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Front Pages

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Published by the Athens Institute

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The *Athens Journal of Psychology* (AJPSY) is an Open Access quarterly double-blind peer reviewed journal and considers papers from all areas of psychology. Many of the papers in this journal have been presented at the various conferences sponsored by Psychology Unit of the Athens Institute. All papers are subject to Athens Institute's Publication Ethical Policy and Statement.

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The current issue is the third of the first volume of the *Athens Journal of Psychology* (AJPSY), by the published by the **Psychology Unit** of the **Athens Institute**. All papers are subject to Athens Institute's Publication Ethical Policy and Statement.

Gregory T. Papanikos
President
Athens Institute

Athens Institute for Education and Research

A World Association of Academics and Researchers

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Academic Members Responsible for the Conference

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Important Dates

- Abstract Submission: **21 October 2025**
- Acceptance of Abstract: 4 Weeks after Submission
- Submission of Paper: **27 April 2026**

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The Social Program Emphasizes the Educational Aspect of the Academic Meetings of Athens Institute.

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- Social Dinner
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Important Dates

- Abstract Submission: **30 September 2025**
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- Submission of Paper: **6 April 2026**

Academic Member Responsible for the Conference

- **Dr. Domenico Maddaloni,** Head, Sociology Research Unit, Athens Institute & Associate Professor, University of Salerno, Italy.
- **Dr. Philip G. Cerny**, Director, Social Sciences Division, Athens Institute & Professor Emeritus, University of Manchester (UK) and Rutgers University (USA).
- **Dr. Nikolaos I. Liodakis,** Associate Professor, Wilfrid Laurier University, Canada.
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More information can be found here: https://www.atiner.gr/social-program

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Queering Psychology Education: Fostering Inclusivity and Destigmatization in Academic Curricula and Mental Health Practices

By Nikolaos Souvlakis[*] & Damien Ridge[±]

The integration of queer perspectives into psychology education is a critical step toward fostering inclusivity, cultural competence, and ethical responsibility within the discipline. Historically, psychology has operated within a heteronormative framework, marginalizing queer identities and perpetuating stigma through exclusionary curricula and outdated diagnostic practices. This exclusion has contributed to significant mental health disparities among LGBTQ+ individuals, who experience higher rates of anxiety, depression, and suicidal ideation due to systemic discrimination and inadequate mental health support. Incorporating queer theories, intersectional frameworks, and empirical research into psychology curricula is essential for preparing future professionals to provide affirming and effective care. Studies indicate that exposure to inclusive educational content enhances cultural competence, reduces bias, and fosters greater empathy among mental health practitioners. Additionally, experiential learning, faculty diversity, and collaboration with LGBTQ+ organizations are crucial for ensuring a comprehensive and representative psychology education. Overcoming systemic barrierssuch as institutional resistance and faculty training deficitsrequires a concerted effort to reform curricula, expand research on LGBTQ+ mental health, and engage queer voices in educational development. Ultimately, integrating queer perspectives into psychology education is not merely an enhancement but a necessity, ensuring that mental health professionals are equipped to support diverse identities with empathy, knowledge, and respect.

Keywords: *Queer-Inclusive Education, Heteronormativity, Psychological Stigma, Cultural Competency.*

Introduction

The incorporation of queer perspectives in psychology education is not merely an enhancement but a fundamental necessity that addresses the persistent omissions and biases prevalent in contemporary academic curricula and mental health practices (Ferguson, 2023; Riggs & Treharne, 2017). Conventional psychology has historically operated within a heteronormative framework promoting the heterosexuality as the normative human sexuality while holding binary assumptions about genders (Ray & Parkhill, 2021), often marginalising or entirely excluding the experiences and identities of queer individuals. Even in more subtle ways, clinical settings may marginalize queer clients by; Assuming heterosexuality or binary gender identities when discussing relationships or mental health concerns. Lacking knowledge of

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unique stressors queer individuals face, such as minority stress, which affects mental health due to chronic discrimination. Failing to offer affirmative care, which validates and supports queer identities rather than viewing them as risk factors for mental distress. This exclusion creates significant gaps in both understanding and ways of addressing the mental health needs of this diverse population. As social awareness of queer identities expands, the urgency of integrating inclusive perspectives into psychology education becomes increasingly important

Literature Review

Empirical research consistently demonstrates that queer individuals experience disproportionately higher rates of mental health issues, including anxiety, depression, and suicidal ideation, compared to their heterosexual counterparts. This research consistently demonstrates that queer individuals experience disproportionately higher rates of mental health issues, including anxiety, depression, and suicidal ideation, compared to their heterosexual counterparts. For instance, a longitudinal analysis of UK data from 2010 to 2021 revealed that psychological distress increased for gay men, lesbians, and women with "other" orientations. (Bai et al., 2024; Cipollina, Eddy, & Sanchez, 2024). These poorer outcomes can largely be attributed to stigma, discrimination, and systemic marginalisation (reference). Although there have been improvements in some areas (e.g. American Psychological Association and British Association for Counsellors and Psychotherapists have guidelines for working with LGBTQ+ individuals, traditional psychology curricula frequently overlook queer realities, failing to equip future mental health professionals with the necessary knowledge and skills to support clients effectively. This educational negligence perpetuates a cycle of misunderstanding and misdiagnosis, which not only endangers the mental well-being of queer individuals but also reinforces broader cultural stigmas surrounding queer identities. many psychologists trained under outdated curricula lack sufficient knowledge of LGBTQ+ mental health, leading to misdiagnosis in clinical settings. A common example is the misdiagnosis of gender dysphoria as borderline personality disorder (BPD) in transgender clients. Studies indicate that some mental health professionals conflate gender identity distress with symptoms of BPD (such as identity instability), failing to recognize the client's struggle as related to gender identity rather than a personality disorder (Rodriguez-Seijas et al., 2023)

The integration of queer perspectives is crucial to cultivating an inclusive and effective psychology curriculum. Research highlights that the exclusion of LGBTQ+ perspectives from education not only limits students' understanding of human diversity but also contributes to biased clinical practices that fail to meet the needs of queer individuals (Bidell & Stepleman, 2017). An effective curriculum must go beyond acknowledging the challenges faced by queer individuals; it must critically examine the cultural, social, and historical factors that shape their lived experiences. For instance, the pathologization of homosexuality in early editions of the DSM led to harmful therapeutic practices, such as conversion therapy, which persisted due to a lack of critical engagement with queer scholarship (Drescher, 2015). To prevent such harmful misconceptions, psychology programs must incorporate queer theories,

empirical research, and intersectional frameworks into core courses, including developmental psychology, clinical training, and social psychology (McDermott et al., 2018). This approach equips future mental health professionals with the skills to challenge heteronormative assumptions and recognize the diverse experiences of LGBTQ+ individuals. For example, a clinician trained in intersectionality may better understand how a Black transgender womans mental health challenges are shaped not only by transphobia but also by racial discrimination and socioeconomic barriers (Cipollina, Eddy, & Sanchez, 2024). By integrating these perspectives, educators can foster a more nuanced and empathetic approach that prepares students to engage effectively with clients from diverse backgrounds. Moreover, the promotion of such inclusivity in psychology education serves as a vital countermeasure against the stigma surrounding queer identities. Research indicates that stigma remains a significant barrier to mental health care for LGBTQ+ individuals, with studies showing that nearly 30-50% of queer individuals avoid seeking psychological support due to fear of discrimination or past negative experiences with clinicians (Meyer, 2012; Ploderl, Mestel, & Fartacek, 2022). For instance, transgender individuals often report being misgendered or having their gender identity invalidated in therapeutic settings, leading to a profound distrust in mental health services (Budge et al., 2013). When psychology education actively integrates queer perspectives, it challenges these stereotypes and misinformation, fostering a more affirming clinical environment. A concrete example of this is the adoption of LGBTQ+ affirmative therapy models, which have been shown to improve therapeutic outcomes by addressing minority stress and validating queer experiences (Horne, 2020). By incorporating these models into training programs, psychology educators can help dismantle deeply ingrained biases, ensuring that future mental health professionals provide competent and compassionate care to LGBTQ+ clients. When psychological education actively integrates queer perspectives, it challenges stereotypes and misinformation that perpetuate discrimination. This affirmative approach not only empowers queer individuals but also normalises discussions of gender and sexual diversity within academic and clinical settings. Future psychologists equipped with a robust understanding of queer issues are better positioned to provide compassionate, informed, and culturally competent care, thereby reducing the barriers that queer individuals frequently encounter in therapeutic contexts (Leitch, McGeough, & Arguello, 2023).

