy and, specifically, how can we cost effectively apply this knowledge in our setting to improve the quality of care?***

APA Ethical Principle about Evidence-Based Practice

- Principle A: Beneficence and Nonmaleficence
  - When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because **psychologists' scientific and professional judgments** and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence.
- Principle B: Fidelity and Responsibility
  - They are **aware of their professional and scientific responsibilities to society and to the specific communities in which they work**.

(APA, 2017)

APA Ethical Principle in regards in Evidence-Based Practice

- 2. Competence
  - 2.04 Bases for Scientific and Professional Judgment
    - **Psychologists' work is based upon established scientific** and professional knowledge of the discipline.

(APA, 2017)

First, does psychotherapy work?

- APA Recognition of Psychotherapy Effectiveness (APA, 2013)
  - *"The general or average effects of psychotherapy are widely accepted to be **significant and large**" (Chorpita et al., 2011; Smith, Glass, & Miller, 1980; Wampold, 2001).*
- Psychotherapy is as **effective as or more effective than psychotropic medications** for various mental disorders, including many depression and anxiety disorders, and results in lower relapse rates than medications (Hollon, Stewart, & Strunk, 2006; Imel, Malterer, McKay, & Wampold, 2008).
- Those who receive psychotherapy achieve **much better outcomes** than they would have had they not received psychotherapy (Lambert & Ogles, 2004; Wampold, 2001, 2007).
- In Smith and Glass's meta-analysis (1977), results showed that average treated person is better off than 75% of the untreated persons (**Large effect size, Cohen's *d* = .8**)

Effect size	*d*	Reference
Very small	0.01	Sawilowsky, 2009
Small	0.20	Cohen, 1988
Medium	0.50	Cohen, 1988
Large	0.80	Cohen, 1988
Very large	1.20	Sawilowsky, 2009
Huge	2.0	Sawilowsky, 2009

Second, note the difference.

Evidence-Based Practice in Psychology (EBP)

$\neq$

Empirically Supported Treatments (ESTs)

The New York Times

(American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Pagoto et al., 2007; Wachtel, 2010; Westen, Novotny, & Thompson-Brenner, 2005; Brown, 2013, The New York Times, p. D4; Luebbe, Radcliffe, Callands, Green, & Thorn, 2007)

The primary reason for the confusion

- Treatment methods have been heavily focused in exploring therapeutic factors

  E.g., Chambless & Crits-Christoph (2006):

  "Of all the aspects of psychotherapy that influence outcome, the treatment method is the ***only*** aspect in which psychotherapists can be trained, it is the ***only*** aspect that can be manipulated in a clinical experiment to test its worth, and, if proven valuable, it is the ***only*** aspect that can be disseminated to other psychotherapists (p. 199, emphasis added).

  E.g., Baker et al. (2008):

  "Research on nonspecific effects [that is, aspects of the CF approach] provides little support for the current practices of psychology, however. Legitimate and important issues surround nonspecific effects, but the resolution of the debate about nonspecific effects has little potential to validate a science-based practice of clinical psychology. It is important to note the ***marginal scientific status*** of those constructs (p. 82, emphasis added)…."

Okay, what is EBP and what are ESTs?

- According to the APA's Presidential Task Force on Evidence-Based Practice (2006, p.273):

- ***"EBPP starts with the patient*** (client) and asks what research evidence (including relevant results from RCTs) will assist the psychologist in achieving the best outcome."

- ***"ESTs start with a treatment*** and ask whether it works for a certain disorder or problem under specified circumstances."

Let's start with ESTs

- Focus on..

  Specificity/specific ingredients (e.g., Baker et al., 2008)

  - Specific techniques
  - Specific mental disorders
  - Specific mechanism of change
  - Specific scientific theory

  Some examples

  - Prolonged exposure (PE) for PTSD (Foa, Hembree, & Rothbaum, 2007)
  - Interpersonal therapy (IPT) for PTSD (Markowitz, Milrod, Bleiberg, & Marshall, 2009)
  - Cognitive behavioral therapy (CBT; Beck, Rush, Shaw, & Emery, 1979) and Acceptance Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012) for depression

Continue with ESTs

- Two core EST predictions
  - -Treatment specificity
    - Varies by Tx
  - -Disorder specificity
    - Varies by Sx
- Specificity in scientific methodologies

  Randomized Controlled Trials (RCTs) and experiments

- In short, ESTs – Specificity

  Specific ingredients → Specific effects

(Laska, Gurman, & Wampold, 2014)

Let's talk about CFs

- The Common Factors approach focuses on all (non-specific) factors that are necessary and sufficient for change:
  (a) an emotionally charged bond between the therapist and patient,
  (b) a confiding healing setting in which therapy takes place,
  (c) a therapist who provides a psychologically derived and *culturally embedded** explanation for emotional distress,
  (d) an explanation that is adaptive (i.e., provides viable and believable options for overcoming specific difficulties) and is accepted by the patient, and
  (e) a set of procedures or rituals engaged by the patient and therapist that leads the patient to enact something that is positive, helpful, or adaptive.

(Laska, Gurman, & Wampold, 2014)

Continue with CFs

- Core predictions (Laska, Gurman, & Wampold, 2014)
  - 1st: CFs will be efficacious in treating the presenting concern
  - 2nd: Relationship factors should predict Tx outcome
  - 3rd: Therapeutic Tx will be superior to placebo conditions
- Some examples
  - Person-centered therapy – the 3 conditions
  - Existential therapy – the 4 givens of existence
- Non-specificity in scientific methodologies
  - Quantitative research: Descriptive statistics, correlational designs…
  - Qualitative research: Case studies, interviews…

- In short, CFs – Commonalities
  - General ingredients → General effects

Then…

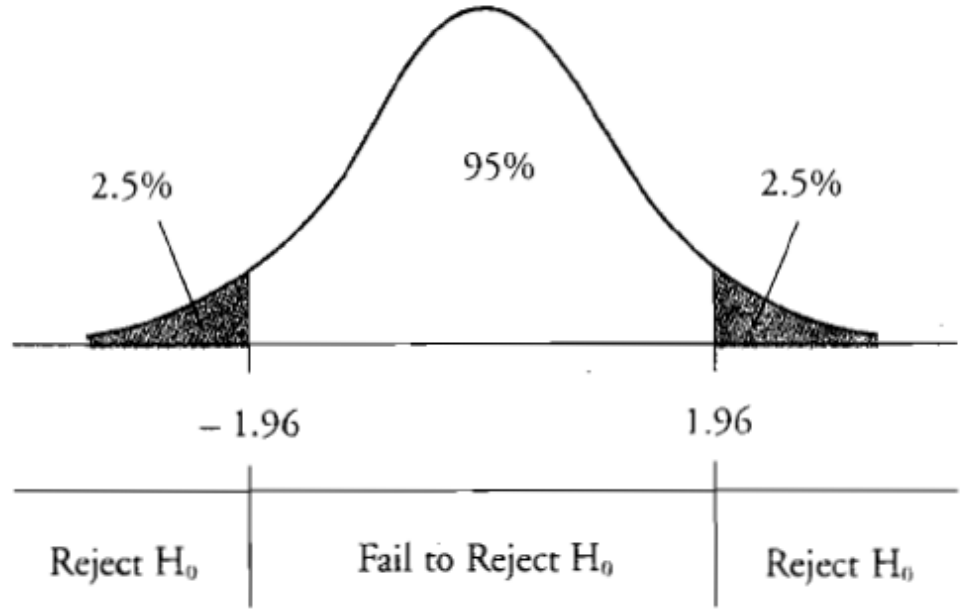
- Here comes the great psychotherapy debate

  ESTs vs. CFs

When $\alpha = 0.05$,

$H_0: \mu = 0$

$H_1: \mu \neq 0$



Therapists' Errors

- **Heuristics and biases—both cognitive and affective** (APA's Presidential Task Force on Evidence-Based Practice, 2006, p. 284)
- **Diagnostic Overshadowing/Underdiagnosing, confirmatory bias, fundamental attributional error** (Spengler, Strohmer, Dixon, & Shivy, 1995)

Efficacy vs. effectiveness of psychotherapy?

- Godwin (2003) stated…

  Efficacy

  - Efficacy trials (explanatory trials) determine whether an intervention produces the expected result under ideal circumstances.

  Effectiveness

  - Effectiveness trials (pragmatic trials) measure the degree of beneficial effect under “real world” clinical settings.