Historically, queer identities have been subjected to pathologisation and stigmatisation within psychology, profoundly shaping contemporary perceptions and practices. From the late nineteenth to the late twentieth century, homosexuality was classified as a mental disorder in psychiatry, with LGBTQ+ individuals being viewed as subjects of scientific control rather than as complex human beings deserving of understanding and empathy. The inclusion of homosexuality in the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) in 1952 exemplifies the political nature of diagnosis. This classification reinforced negative stereotypes and legitimised discrimination, leading to widespread misunderstandings and mistreatment of queer individuals across various social sectors, including healthcare (Sharon, 2023). Although the American Psychiatric Association removed homosexuality from the DSM-II in 1973 after intense political pressure, the legacy of pathologisation continues to affect the experiences of queer individuals in therapeutic contexts. Many

psychologists, influenced by outdated training and societal norms, have maintained biases that shape their perceptions of LGBTQ+ clients (Lytle, 2014; Pedersen et al., 2024). Recognising this historical context is essential to understanding the persistence of stigma and misunderstanding in contemporary mental health practices. Research indicates that many mental health professionals still lack adequate training in affirmative LGBTQ+ care, often resulting in a continued sense of alienation among queer clients seeking support (Ploderl et al., 2022).

The lack of queer perspectives from psychology curricula perpetuates a narrow understanding of human sexuality and identity, depriving students of a comprehensive view of psychological diversity in the population. This not only limits their educational experience but also sustains stereotypes about queer identities among future mental health professionals. When psychology education disregards queer perspectives, it fails to provide emerging psychologists with the necessary tools to challenge their biases and destigmatise the experiences of their clients (Tomicic et al., 2020). One imperative to integrating queer perspectives into psychology education is underscored by a growing body of research demonstrating the positive outcomes of inclusive curricula on the mental health and well-being of LGBTQ+ populations. Studies have shown that the absence of queer-inclusive content in psychology education perpetuates stigma and can significantly impact the therapeutic alliance between professionals and LGBTQ+ clients (McGeough & Aguilera, 2020). Research further indicates that students exposed to inclusive materials exhibit decreased levels of prejudice and an increased understanding of LGBTQ+ issues (Heredia & Rider, 2020). This shift in perspective is crucial, as mental health professionals with a comprehensive understanding of queer experiences are better equipped to navigate the complexities of their clients' lives, fostering an environment conducive to healing and acceptance.

Furthermore, the intersectionality (how identities/social positions overlap and interact to create unique experiences of oppression and privilege) of queerness with other identities heightens the necessity for inclusive education. Studies highlight that LGBTQ+ individuals frequently belong to multiple identity and social groups including along the lines of disabilities, ethnicity, gender, and socioeconomic status, In turn, these intersections influence mental health outcomes (Cipollina et al., 2024). Studies show that Black transgender women face disproportionately high rates of unemployment (26%) and housing instability (41%) compared to both cisgender Black women and white transgender individuals (National Center for Transgender Equality, 2020). These intersecting oppressions contribute to chronic stress, heightened vulnerability to mental health issues, and reluctance to seek professional support due to past discriminatory experiences in healthcare settings (Singh & McKleroy, 2011).

If her therapist has not been trained in intersectional frameworks within psychology education, they might only focus on one aspect of her identity such as gender dysphoria while overlooking the compounded effects of racial discrimination and economic precarity. Without an inclusive and intersectional approach, there is a risk of misdiagnosis or ineffective treatment that fails to address the root causes of distress. However, a clinician trained in intersectional, queer-affirmative therapy would recognize how these overlapping factors shape her lived experience and tailor

interventions accordingly, ensuring culturally competent and holistic care (Mizock & Lundquist, 2016).

By incorporating intersectional frameworks into psychology education, future professionals can develop a more nuanced understanding of the barriers and opportunities faced by LGBTQ+ individuals, enabling them to tailor interventions and advocacy efforts accordingly. One transformative aspect of queer-inclusive curricula is the ß potential to normalise discussions about gender and sexual diversity. Educational approaches that challenge heteronormative assumptions and expose students to the lived realities of queer individuals can enhance empathy and cultural humility among students. This, in turn, creates a more inclusive academic environment, benefiting both LGBTQ+ students and future professionals by fostering an ethos of acceptance and understanding (Ginicola et al., 2017).

Methodological Orientation

Based on our empirical data from teaching, clinical practice, and supervising psychologists and psychotherapists, we believe that the integration of queer perspectives in psychology education is crucial for cultivating a competent and inclusive mental health workforce where everybody matters. Our experiences in both academic and clinical settings consistently reveal that many trainees and early-career mental health professionals enter the field with limited exposure to LGBTQ+ affirmative frameworks. This gap in education often results in uncertainty or discomfort when working with queer clients, sometimes leading to misdiagnosis, ineffective interventions, or even unintentional reinforcement of stigma (Bidell, 2017).

For instance, in our supervision of trainees, we frequently encounter cases where students default to heteronormative assumptions for example, assuming a clients distress is rooted in their queer identity rather than external factors such as discrimination or family rejection. Some trainees also struggle with applying intersectional perspectives, failing to recognize how race, disability, and socioeconomic status interact with a clients queer identity to shape their mental health needs (Mizock & Lundquist, 2016). These observations align with research highlighting that psychology students trained in LGBTQ+ affirmative care exhibit greater competency, reduced biases, and improved client outcomes (O'Shaughnessy & Spokane, 2013).

In our teaching roles, we have also observed that students who are exposed to queer theory and LGBTQ+ case studies show marked improvements in their ability to think critically about psychological frameworks. In class discussions, many report that learning about heteronormativity, minority stress, and intersectionality challenges their pre-existing assumptions and enhances their empathy for clients with marginalized identities. These qualitative findings are reinforced by empirical studies demonstrating that integrating queer perspectives into psychology curricula leads to lower levels of implicit bias and greater self-efficacy among trainees in working with LGBTQ+ populations (Moradi et al., 2020).

Discussion

As studies demonstrate, LGBTQ+ individuals face significant mental health disparities, which are largely due to stigma, discrimination, and the lack of affirmative (i.e. recognising, validating, and supporting identities and experiences) LGBTQ+ care (Cipollina et al., 2024). To address these challenges, psychology curricula must include both theoretical and practical training that reflects the diverse realities of queer lives. Such an approach requires a deep understanding of the historical and social contexts that have shaped LGBTQ+ identities and standing in society, and the unique struggles queer individuals face, including discrimination and exclusion from healthcare systems e.g. puberty blockers for trans in the UK (Zeeman et al., 2019).

Bidell and Stepleman (2017) argue that an effective competence framework for mental health professionals should incorporate knowledge of diverse gender and sexual identities and the cultural nuances that inform these identities. Such education is vital to prevent the pathologisation of LGBTQ+ clients and to help clinicians challenge traditional heteronormative frameworks. The incorporation of queer theory (a critical approach that challenges normative understandings of gender and sexuality, arguing that identities should be considered fluid, socially constructed, and shaped by power dynamics) into psychology courses can equip students with the critical tools necessary to recognize how identities can be marginalised within conventional psychological models (McDermott et al., 2018; Ruments, et al., 2018). Furthermore, training in LGBTQ+ competencies prepares professionals to address the specific needs of queer clients by fostering a deeper understanding of minority stress (refers to the chronic stress experienced by individuals from marginalized groups due to stigma, discrimination, and social exclusion, which negatively impacts mental and physical health) and its impact on mental health (Meyer, 2003; Testa et al., 2015).

In line with this, experiential learning is helpful to developing empathy and competence among psychology students. Clinical training experiences that expose students to real-world LGBTQ+ client as case studies provide opportunities to apply theoretical knowledge while building emotional and professional competencies (Bidell & Stepleman, 2017). This approach is reinforced by research that highlights the importance of involving LGBTQ+ individuals in the educational process whether as guest speakers, educators, or role models ensuring that the curriculum is reflective of the voices and experiences of those it aims to support (Jeffery & Tweed, 2014).

Moreover, professional ethical guidelines emphasize the necessity of culturally competent care. The American Psychological Association (2000) provides clear guidelines for psychotherapy with lesbian, gay, and bisexual clients, underscoring the need for clinicians to offer a nonjudgmental, inclusive environment that respects the diverse sexual and gender identities of clients. Inadequate training on LGBTQ+ issues perpetuates disparities in care and contributes to systemic inequalities in healthcare access (Harper et al., 2013). The failure to equip mental health professionals with these competencies could reinforce biases that further alienate LGBTQ+ individuals in therapeutic settings.