My stance here

Expanding the lens of EBP:

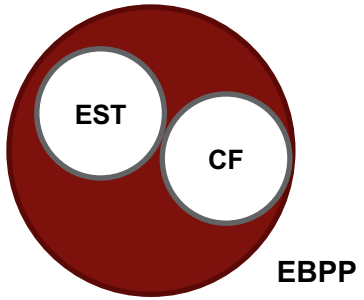
Embracing ESTs, but going beyond to appreciate CFs

Resolving the great debate

- The Dodo Bird Verdict (Luborsky, Singer, & Luborsky, 1975; Luborsky et al., 2002)
  - Psychotherapies reviewed were **generally equivalent** in terms of their outcomes, and decreed that the Dodo bird was correct.
- APA Recognition of Psychotherapy Effectiveness (APA, 2013, p.103)
  - *"Comparisons of different forms of psychotherapy most often result in relatively* ***nonsignificant difference****, and* ***contextual and relationship factors often mediate or moderate outcomes****."*

Best available research evidence

- Back to EBPP
  - Evidence-based practice in psychology (EBPP) is the **integration of the best available research** with clinical expertise in the context of patient characteristics, culture, and preferences (APA's Presidential Task Force on Evidence-Based Practice, 2006).
- Best research evidence refers to **scientific results related to** intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields (APA's Presidential Task Force on Evidence-Based Practice, 2006).
- **Multiple research designs contribute to evidence-based practice**, and **different research designs are better suited to address different types of questions** (Greenberg & Newman, 1996).



Best available research evidence

- Multiple types of research evidence
  Tx efficacy and clinical utility
- Research directions
- Clinical expertise
  Competence attained by psychologists through education, training, and experience that results in effective practice
    - Assessment, diagnostic judgment, systematic case formulation, tx planning
    - Clinical decision making, tx implementation, monitoring of client progress
    - Interpersonal expertise
    - Continual self-reflection and acquisition of skills
    - Evaluation and use of research evidence
    - Understanding of individual, cultural, and contextual differences on tx
    - Seeking available resources as needed (e.g., consultation, alternative services)
    - A cogent rationale for clinical strategies
- Client characteristics
- Individual differences

(APA's Presidential Task Force on Evidence-Based Practice, 2006)

Further note on clinical judgment and best available evidence

- Statistical prediction versus clinical judgment

  Statistical prediction

  - Definition: Based on empirical grounds, with statistical forumlae providing “objective” actuarial basis for decision-making

  Clinical judgment

  - “...cumulative wisdom that practitioners acquire from experience” (p. 24, Wiener & Greene, 2017)

Further note on clinical judgment and best available evidence

- Dawes, Faust & Meehl (1989):
  - Review of nearly 100 studies, with statistical prediction **equal or superior** to clinical in every study!
- Grove et al. (2000):
  - Meta-analysis of 136 studies, with statistical prediction approx **10% more accurate** on average
- Æquisdótti et al. (2006)
  - Meta-analysis of 67 studies, with statistical prediction approx **13% more accurate** on average

Defining psychotherapy

- Psychotherapy

  "… *is the informed and intentional application of* ***clinical methods*** *and* ***interpersonal stances*** *derived from* ***established psychological principles*** *for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that* ***the participants deem desirable***." (Norcross, 1990, p. 218-220)

  "…a primarily **interpersonal treatment** that is
  1) based on **psychological principles**;
  2) involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint;
  3) is intended by the therapist to be remedial for the client disorder; problem, or complaint;
  and 4) is **adapted or individualized** for the particular client and his or her disorder, problem, or complaint." (Wampold & Imel, 2015)