A commitment to integrating LGBTQ+ competencies also addresses a significant ethical imperative in the field: the duty to do no harm. Studies show that without adequate training on topics such as cisnormativity, heteronormativity, and

intersectionality, professionals may unintentionally perpetuate harmful stereotypes or miss the specific needs of their clients (Winters & Randall, 2010). By adopting a framework as proposed by Bidell and Stepleman (2017), i.e. emphasising cultural humility, self-awareness, advocacy, intersectionality, minority stress theory, and affirmative therapeutic practices, psychology programs can improve their ability to provide culturally competent care while fostering an inclusive environment where all identities are affirmed.

Additionally, the inclusion of LGBTQ+ perspectives has gained traction in several universities, such as the University of Toronto Scarborough, which introduced a course on "Queer Psychology" aimed at addressing the gaps in traditional psychological theories. This course has been instrumental in enhancing students' awareness of gender and sexual diversity, thus contributing to the reduction of stigma surrounding queer identities (Bleasdale et al., 2024). Such curriculum reforms underscore the importance of institutional commitment to inclusivity, challenging long-standing paradigms that have historically marginalized LGBTQ+ identities. Likewise, universities like the University of Amsterdam have embedded queer perspectives throughout their programs, offering both theoretical knowledge and practical experiences that prepare students to engage with LGBTQ+ clients effectively.

However, while there is growing momentum for curricular reform, systemic barriers still pose significant challenges. Institutional resistance, financial constraints, and a shortage of trained faculty capable of teaching LGBTQ+ issues all hinder the widespread integration of queer perspectives into psychology education (Goldfried, 2019). Overcoming these barriers requires a concerted effort to diversify faculty, secure targeted funding, and ensure that curricula are continually updated to reflect the evolving needs of LGBTQ+ populations. Engaging LGBTQ+ students in the process of curricular reform is essential to ensure that their needs and experiences are adequately represented. By creating spaces where LGBTQ+ voices are heard, universities can cultivate a more inclusive academic environment. These efforts will help dismantle the power dynamics that have historically relegated queer identities to the margins, ultimately fostering a more equitable and effective psychology education system (Monro, 2021).

Implications for Psychology Education

Educators need to be equipped with the tools, knowledge, and training necessary to confront their own biases and effectively teach about queer theories and identities. Therefore, we propose that workshops, training programs, and ongoing professional development opportunities are needed to help educators become more inclusive, reflective, and supportive in their teaching approach. Educators trained to teach about queer identities can create a more supportive academic environment that encourages acceptance, challenges stereotypes, and results in a more compassionate and understanding educational experience for students. For example, workshops focused on queer identities can offer educators practical strategies for adapting their teaching methods, making them not only effective but sensitive to the needs of queer students.

Additionally, universities will need to prioritise the recruitment of a diverse faculty, including individuals who can offer queer perspectives in the classroom, if they are to produce psychologists who can respond to the full range of human experiences. Representation in academia is also critical for students, who are more likely to feel validated in their identity when they see their experiences reflected in their instructors. The presence of queer faculty not only provides students with role models, but also fosters a culture of inclusivity that benefits all students. Institutions should actively recruit and support queer academics, ensuring that their contributions are integrated into the curriculum. This approach not only enriches psychology programs but also reflects the diverse perspectives that are essential to the discipline (Salpietro, Ausloos, & Clark, 2019).

Collaboration between educators, mental health professionals, and LGBTQ+ community organizations plays a crucial role in creating a more inclusive psychology curriculum. Mental health professionals, educators, and LGBTQ+ advocates must work together to ensure that psychological training programs are responsive to the realities faced by queer individuals. Partnerships with LGBTQ+ organizations offer future mental health practitioners valuable opportunities to engage directly with the community, challenging preconceived notions and fostering empathy (Smith-Millman, Harrison, Pierce, & Flaspohler, 2019). These relationships allow educators to design more inclusive curricula that reflect the diversity of queer experiences, addressing gaps in programs that fail to represent or misrepresent queer issues. This collaboration strengthens academic content and empowers LGBTQ+ individuals, reinforcing their presence within academic and professional frameworks.

Conclusion

The integration of queer perspectives into education can also lead to transformative changes in the mental health field. As educators and mental health professionals become more attuned to the intersectionality of queer identities including how race, gender, socioeconomic status, and disability intersect with sexual orientation and gender identity they can offer more culturally competent care (Smith, Altman, Meeks, & Hinrichs, 2019). A nuanced understanding ensures that queer individuals receive the mental health support they need and deserve, ultimately improving therapeutic outcomes. Additionally, such training fosters an environment where queer identities are not marginalized but celebrated as integral aspects of the human experience (Serchen, Hilden, & Beachy, 2024).

Future research in queer-inclusive psychology education should explore the impact of microaggressions, such as subtle forms of discrimination in clinical and academic settings. These might include a therapist assuming a clients partner is of the opposite sex, misgendering a transgender client despite prior correction, or questioning the legitimacy of non-binary identities. In educational contexts, microaggressions can manifest through exclusionary language in textbooks, lack of representation in course materials, or professors dismissing LGBTQ+ concerns as "niche issues." Research should investigate how these repeated, seemingly small instances contribute to cumulative stress, identity trauma, and avoidance of mental health services among

LGBTQ+ individuals.and resultant identity trauma on LGBTQ+ populations. Microaggressions subtle, often unconscious expressions of biascan significantly affect mental health. As Smith-Millman et al. (2019) and others have highlighted, these minor but repetitive incidents create a hostile environment that can severely impact the well-being of LGBTQ+ individuals. Incorporating discussions on microaggressions into psychology curricula would provide future professionals with the tools to identify and address these issues in clinical practice, improving their ability to offer supportive, nonjudgmental care.

Similarly, addressing identity trauma the psychological distress caused by the invalidation or denial of one's identity due to societal rejection is essential in psychology education. Research linking identity trauma to mental health outcomes will enhance understanding of the unique challenges queer individuals face. By addressing identity trauma, mental health professionals can foster therapeutic environments that validate queer identities and facilitate healing from societal rejection and marginalization (Serchen et al., 2024). Incorporating an intersectional approach is crucial. Factors such as race, socioeconomic status, and geographic location deeply shape the experiences of microaggressions and identity trauma within queer populations. Understanding these intersecting identities ensures that future practitioners can offer a holistic and inclusive approach to care, one that addresses the full range of challenges faced by queer individuals, particularly in underserved communities (Van Ryn & Fu, 2003; Smith et al., 2019).

Finally, research on the effectiveness of queer-inclusive therapeutic interventions is vital. Investigating which therapeutic strategies affirm queer identities and improve the therapeutic process for LGBTQ+ clients can offer evidence-based practices for educators. Qualitative research that captures the narratives of LGBTQ+ individuals in therapy will bridge the gap between theory and lived experience, ensuring that psychology programs equip future professionals to provide competent, compassionate care (Smith-Millman et al., 2019).

Integrating queer perspectives into psychology education is not just an academic enhancement but an ethical and professional necessity. Without meaningful inclusion, psychology risks perpetuating outdated biases, contributing to the marginalisation of LGBTQ+ individuals, and failing to equip future professionals with the competencies required for culturally responsive care. However, achieving full integration remains an ongoing challenge due to institutional resistance, faculty training deficits, and the persistence of heteronormative frameworks in both academia and clinical practice. To overcome these barriers, psychology education must implement structural changes, such as mandatory LGBTQ+ competency training for faculty, curricular reforms that embed queer perspectives across all psychology subfields, and stronger collaborations between universities and LGBTQ+ advocacy organisations. Additionally, institutions must address resistance by fostering open dialogue, providing educators with the necessary resources to challenge biases, and actively recruiting diverse faculty who can bring lived and academic expertise to these discussions. By embracing these strategies, psychology can evolve into a field that not only acknowledges but actively affirms the lived realities of LGBTQ+ individuals. The goal is not just to include queer perspectives but to ensure that they become foundational in shaping future mental health practice. A truly inclusive psychology education does more than recognise

diversity it empowers future professionals to dismantle stigma, challenge systemic inequalities, and foster a mental health landscape that prioritises the well-being of all individuals, regardless of their gender identity or sexual orientation.

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Resilience, Empathy, and Well-Being in Tagore's *Kabuliwala*: A Positive Psychology Perspective

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Rabindranath Tagore, a Nobel laureate renowned for his profound contributions to literature, penned the short story Kabuliwala, a narrative that has resonated with readers across generations and cultures. This article examines Kabuliwala through the lens of positive psychology. Using the PERMA model developed by Seligman, the article analyzes the story from the perspective of positive psychology. All elements of the PERMA model—Positive Emotion, Engagement, Relationships, Meaning, and Accomplishment—are present in the story, with Relationships emerging as the predominant theme. In addition, this article explores Kabuliwala in terms of human resilience and empathy. The story offers a rich portrayal of these qualities through its central characters, Rahamat and Mini's father. Kabuliwala exemplifies how classical literary works can serve not only as sites of aesthetic beauty but also as reservoirs of psychological insight, inviting scholars to further integrate positive psychology with literary studies to reexamine narratives of human well-being.

Keywords: *Kabuliwala, Well-being, Resilience, Empathy, Postive- Psychology*

Introduction

Rabindranath Tagore's celebrated short story *Kabuliwala* (1892/2009) narrates the unexpected friendship between a Kabul-born fruit seller, Rahamat (the "Kabuliwala"), and Mini, a young Bengali girl. The story, set in colonial Calcutta, explores universal themes of fatherhood, separation, and cross-cultural friendship. From the first meeting – when Mini's fear overpowers her curiosity of the towering stranger – to the final reunion on Mini's wedding day, Tagore portrays a rich tapestry of human emotion. In particular, *Kabuliwala* highlights how affection and understanding can flourish despite hardship.

The objective of this research paper is to revisit *Kabuliwala* through the lens of positive psychology, specifically analyzing how the narrative illustrates fundamental principles of human well-being, resilience, and empathy. Using Seligman's PERMA model (2011) - which includes Positive Emotion, Engagement, Relationships, Meaning, and Accomplishment - as the primary analytical framework, we demonstrate how this classic literary work serves as a rich repository of psychological insights that transcend cultural and temporal boundaries. The analysis proceeds through three interconnected sections: first, we establish the theoretical foundation by examining positive psychology and the PERMA model's relevance to literary analysis; second, we systematically apply each component of the PERMA framework to key narrative elements and character interactions in *Kabuliwala*; third, we explore the manifestations of resilience and empathy in Rahamat and the narrator throughout the story.

This interdisciplinary approach reveals how classical literature can illuminate

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contemporary understanding of human flourishing and psychological well-being. This paper analyzes how Rabindranath Tagore's *Kabuliwala* (1892) exemplifies core principles of positive psychology through its portrayal of well-being, resilience, and empathy.

Review of Literature on *Kabuliwala*

Kabuliwala has been the subject of various scholarly interpretations, offering diverse critical perspectives. Khan and Shah (2025) employ Marxist theory, specifically the concept of alienated labor, to analyze Rahmat's experiences in *Kabuliwala*. It examines how Rahmat's life as an Afghan merchant in Calcutta reflects his estrangement from his homeland, his work, and his personal relationships due to capitalist systems. It also critiques the commodification of personal bonds and the socio-economic disparities between the rich and the poor in colonial society. From a postcolonial perspective, Hanifi (2018), highlights the tension between the rigid concept of the nation-state (a colonial construct) and the historical realities of human mobility and cultural hybridity. It implicitly critiques colonial policies, which restricted the traditional movement of people like Afghans, reclassifying their historical mobility as "illegal."

Meanwhile, Lal (2010) reflects on Tagore's portrayal of the "Other" in "Kabuliwala" to show how he could overcome barriers of gender and racial identity to empathize with "difference." It suggests that while the story primarily focuses on paternal love, it also offers insights into the portrayal of women and gender roles, even implicitly challenging stereotypes.

Together, these critical approaches demonstrate that *Kabuliwala* operates simultaneously as a simple story of human connection and a complex meditation on the social, economic, and political forces that shape cultural encounter.

Positive Psychology and the PERMA Model

Positive psychology, a relatively recent branch of psychology, shifts the traditional focus from pathology and dysfunction to understanding the factors that enable individuals and communities to thrive. It seeks to identify and cultivate strengths, foster positive experiences, and promote overall well-being. In positive psychology, well-being is generally described as a state of happiness and contentment, characterized by low levels of distress, overall good physical and mental health, and a positive outlook or a good quality of life (APA Dictionary of Psychology, 2023). Well-being has both subjective and objective dimensions, encompassing how people feel and how they function on a personal and social level, as well as how they evaluate their lives as a whole (Oades & Mossman, 2017).

Seligman's PERMA model (2011) offers a comprehensive framework for understanding well-being and human flourishing, identifying five key building blocks: Positive Emotion, Engagement, Relationships, Meaning, and Accomplishment. This model suggests that well-being is not solely about feeling good but also about functioning well in various aspects of life. An explanation of the five elements of the PERMA model is provided below:

Positive Emotion: This element refers to experiencing feelings like joy, contentment, inspiration, and hope (Fredrickson, 2001; Cohn & Fredrickson, 2009). It's about cultivating an optimistic outlook and savoring positive moments.
Engagement: Engagement involves being fully absorbed and present in activities, often leading to a state of "flow" (Csikszentmihalyi, 1990).
Relationships: A significant factor contributing to overall well-being is the presence and quality of social relationships, which can amplify positive experiences and provide support during challenging times. Nurturing meaningful connections with others is crucial for human flourishing. Some researchers have considered it to be one of the most important predictors of well-being (Argyle, 2001; Myers, 2000).
Meaning: This component relates to having a sense of purpose and belonging to something larger than oneself (Steger, 2012). It involves identifying one's values and aligning actions with those values.
Accomplishment: Accomplishment involves achieving goals, mastering skills, and experiencing a sense of competence and success (Seligman, 2011). It's about striving for and attaining meaningful outcomes.

Cultivating positive emotions, engaging in activities that provide a sense of flow, nurturing meaningful relationships, finding purpose in life, and achieving a sense of accomplishment are all considered essential pathways to enhanced well-being. The application of such psychological frameworks to literary analysis allows for a deeper exploration of character motivations, narrative themes, and the human condition as depicted in stories.

PERMA Model in Kabuliwala

In *Kabuliwala*, these elements are subtly interwoven into the narrative fabric. By applying the PERMA framework, we can see how the story promotes well-being through its portrayal of laughter and play (Positive Emotion, Engagement), cross-cultural friendship (Relationships), paternal love and purpose (Meaning), and the fulfillment of emotional resolution (Accomplishment). Throughout the story there are many sentences that are in accordance with the theme of these concepts.

Positive Emotion

While overt joy isn't the dominant tone, *Kabuliwala* features significant moments of positive emotion, particularly in the burgeoning friendship between Mini and Rahamat. Mini's innocent fascination with the *Kabuliwala* is a recurring motif, evident in her playful banter – her eager inquiries like "*O Kabuliwala, what is in your sack?*" – and the simple delight of her laughter during their encounters. In the busy rhythm of family life, Rahamat's visits initially served as a welcome diversion for Mini, a seemingly harmless and even educational interaction that broadened her limited world. The friendship itself becomes a wellspring of joy for both. Tagore highlights how their daily meetings are a highlight in her young life as Rahamat was an exceptionally patient listener, second only to her father. Their conversations, characterized by Mini's endless chatter and Rahamat's grand yet affectionate replies, fostered a shared sense of wonder, as seen when they both enjoyed the simple witticism about the elephant in his bag as can be seen in the narration below. The narrator's explaination that "*The essence of the joke was that the man had an elephant in his sack. Not that the joke was very witty, but it caused the two friends to double up*

in laughter, and the sight of that innocent joy between a little girl and a grown man on autumn mornings used to move me deeply." itself showcase the positive emotion in the story.

Furthermore, Rahamat's affection for Mini is evident in his willingness to engage in her games such as in answering to her question about in- laws, he would make "…. *a huge fist with his hand, Rahamat would pretend to punch at his imaginary in-law and say, I'll wallop my in-law.*" The joy it brings to Mini can be seen in the narration which says "*thinking of the plight of the unknown creature called father-in-law, Mini would explode into laughter.*" In addition, he remembered her across time which suggests a deep warmth and perhaps even a vicarious joy derived from their connection. The narrator witnesses the genuine affection Rahamat holds for Mini, evidenced by his small gifts, his patient participation in her play, and the longing in his eyes when he speaks of his own daughter. The narrator, Mini's father, experiences a bittersweet positive emotion as he observes this unusual friendship, initially with amusement and later with a deeper understanding and empathy. This sentimentality extends to moments of tenderness and compassion, particularly when he empathizes with Rahamat on Mini's wedding day, recognizing the shared fatherly love that binds them despite their different circumstances.

Engagement

The element of Engagement in *Kabuliwala* vividly manifests in the deep absorption both Mini and Rahamat experience during their unique connection. Rahamat's engagement is profoundly emotional and psychological; he is fully mentally present during their visits, setting aside his burdens to become completely absorbed in those short but meaningful interactions with the little girl. This isn't mere politeness; it's a focused attention driven by a deeper, perhaps subconscious, need for connection. Mini, in turn, exhibits childlike enthusiasm and curiosity, becoming fully engaged in her storytelling and conversations with him. Her intense curiosity and playful interactions demonstrate her complete absorption in the moment, drawing her into a world of simple yet captivating imaginative exchanges with the Kabuliwala that transcend typical adult-child interactions.