The Heart and Soul of Change: What Works in Psychotherapy

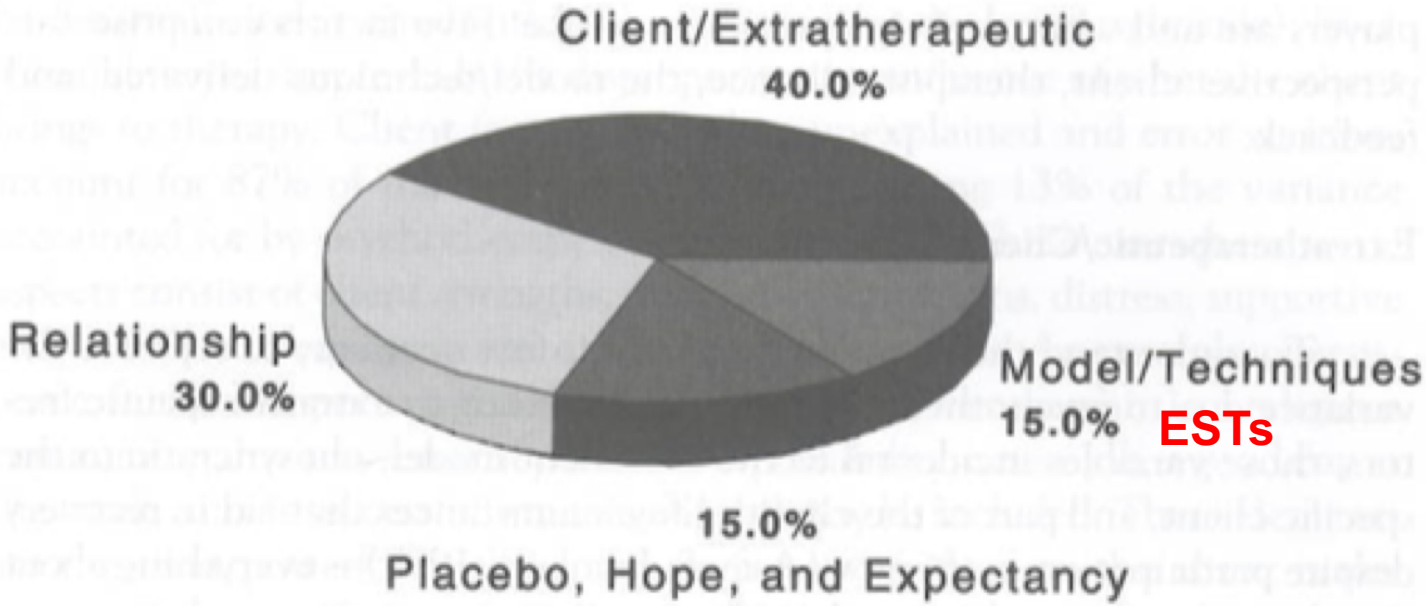


Figure 1.2. Lambert's Common Factors. From "The Empirical Case for the Common Factors in Therapy: Quantitative Findings," by T. P. Asay and M. J. Lambert, 1999, in M. A. Hubble, B. L. Duncan, and S. D. Miller (Eds.), *The Heart and Soul of Change: What Works in Therapy,* pp. 33–56. Copyright 1999 by the American Psychological Association. Adapted with permission.

Specifically, what the therapist can contribute?

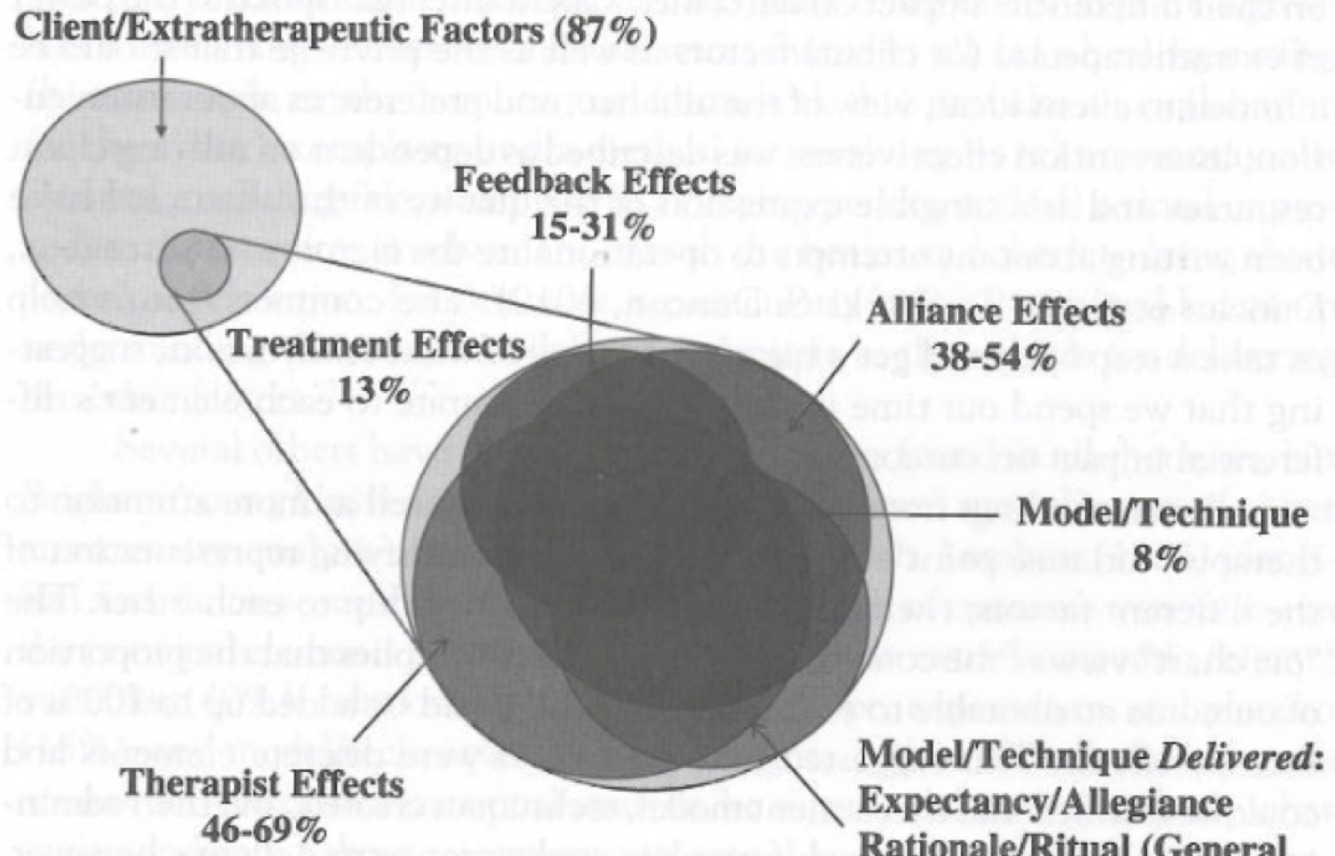


Figure 1.3. The Evolution of Common Factors with the Proposed Feedback Factor.

(Hubble, Duncan, & Miller, 1999)

Factors Influencing Successful Psychotherapy Outcomes

Therapist	Client	Therapist & Client	Therapy	Measurement of Outcome
Character Qualities (Wampold, 2011)	Client characteristics	Multicultural factors	Therapeutic modality*	Psychometric issues (reliability & validity)
Knowledge*	Stages of change	Communication	Therapeutic Healing setting	Research concerns
Training*	Psychopathology*	Therapeutic alliance (=Transference + Working alliance)	Therapy intensity, frequency*	Consistency
Therapist expertise	Symptomology*	Working alliance (=Tasks + Goals + Bonds)	Common factors	Timeliness
Clinical experience	Therapy expectation			Readability
Empathy	Help-seeking behavior			

14 Qualities of Effective Therapist (Wampold, 2011)

1. **Sophisticated set of interpersonal skills**, including verbal fluency, interpersonal perception, affective modulation and expressiveness, warmth and acceptance, empathy, focus on other
2. The therapist **creates trusting conditions in the first moments** of the interaction through verbal and importantly non-verbal behavior.
3. **Able to form working alliance** with a broad range of clients.
4. Provide an **acceptable and adaptive explanation** for the client's distress.
5. Provides a **treatment plan that is consistent with the explanation** provided to the client.
6. Therapist is **influential, persuasive, and convincing.**
7. Therapist **continually monitors client progress in an authentic way.**

14 Qualities of Effective Therapist (Wampold, 2011)

8. Therapist is **flexible and will adjust therapy** if resistance to the treatment is apparent or the client is not making adequate progress.

9. Therapist **does not avoid difficult material** in therapy and uses such difficulties therapeutically.

10. The effective therapist **communicates hope and optimism**.

11. Effective therapists are **aware of the client's characteristics and context**.

12. The effective therapist is **aware of his or her own psychological process** and **does not inject** his or her own material into the therapy process unless such actions are deliberate and therapeutic.

13. The effective therapist is **aware of the best research evidence related to the particular client, in terms of treatment, problems, social context**, and so forth.