On the narrator's part, though not related to the main story, he also seems to be fully engulfed in the story writing which is time and again disturbed by his daughter's activities.

Relationship

"*The sight of that innocent joy between a little girl and a grown man on autumn mornings used to move me deeply.*" This sentence represents not only the relation that transcends age and culture but also the empathy that narrator has for them. Friendship between Mini and Rahamat, that is free of prejudice, aligns with positive psychology's emphasis on social bonds as a source of happiness.

Kabuliwala fundamentally explores relationships through simple interactions that reveal deep bonds of love, empathy, and connection.

Despite being strangers from different cultures, Mini and Rahamat form a beautiful bond built on affection and fun. The Kabuliwala finds comfort in Mini's chatter, which reminds him of his own daughter in Kabul whereas Mini trusts him and eagerly talks to him, without fear or prejudice. Rahamat's determined return to seek out Mini after his release, despite the passage of time and the uncertainty of her reaction, showcases the deep connection he felt with the child.

Another relationship that is present in this story is between Mini and Her Father. As the narrator of the story, his love for his daughter is evident. He is initially wary of the Kabuliwala, as any protective father might be, but later shows understanding and compassion.

Third and very important relation is between Rahamat and his daughter, which is very much present in the story though his daughter never appears in the story. The memory of the Kabuliwala's daughter drives his actions. His visits to Mini are not just casual; they reflect his yearning for his child, whom he has not seen in years. The worn paper with his daughter's handprint symbolizes the emotional weight he carries.

Meaning

Meaning and purpose also emerge strongly. For Rahamat, the meaning of life is his daughter. He articulates this explicitly when he says to the narrator: "*Just as you have a daughter, I too have one back home. It is remembering her face that I bring these gifts for your child. I don't come here for business*." Here Rahamat confesses that his role in Mini's life is sustained not by commerce but by an aching paternal love. His journey to Calcutta each year is meaningful because it keeps him connected to his daughter's memory. Even the simple paper handprint is suffused with purpose. Tagore notes that "*as if the soft touch of that little hand kept his huge, lonely heart fed with love and happiness*", implying that Rahamat's identity and will to continue are inseparable from that connection. This sense of meaning – a life guided by love and duty – is a key aspect of his well-being.

The narrator, too, finds deeper meaning by the end of the story. Preparing for Mini's marriage, he is confronted with Rahamat's plight. Rather than resenting the intrusion, he reexamines his values: seeing Rahamat's love reminds him of his own paternal love. In giving Rahamat money for passage home, he enacts an altruistic purpose. He even muses to himself that foregoing some extravagance (the marriage band, extra lights) makes "*auspicious ceremony became more luminous*." The narrator derives meaning from this cross-cultural compassion. Thus, by the story's end, both characters' actions fulfill Meaning (purpose driven by family bonds).

Accomplishment

Although accomplishment is less overt in the plot, we can interpret the narrator's benevolence as a self-transcendent achievement. The narrator forgoes using money intended for his daughter's wedding—a deeply significant family celebration—to instead help the Kabuliwala return to Afghanistan to see his own daughter. This is a genuine sacrifice of personal and family interests for the benefit of another person who has no claim of family or close friendship. The decision demonstrates impartial moral consideration—treating the Kabuliwala's relationship with his daughter as equally valuable to his own family celebrations. This moral accomplishment ultimately enriches the narrator's life with meaning that professional or material success could never provide.

Resilience

Resilience—the capacity to adapt effectively when facing adversity (American Psychological Association, 2012)—emerges as a central theme through Rahamat's character. The American Psychological Association (APA) defines resilience as the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress (n.d.). This adaptation is not merely about returning to a previous state, but can also involve profound personal growth, allowing individuals to emerge stronger and more capable from challenging situations. Resilience is both a process and an outcome, characterized by mental, emotional, and behavioral flexibility in response to both external and internal demands (American Psychological Association, n.d.). It is crucial to recognize that being resilient does not imply an absence of difficulty or distress; rather, it is the ability to navigate and work through these painful experiences. Furthermore, resilience is not considered an extraordinary trait possessed by only a few, but rather a set of learnable behaviors, thoughts, and actions that can be developed by anyone.

Resilience was defined by Zautra et al. (2010) as the ability to adapt effectively when facing adverse circumstances. Similarly, Luthar et al. (2000) characterized resilience as a dynamic process that involves positive adaptation when confronted with significant adversity. Several factors contribute to an individual's resilience, including their coping strategies, the availability and quality of social resources, and their individual perspectives on the world. The ability to view challenges as opportunities for growth, maintain a sense of control, engage the support of others, and possess effective problem-solving skills are all associated with greater resilience.

Resilience in Kabuliwala

Resilience is a salient but understated theme in *Kabuliwala*. Rahamat endures the heartache of being a foreign labourer in India, far from his child. Despite this deep loss, he maintains his livelihood selling dry fruit on the streets of Calcutta. He faces significant adversity through his separation from his native Afghanistan and his daughter, coupled with his eventual imprisonment in a foreign land. Despite these considerable challenges, Rahamat demonstrates notable resilience in several aspects of his life. His consistent annual return to his homeland to visit his family underscores a powerful desire to maintain these crucial familial ties. This yearly journey, undertaken despite the inherent difficulties of traversing the long distance between Kabul and Calcutta and the demands of his profession as a traveling merchant and moneylender. The narrative never explicitly labels him "resilient," but his actions convey a stoic endurance. For example, when a financial dispute lands him in jail, he calmly accepts his fate even as eight years slip by. Upon release, he returns to find that Mini – the little girl with whom he had played – has grown up and married. In this poignant reunion, Tagore reveals Rahamat's inner strength and sadness. He "*slouched on the floor with a long, deep sigh*" when he saw Mini in bridal dress, acutely realizing that his own daughter "*had grown up as well*" and that he would face an unfamiliar child upon return. Though his heart breaks at this prospect, he does not despair. His dignity remains intact; he gently conceals his turmoil even when he is bewildered by the change in his young friend's demeanor.

Rahamat's resilience is embodied physically by a single cherished possession:

"*the trace of a tiny hand created with burnt charcoal daubed on the palm*". He has carried this crude memento year after year in his robe, keeping "*the trace of a tiny hand*" close to his heart. This handprint symbolizes his enduring hope and resilience, serving as a tangible link to his past and a constant reminder of his love for his daughter and his ultimate goal of returning to her. This signifies a powerful display of resilience, maintaining a connection to loved ones and a sense of purpose even within the harsh and isolating environment of prison, aligning with the resilience factor of holding onto hope.

Empathy

The definition of empathy is "understanding a person from their frame of reference rather than one's own, or vicariously experiencing that person's feelings, perceptions, and thoughts" (APA Dictionary of Psychology, 2023). Empathy is the intricate ability to both understand and share the feelings of another person, often leading to compassionate actions. According to Hodges and Myers (2007), empathy involves three emotional components. First, it's about experiencing the same emotion as someone else. Second, personal distress arises from one's own feelings of unease when witnessing another's suffering. Finally, the third component, feeling compassion for another person, is the aspect most often studied in psychology when examining empathy.

Empathy in Kabuliwala

Kabuliwala is deeply imbued with the theme of empathy, intricately woven into the interactions between its characters and the narrator's evolving perspective. The initial encounters between Rahamat and Mini serve as a compelling study in the development of empathy. Despite Mini's initial fear rooted in Rahamat's foreign appearance, Rahamat patiently bridges this apprehension through consistent kindness and the offering of gifts. His gentle demeanor and unwavering patience in the face of her childish fear demonstrate an early form of empathy, as he intuitively recognizes her vulnerability as a young child and acts in a way that gradually cultivates trust. Their deepening bond, fostered through shared jokes, lighthearted conversations, and the mutual enjoyment of each other's company, further underscores this growing emotional connection. Their shared laughter at simple humor and the narrator's observation of their "innocent joy" reflect both emotional empathy, where they share feelings of joy, and cognitive empathy, where Rahamat understands Mini's innocent perspective, and Mini, in her own way, appreciates his responses.

Rahamat's ability to comprehend Mini's innocent inquiries and respond in a manner accessible to her highlights his cognitive empathy. The "father-in-law's house" joke is a prime example, where Rahamat employs a culturally relevant euphemism playfully, and Mini, despite not grasping its literal meaning, finds it amusing. This showcases Rahamat's capacity to perceive the world from Mini's viewpoint and tailor his communication accordingly. Conversely, Mini's ability to connect with Rahamat on an emotional level, unburdened by the biases of the adult world, emphasizes the potent nature of genuine human connection in transcending societal barriers. The poignant moment of Rahamat's return after years of imprisonment, recognizing the grown-up Mini and triggering the realization that his own daughter must have similarly matured, powerfully illustrates his deep empathy. This allows him to connect

his experience of Mini's transformation to the likely transformation of his own child over their years of separation. His subsequent sigh and the understanding that he will need to "make friends with her anew" underscore the universal nature of parental love and the shared human experience of time's passage and its impact on familial bonds.

The narrator, initially observing the relationship with a degree of amusement tinged with societal awareness, gradually develops a profound sense of empathy. While he initially finds their interactions strangely fascinating, his perspective reflects the prevailing social norms, creating a subtle distance. The narrator's reaction to Rahamat's imprisonment marks a shift in his perspective, acknowledging the gravity of Rahamat's situation. Yet, the subsequent years lead to a gradual fading of Rahamat from his daily thoughts, highlighting the influence of personal circumstances and time on empathy. The narrator's most significant display of empathy occurs upon Rahamat's unexpected return on Mini's wedding day. "*In a moment I realised that we were both just the same – he was a father and so was I.*" This realization compels him to a significant act of compassion, choosing to reduce the wedding festivities to provide Rahamat with the financial means to reunite with his own daughter. This prioritization of Rahamat's deep emotional need over societal expectations and personal desires exemplifies a profound act of empathy, moving beyond mere understanding to active compassion and a desire to foster Rahamat's well-being. The narrator's feeling that the "*ceremony became more luminous*" underscores the intrinsic reward of acting on empathy and contributing to the well-being of another, solidifying empathy as a central and resonant theme of *Kabuliwala*.

Conclusion

This analysis of *Kabuliwala* through the lens of positive psychology reveals the story's profound exploration of resilience, empathy, and well-being. Rahamat's resilience in facing separation and hardship demonstrates the human capacity to adapt and find meaning even in challenging circumstances. The bond between Rahamat and Mini serves as a powerful testament to the strength of human connection and the significance of empathy in fostering joy and understanding across societal divides. Furthermore, the narrator's journey toward greater empathy and his compassionate act at the story's conclusion underscore the potential for positive change and the prioritization of human flourishing.

By examining *Kabuliwala* through the framework of positive psychology, we gain deeper insights into the enduring power of human connection, the importance of resilience in navigating adversity, and the profound impact of empathy on individual and collective well-being, ultimately highlighting the factors that contribute to a life well-lived as portrayed in this timeless literary work.

This interdisciplinary approach demonstrates the value of applying psychological frameworks to literary analysis, suggesting that positive psychology can serve as a valuable lens for understanding how literature portrays human flourishing. Such analysis not only enriches our understanding of literary works but also provides concrete examples of psychological principles in action, making abstract concepts more accessible and meaningful. Future research might explore how other literary works reflect positive psychology principles, potentially developing a more comprehensive understanding of how literature both reflects and shapes our understanding of human well-being.

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"I Am Not the First, and I Won't Be the Last": Exploring Women's Coping Strategies in Cohabitation Relationships in Ghana

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Despite its prevalence in modern Ghana, cohabitation is still laden with social and cultural consequences due to deeply entrenched societal expectations and the largely conservative Ghanaian culture. In cohabitation, women are scrutinised more than men because they are expected to uphold cultural values, be morally upright, and be socially conscious. These expectations can pose a challenge in handling the conflict between the reality of their situation and their desires for marriage, since they know culture demands marriage rites before moving in with a man. Using a qualitative design, this study investigated how women cope in such non-marital unions. Twelve women shared their experiences through semi-structured in-depth interviews. Data was analysed using reflexive thematic analysis revealing three themes (with subthemes in parentheses): Suicidal Ideation (Child maltreatment, Death is final), Hope (In God, Children's Success) and Solidarity. In examining issues of immense psychological distress, coping through social networks and hope, we delineate the importance of healthy support systems and highlight how suicidal ideation, while not trivial, become a turning point for survival and resilience. We recommend stakeholders collaborate with religious institutions to provide faith-based counselling services that address women's social, emotional, and mental health needs in cohabiting relationships.

Keywords: *Cohabitation, coping, relationships, suicidal ideation, Ghana*

Introduction

In Ghana, it is customary for men to seek women's hands in marriage, a tradition shared across the country's diverse ethnic groups and other African countries (Mafela, 2016; Tonah, 2024). Typically, a man, accompanied by his family or represented solely by them, approaches the woman's family to formally express intentions to marry her and make the necessary arrangements for marriage (Tonah, 2024). As part of this process, a woman's belongings are ceremoniously packed into a suitcase and sent to her husband's house, demonstrating her formal transition from her family home to his (Kanu & Igboechesi, 2023). However, sometimes, these marriage rites are bypassed, and a couple begins living together without performing the traditional or legal formalities of marriage. This practice, known as cohabitation, is widely frowned upon in most Ghanaian cultures though it was common in some regions. A historical

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perspective of cohabitation in Ghana shows that it was common among the Ashantis in the nineteenth century, during, and perhaps before, the time of Yaa Asantewaa, an Ashanti warrior Queen (Obeng-Hinneh, 2023). Known as *mpenawadiɛ*, a Twi term literally translating to girlfriend/ boyfriend marriage, it was the intimate union of two consenting adults who rendered spousal duties to each other, however, there was no bride price. A bride price, also known as bride wealth, is an essential aspect of a marriage. It is a cultural practice where the groom or his family gives money, goods, or other forms of wealth to the bride's family as part of the marriage arrangement (Forkuor et al., 2018; Wan, 2024). It confers on the groom exclusive sexual and reproductive rights to the woman, legitimises children born into the union, and the bride to food, shelter and clothing from her husband (Obeng-Hinneh, 2023). Hence, if the bride price was absent, a woman in an *mpenawadiɛ* relationship was not entitled to any of those. In this precolonial era, cohabitation was prevalent for the interesting reason that it was easier to split up the union simply because there was no bride price. Therefore, a woman could quickly return to her family in the event of a misunderstanding or a disinterest in continuing the relationship. With time, the reason changed from deliberately avoiding a bride price to not being able to afford it (Ademiluka, 2021; Besong, 2018; Lowes & Nunn, 2018; Okyere-Manu, 2015). Additionally, the fear of divorce and the desire to retain flexibility in the relationship played a role in choosing to cohabit (Harris, 2020; Jamison & Proulx, 2012). In recent years, however, cohabitation has been increasingly regarded as unconventional or deviant in many African contexts (Obeng-Hinneh, 2022; Posel & Rudwick, 2013).

When a couple cohabits, the focus dwells on their potential or guaranteed sexual relations which have not been sanctioned through marriage (Critell, 2022; Ojo & Akazue, 2020). In Ghana, marriage remains the only socially and culturally accepted context for sexual intimacy and childbearing (Ahonsi et al., 2019). Ghana is highly religious, being majority Christian and Islam. These two religions strongly oppose premarital sex, and, particularly for women, virginity is held in high esteem (Dwamena, 2023; Osafo et al., 2014). Therefore, women often bear the burden of societal judgment for deviations from sexual norms (Nasongo et al., 2025). Cohabitation is one such deviation that attracts significant social disapproval. Cohabiting women are often criticised and pressured to conform through subtle or overt messages (Obeng-Hinneh, 2022). In many societies, girls are raised with the knowledge that marriage is the right context for sexual intimacy and childbearing (Allendorf et al., 2020; Mafela, 2016). This shapes their values and perceptions of relationships. Consequently, women who enter cohabitation may do so with an end-justifying-the-means mindset, hoping it will transition to marriage, easing their guilt about engaging in premarital sex. However, when this transition is delayed or does not materialise, it results in frustration and disappointment. Moreover, failing to conform according to society's standards of a relationship often leads to further marginalisation. As Obeng-Hinneh and Kpoor (2021) found, when women in such unions experience hardships in their relationships, they are frequently perceived as having brought these outcomes upon themselves and are, therefore, deemed unworthy of sympathy or support. This perception justifies, in the eyes of some families and communities, the withdrawal of emotional and material assistance. Instead of receiving help during vulnerable periods, these women are often left to handle their hardships alone.