14. The effective therapist **seeks to continually improve**.

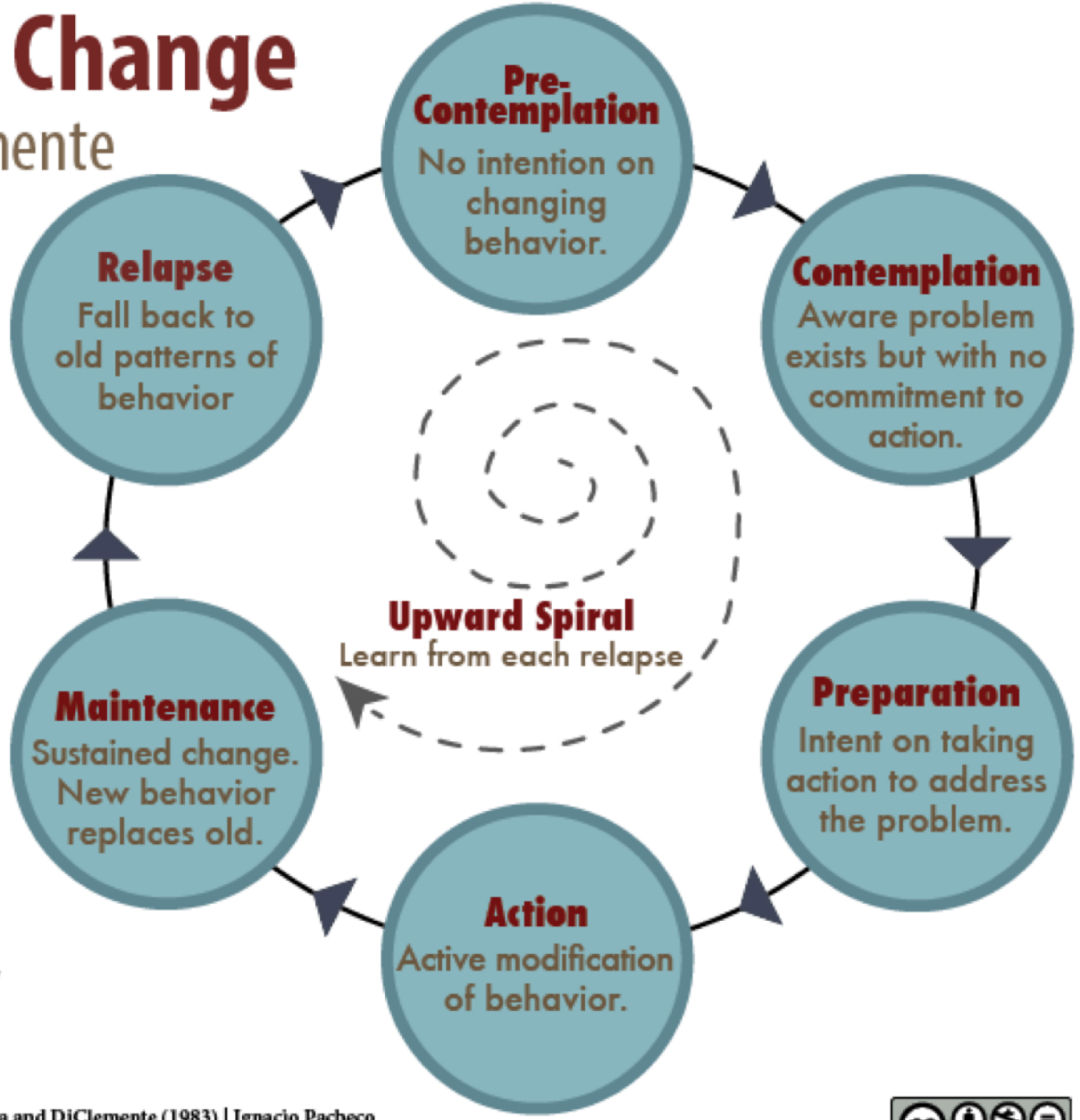
Therapist Expertise (Hill et al., 2017)

Criteria	Possible ways to assess criteria
1. Performance*	Client-rated working alliance, real relationship…
2. Cognitive functioning	Observer-rated assessment of cognitive processing, case conceptualization ability
3. Client outcomes*	Engagement in therapy/dropout rates
	Clinically significant change on reports by clients, outcome measures…etc.
	Behavioral assessments
4. Experience*	Years of experience, Number of client hours, Variety of clients, Amount of training, supervision, reading
5. Personal and relational qualities of the therapist*	Empathy ability, Self-rated self-actualization, well-being, quality of life, lack of symptomatology, reflectivity, mindfulness, flexibility, Nonverbal assessments of empathy
6. Credentials	Graduation from an accredited training program, Board certification
7. Reputation	Professional interactions, Lack of ethical complaints, reports from colleagues and friends, positive feedback and referrals from others, invitations for workshops
8. Therapist self-assessment*	Evaluation of own skills