Literature Review

Research shows that in some contexts, women invest emotionally, socially, and financially in anticipation of transitioning from cohabitation to a formal union (Grundström et al., 2021; Sassler et al., 2018). In contrast, men often perceive cohabitation as an alternative to marriage or approach it with less commitment (Huang et al., 2011; Parker, 2020). The reason for this was addressed in an insightful study, where Obeng-Hinneh (2022) discovered that many men in cohabiting unions in Ghana secretly had no intention of marrying their partners, citing reasons such as financial costs and/or their partners' alleged misbehaviour. Other studies reveal that women in cohabiting relationships face pressure from family, friends, and religious communities to conform to societal expectations of marriage, causing them to resort to strategies such as deliberately excelling or failing in "wifely duties" to encourage commitment from their partner, or exhibiting nonchalance to rouse their partner's interest and thereby transition to marriage (Obeng-Hinneh, 2018, 2022; Obeng-Hinneh & Kpoor, 2021; Okyere-Manu, 2015). However, as the results go on to show, these efforts frequently fail to yield the desired outcome, rather resulting in intimate partner violence, emotional distress, and a strain between the couple. Similar findings across Sub-Saharan Africa point to adverse effects of cohabitation such as unplanned pregnancies, risky abortions, intimate partner violence, and depression, particularly among cohabiting female university students in Nigeria (Kalu et al., 2021; Obarisiagbon, 2023; Onoyase, 2020). Psychological and social consequences extend beyond Sub-Saharan Africa, as seen in a study from Iran (Kakavand & Khodabakhshi-koolaee, 2021), where cohabiting women reported feelings of insecurity, societal disapproval, and concerns about their futures. Although cohabitation can fulfil needs for emotional support or freedom, its disadvantages—such as lack of legal protection and societal stigma—often outweigh its benefits. While some women see cohabitation as a means of independence or a precursor to marriage, cultural disapproval and unmet marital expectations exacerbate their vulnerability (Acquaah, 2023).

In relationships, various challenges naturally arise, some more stressful than others, and women have been reported to bear this stress in relationships more than men (Tipre & Carson, 2022). In cohabitation, additional stressors could occur in the form of obscurity on whether they are a wife, girlfriend, or something in between, and uncertainty about the direction of the relationship. Dealing with stressors necessitate coping mechanisms, which are psychological and behavioural efforts that individuals use to manage stressors and challenges in their daily lives (Lazarus & Folkman, 1984; Steuber et al., 2014). These strategies can be categorized into problem-focused coping, emotion-focused coping, and avoidance coping (Carver, 2011). Problem-focused coping involves taking active steps to mitigate relationship stressors, such as open communication, conflict resolution strategies, and financial planning (Falconier et al., 2015). This approach is particularly effective when stressors are perceived as controllable (Neff & Karney, 2009). Emotion-focused coping, on the other hand, centres on managing emotional distress rather than altering the stressor itself. Women in cohabiting relationships may use social support, self-care, and cognitive reappraisal to handle relational difficulties (Randall & Bodenmann, 2017). Lastly, avoidance

coping, which includes behaviours such as denial, withdrawal, or substance use, is often maladaptive. When used, it may lead to increased relational dissatisfaction and mental health issues (Allen, 2021; Parcesepe et al., 2023). Research suggests that avoidance coping is more prevalent in relationships where partners experience high levels of unresolved conflict (Donato et al., 2015). Women tend to use more emotion-focused coping compared to men, particularly in romantic relationships (Graves et al., 2021). Hence, they would be more likely to seek social support, and engage in cognitive reframing, which is changing their perspective on cohabitation by being more optimistic and positive about it, whereas men are more inclined toward problem-focused coping, focusing on finding solutions rather than processing emotions (Janney, 2017). These gender differences are influenced by socialization processes that encourage women to be emotionally expressive and men to adopt a problem-solving approach (Rose & Rudolph, 2016).

Despite the growing prevalence of cohabitation, there is limited empirical scholarly attention on the specific coping mechanisms women in cohabiting relationships use to navigate emotional and psychological challenges, particularly in socio-cultural contexts where marriage remains the normative ideal. The focus on cohabitation, especially in Ghana, has been on consequences of cohabitation, mostly proving that women are disadvantaged on personal, social, and economic levels. The question remains as to how women specifically handle these challenges. This study therefore aimed to explore how women cope with internal and external pressure to get married by answering the following research questions:

1. How do women deal with the personal challenges that come with the internal pressure to get married?
2. How do women cope with the social challenges that come with the external pressure to progress from cohabitation to marriage?

Methodology

Research Approach and Design

This study was part of a larger study on the psychosocial experiences of women in cohabitation, and used an Interpretative Phenomenological Analysis as the specific design. The primary aim of IPA is to explore how individuals experience phenomena and how they make sense of it (Howitt, 2014). Given that the study sought to understand the subjective, emotionally layered, and socially embedded coping strategies of women in cohabitation, IPA provided an approach that allowed for both descriptive depth and interpretative insight. IPA also acknowledges the researcher's role in co-constructing meaning, and interpreting the participants' perception of their lives. IPA's focus on lived experience and its interpretative depth made it a suitable methodological approach for accessing the context-specific ways in which participants understood and articulated their coping strategies.

Participants

The participants for this study were recruited from two peri-urban areas in Accra, Nungua and Okponglo. Nungua is one of the significant towns in Accra, predominantly consisting of Ga people. However, there is also the presence of other ethnic groups, such as the Akans and Ewes (Oduro et al., 2015). Okponglo, a peri-urban settlement also in Accra, though much smaller, has a concentration of people from different ethnic backgrounds and socio-economic levels. The choice of these two locations was primarily based on convenience, as each of the first two participants were identified in each of these areas, and it was found that there was a significant presence of cohabiting women who could be potential participants. Therefore, purposive and convenience sampling techniques were used to ensure a relevant participation pool. Purposive sampling involved choosing participants based on cohabitation as the specific criterion. The inclusion criterion was for the participants to have lived with a man to whom they are not legally married, with or without children, for more than two years.

Women whose partners initiated the marriage process by "knocking" were excluded from participating in this study. In Ghanaian custom, knocking is when a man comes with his family to the woman's family to formally ask for their daughter's hand in marriage (Yin, 2014). It is also a message to the woman's family that the man is responsible for their daughter's whereabouts. They, therefore, have the right to enquire from the man where she was and perform the necessary background checks on him and his family before the final marriage rites (Nuworsu et al., 2019). This was an exclusion criterion because initiation of marriage rites could be enough for some people to consider themselves married, and therefore subject to different experiences then women whose marriage rites have not been initiated at all. To protect their identities, the participants' names were replaced with pseudonyms.

Data Collection

Data was collected using a semi-structured interview guide. To assess its clarity, appropriateness, and effectiveness, a pilot study was first conducted with three participants. This was also to identify any potential challenges or ambiguities in the data collection process. Before each interview, the researcher gained verbal consent, informing and explaining what to expect from the interview, including the likelihood of sharing some very sensitive and private information. Participants were also informed of the freedom to stop, without consequence, if they were uncomfortable. After participants gave consent for the interviews to be recorded, the interviews began with closed-ended questions about the participants' demographic information. During the pilot phase, it was observed that these questions, such as "How long have you been in a relationship for?" and "How many children do you have?" did not allow a smooth transition into the ensuing questions about their relationship experiences. The questions also limited the richness and depth of responses, possibly resulting from the feeling of being interrogated instead of feeling at ease and having the freedom of expression.

Considering this, the interview process was adapted to Jackson and Russell's (2010) life history interviewing approach. This approach facilitates the expression of narrative accounts of a person's life, thus encouraging participants to share detailed stories about notable events, transitions, and experiences. Due to the open-ended nature of this approach, the first question to participants was "Tell me about yourself" to allow them to express themselves freely. The interviews were conducted in two local Ghanaian languages, Ga and Twi, later translated and transcribed into English. Each interview lasted between 45 minutes and an hour.

Translation and Transcription

The interviews conducted in Ga and Twi were transcribed and translated meticulously by native speakers and language experts in the Linguistics Department of the University of Ghana to ensure their accuracy and authenticity. Initially, the interviews were transcribed verbatim from the local languages to English. Once the transcriptions were completed, they were translated back into the original languages to verify the credibility of the initial English translations. This back-translation process helped to identify any discrepancies or misunderstandings that might have occurred during the initial translation. To further enhance the reliability of this process, native speakers of Ga and Twi who were also proficient in English were consulted. These bilingual experts reviewed the transcriptions and translations to provide additional validation. This collaborative approach confirmed the translations' accuracy and helped preserve the cultural and contextual integrity of the participants' responses. This rigorous transcription and translation methodology ensured that the study's findings were grounded in the authentic voices of the participants, thereby enhancing the credibility and validity of the research outcomes.