The Cycle of Change

Prochaska & DiClemente

- **Precontemplation:** A logical starting point for the model, where there is no intention of changing behavior; the person may be unaware that a problem exists
- **Contemplation:** The person becomes aware that there is a problem, but has made no commitment to change
- **Preparation:** The person is intent on taking action to correct the problem; usually requires buy-in from the client (i.e. the client is convinced that the change is good) and increased self-efficacy (i.e. the client believes s/he can make change)
- **Action:** The person is in active modification of behavior
- **Maintenance:** Sustained change occurs and new behavior(s) replaces old ones. Per this model, this stage is also transitional
- **Relapse:** The person falls back into old patterns of behavior
- **Upward Spiral:** Each time a person goes through the cycle, they learn from each relapse and (hopefully) grow stronger so that relapse is shorter or less devastating.



Social Work Tech!

The Cycle of Change
Adapted from a work by Prochaska and DiClemente (1983) | Ignacio Pacheco

What's the client's benefit?

- Evidence-Based Practice in Psychology (EBPP)

  Starts with the ***client*** and asks what research evidence (including relevant results from RCTs) will assist the psychologist in achieving the best outcome.
- Ethical standard
- Aspirational effect

→Focusing on the client

Add the ORS and the SRS to your practice

- Outcome Rating Scale
- Session Rating Scale
- 2 minutes to administer and score.
- Strong internal consistency
- Good concurrent validity
- Good face validity compared to longer measures.

The ORS has good psychometric properties

- Strong **internal consistency** (α = .87-.96)
- Respectable **construct validity** (r=.59)

  With much lengthier, well-validated OQ-45.2
- Child version (ages 6-12)

The ORS contains 4 scales.

- Measures the client's view of change relative to the initial complaint from the first session and across all sessions.

1. **Individual** well-being
2. **Interpersonal** well-being
3. **Social** well-being
4. **Overall**

How to use the ORS?

- Takes **1 minute** to administer and score!
- Get informed consent
- Administer at the **beginning of each session** to find out how your client has been doing since last session.
- Score and discuss immediately.
- Embrace the process with humility and openness.
- Connect client's presenting problems to scores.
- Use to promote dialogue.
- Construct a simple line graph of scores between sessions.

The SRS contains 4 scales.

1. Client's view of the **therapeutic alliance** for a particular session
2. The **goals and topics** of the session
3. The **approach or method** of the session
4. **Overall**

The SRS has good psychometric properties.

- Strong **internal consistency** (α = .88)
- Good **test-retest reliability** (.64)
- Good **construct validity**:

  Working Alliance Inventory (r = .63)
- Child version (ages 6-12)

SRS

- Takes **1 minute** to administer and score!
- Available in **25 languages**!
- Administer at **end of session**.

Outcome Questionnaire 45.2

- Standardized and has empirical support
  - High **internal consistency (.93)** and **test-retest reliability (.84)**
  - Convergent validity: Significant correlations with measures of **depression** and **anxiety**
  - Sensitive to change in treatment populations
    - (not a diagnostics measure,, just measure disorder
- Available in English, Canadian French, Norwegian, Spanish and Swedish
- Takes 3-5 minutes to administer
- 3 subscales
  - **Symptom distress** (depression and anxiety)
  - **Interpersonal relationships** (loneliness, conflict with others, marriage and family difficulties)
  - **Social role** (difficulties in the workplace, school or home)
- Allows you to **monitor change over time (Can be before session)**
  - Is your client getting reliably worse, better, or not changing at all? –Reliable change
  - Offer clinical cutoff
- Can use for risk assessment (SI, substance abuse, and potential violence at work)

Clinical Cutoffs and Reliable Change

- Total Score
  - Clinical cutoff = 63
  - Reliable change = 14
- **Symptom Distress**
  - Clinical cutoff = 36
  - Reliable change = 10
- **Interpersonal Relationships**
  - Clinical cutoff = 15
  - Reliable change = 8
- **Social Role**
  - Clinical cutoff = 12
  - Reliable change = 7

Scores on Outcome Questionnaire-45.2 for the Present Study as Compared with University Counseling Centers (Minami et al., 2009)

OQ-45.2	Pre-	Post-
University counseling centers	87.44	71.39

Note. OQ-45.2 = Outcome Questionnaire-45.2. Decreases in OQ-45.2 suggest positive client functioning and treatment outcome.

Cross-cultural validity

- Spanish speakers in the community obtained elevated scores (Juardo, 2007)

  Authors recommend higher cutoff for Total scale score of 65
- "Mainland Caucasians" **exhibited lower Total scale scores** compared to "Hawaiian Caucasian," "Pacific Islander," "Asian Chinese," and "Korean" groups (Gregersen et al, 2004)
- Native American and Asian/Pacific Islander college students **exhibited higher Total scale scores** compared to Latinx and White students (Lambert et al., 2006)
- African Americans and Whites **produced similar Total scale scores**, but Whites **scored higher** on anxiety and depressive symptoms, while African Americans **scored higher** on social role items (Abanishe, 2008)

OQ-45.2 in Chinese samples

- Li & Luo (2009) found a **high reliability and a good validity** in **Chinese colleges, clinics and psychological counseling agencies samples**…
  - Good internal reliability (the Cronbach α coefficients ranged from 0.91 to 0.92).
  - The test-retest reliability was 0.71 [$p < 0.01$]
  - The confirmatory factor analysis showed that the fit indexes for GFI, AGFI, NFI, NNFI, CFI and IFI were all >0.90, RMSEA = 0.07, $X^2/df = 2.16$.
  - Correlations with SCL-90 and BDI were in range of 0.62-0.72 ($p < 0.01$)
  - It's construct validity could also be accepted and good discriminate validity could discriminate patients from normal ($p < 0.001$)

Use of OQ-45.2 and Personal Example

Critical research on OQ-45.2

An Analysis of Therapist Treatment Effects: Toward Providing Feedback to Individual Therapists on Their Clients' Psychotherapy Outcome

John C. Okiishi, Michael J. Lambert, Dennis Eggett, Lars Nielsen, and David D. Dayton
Brigham Young University

David A. Vermeersch
Loma Linda University

Possible uses of OQ-45.2 in Hong Kong

- Clinical feedback

  Discuss therapy progress and process with the client in sessions

  Techniques, Tx…
- Client assignment
  - Client-therapist assignment for cost-effectiveness
- Therapist training
  - Identify low-score therapists and encourage them to be trainees
  - Identify high-score therapists and encourage them to be trainers
- Clinical supervision
  - Using clinical outcomes
- Psychotherapy research
  - Cultural differences, different techniques and tx…
  - Clinical evidence - the effectiveness and efficacy of the counseling center
  - Applying for funding and measuring clinical research progress

In summary, back to the basics.

The Role of Counseling Psychologists

In the 1st edition of the *Handbook of Counseling Psychology*, Brown and Lent (1984) defined Counseling Psychology *as:*

- *"An applied psychological discipline devoted to **scientifically** generating, applying, and disseminating knowledge on **the remediation and prevention** of vocational, educational, and personal adjustment difficulties*" (p. ix).

The Scientist-Practitioner Model

Blair (2010, p.20)

- *"The scientist-practitioner should be **able to apply psychological knowledge to their therapeutic work** with clients or patients, including psychological assessment. **Research and practice should be synthesized into an integrated way of working**, which will be expressed in practice by employing a scientific attitude. **Research should also flow out of practice, providing practice-based evidence**."*

Going back to EBPP

- ***EBPP starts with the client*** and asks what **research evidence** (including relevant results from RCTs) will assist the psychologist in achieving **the best outcome**.

(APA's Presidential Task Force on Evidence-Based Practice, 2006)

Come join tomorrow's workshop: Aug 3rd 7-10pm

- ***"Working with Diverse Clients and Going Beyond the Therapy Room: Multicultural and Social Justice Counseling Competencies"***
  1. Do you know that "culture" goes beyond language, nationalities/ethnicities/ and geographies?
  2. Do you know "cultural components" are affecting your every therapy work and clinical outcomes?
  3. How can we maximize our scope of clientele and counseling competence, so that we can be confident to work with clients from diverse cultures?
  4. Do you want to use your professional expertise to make a difference in the society, promoting justice and empowering the minorities?

THANK YOU!

- **Jonah Li, M.A.**
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Recommended reading list:

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