Ethical Considerations

Ethical clearance was acquired from the Departmental Research and Ethics Committee (DREC) of the Department of Psychology at the University of Ghana for data collection and analysis (Protocol number: DREC/017/22-23). We observed the ethical considerations of honesty and integrity by truthfully explaining that the research was intended for educational purposes only and by not manipulating participants to participate in the data collection process through fake promises of turning their lives around for the better. We also provided a safe place for the participants to be interviewed at their own time and convenience. Also, confidentiality was considered and adhered to by not using participants' real names in the interviews and to identify the transcripts.

Data Presentation and Analysis

Data was analysed using Reflexive Thematic Analysis (RTA; Braun & Clarke, 2019), which includes the researcher's interpretation as part of the analysis process. The RTA method follows the six-phase analytical process proposed by Braun and Clarke (2006). The first phase involved familiarising with the data by listening to,

reading, and re-reading the transcripts to identify relevant information. Manual transcription enabled deep engagement with the data. In phase two, initial codes were generated by identifying recurring meaningful concepts. These codes were linked to broader themes such as cohabitation experiences, coping strategies, and help-seeking behaviours. In phase three, related codes were merged to form sub-themes and themes, with attention paid to the meaning of the data rather than a strict code count. Phase four involved reviewing and refining themes to ensure they accurately reflected the data. Finally, in phase five, the themes were defined, and in phase six, the final report was written, supported by excerpts from participant narratives.

Findings and Discussion

Using RTA, three key themes (with subthemes in parentheses) were identified which included suicidal ideation (child maltreatment, death is final), hope (children, God) and solidarity. All the participants had cohabited for at least two years. Five participants were Ga, five were Ewe, and two were Akan, all tribes from the southern belt of Ghana. Their ages ranged from 27 to 52 years. The participants had little to no education, the highest educational level being Junior High School. Two participants were unemployed. The remaining participants had modest jobs like shopkeeping and selling sachet water, fruit, ice, charcoal, and popcorn. All the participants had borne children with their partners. The themes and subthemes that emerged from data analysis are discussed below along with the direct quotes from participants.

Suicidal Ideation

In exploring the coping mechanisms of women in cohabiting relationships in Ghana, it became evident that many of them faced emotional distress, with suicidal ideation emerging as a response. Under this theme, two subthemes emerged; *Child Maltreatment* and *Death is Final*. Suicidal ideation refers to thoughts about self-inflicted death, that can range from fleeting considerations to detailed planning (Knipe et al., 2022). This assertion rings true in the responses of these participants:

> *"Many things go through my mind. There are times when I ask myself that this world that I came to, how did I come? As I am sitting here what use am I? If I die, that will be better."* (Elorm, mother of four)

> *"I said to myself, what am I doing in this world? Because the suffering is too much. If I die, it will be better.* (Dela, mother of three)
> *"I feel like I should end it all so my suffering will stop."* (Enam, mother of two)

> *"I think that because things are not going well, the only way to end it is to die. Everywhere I turn, things are not right. No one is helping you; no one is minding you. So, what am I sitting here doing?"* (Shika, mother of four)

The accounts of the participants in this study—most of whom were economically disadvantaged and emotionally unsupported in their cohabiting unions—reflect what

Osafo (2021) identifies as "existential suffering" among women in patriarchal contexts. Existential suffering refers to an inner distress that life has lost its meaning (Osafo, 2021; Pesut et al., 2021). The women thinking to take their lives because of problems with their relationships aligns with research showing that women experiencing psychological distress may find themselves struggling with suicidal ideation to escape or alleviate their suffering (Quarshie & Odame, 2021). Because women experience higher levels of emotions than men (Chaplin, 2015), it makes them more vulnerable to suicidal thoughts when facing relationship difficulties on personal and social levels. However, despite having these thoughts, the women did not attempt to take their lives because of reasons which manifested in two subthemes: *Child Maltreatment,* and *Death is Final.*

Child Maltreatment

This subtheme spoke to the women's fear of leaving their children behind to the mercy of those who would not love or care for them the same way. They also felt that if they died from suicide, the children would experience lifelong stigma, and their social identity would be tarnished. The following responses exemplify this:

> *"Later, I told myself, no, don't leave your children like that. If you die and leave them, who will take care of them like the way you do?"* (Dela, mother of three)

> *"Ooh it was just a thought, but I will not do it. Sometimes when you think too much evil things enter your mind. Why won't that happen when the suffering is too much? But...because of the children. If I'm not there they will suffer. They will really suffer."* (Esi, mother of two)

> *"I will worry them for nothing if I do it. Because it will follow them for the rest of their lives, that their mother killed herself. They are still young and they need me to be there for them."* (Kai, mother of six)

In Ghanaian society, suicide is often considered a taboo subject, and to attempt to take one's life is a crime (Akotia et al., 2018; Osafo et al., 2014). Considered forbidden in some countries, it is not openly discussed (Dutiro & Chegevenga, 2025). In some traditions, suicide is seen as a defilement that requires ritual cleansing, and in extreme cases, those who die by suicide are buried outside the town or denied full funeral rites (Osafo, 2021). Families of individuals who attempt or die by suicide often face social ostracism and community stigma (Vivekanandhan et al., 2024). Such practices and treatment can deepen the emotional trauma and shame for the bereaved, especially among children. Being aware of this, the women who had thoughts of suicide in this study desisted from attempting it to save their children from harsh treatment from society.

Death is Final

The second subtheme, Death is Final, shows how much the participants believed that death is permanent, spiritually uncertain, and morally consequential. It also shows how religious teachings prevented suicidal action. While some openly admitted to entertaining thoughts of death as a response to overwhelming emotional and relational

distress, the act of suicide itself was often halted by a profound fear of its irreversibility, especially in the spiritual sense of facing unknown or feared consequences in the afterlife. Grace articulates this hesitation clearly when she said, *"No one has come back from the dead to tell us that it is a good place or not, so I said, why should I kill myself?"* (Grace, mother of two). For another participant, Dede, her uncertainty obviously originates from religious doctrine. She said, *"Even though I have thought of it, I'll be a fool to do it. Why, because it is in the Bible that when you kill yourself you will go to hell."* (Dede, mother of three).

According to Christian doctrine, suicide is a sin against God and the body (Akotia et al., 2024). This belief, therefore, is a moral and spiritual deterrent for women who profess Christianity, and creates a barrier that they are afraid to cross out of fear and reverence. Elorm, on the other hand, interprets the finality of death not out of fear but out of the hope that being alive provides. She said, "*If I die, there is nothing I can do. But once I'm still alive, I can do something for myself. I can keep trying to make things better for myself."* (Elorm, mother of four). Her perspective shows a shift from despair to resilience. While she acknowledges the presence of suicidal thoughts, she emphasises that death forecloses all future possibility. As long as she is alive, however hard life may be, there remains the chance to change her situation. This sense of future possibility becomes a psychological and spiritual anchor, reinforcing the value of endurance over escape. These insights are consistent with existing literature, which affirms that religious beliefs often serve as a protective factor against suicide attempts, even when they do not eliminate suicidal ideation (Adamiak & Dohnalik, 2023; Lawrence et al., 2016). Though these ideations never led to an actual attempt, it is still unsettling that they had thoughts of taking their lives, as that alone is a risk and the first step before suicide (Acheampong & Aziato, 2018; Quarshie & Odame, 2021). The suicidal ideation might have been a form of coping to deal with the stress of their relationships. For some participants, however, having suicidal thoughts appeared to serve not only as a marker of acute psychological distress, but also as a pivotal moment of reflection and reorientation.

While suicidal thoughts are typically associated with despair and perceived hopelessness, in this study, they occasionally functioned as a catalyst for renewed purpose. Confronting the possibility of death prompted several women to re-evaluate their desire to live and to consider what aspects of their lives were still worth preserving or fighting for. Rather than progressing toward action, these thoughts often halted at the threshold of decision and, paradoxically, gave rise to clarity and resolve. The contemplation of death led to a recognition of the value embedded in life, particularly in their roles as mothers and as believers in the spiritual. This sense of maternal duty and protective instinct is similar to findings by Acheampong and Aziato (2018), where single mothers living with disabilities contemplated, but later dispelled thoughts of suicide because of their responsibility to their children.

Hope

A second major theme that emerged was hope. This hope manifested in two primary ways: *Hope in Children*, where participants found purpose and strength in the

possibility of their children's better futures, and *Hope in God*, where spiritual belief sustained them amidst uncertainty and suffering.

Hope in Children's Success

Lawlor (2021) opines that individuals need hope for their brains to function more effectively and to feel better when faced with adversity and uncertainty. This manifested in how women looked up to their children to cheer them up and felt better when they thought about how successful they would become one day. It helped them to put up with the challenges in their relationships, therefore, they channelled their efforts to ensuring their children were enrolled in school by working hard to pay fees and provide necessities for a more comfortable life. This is how some of them put it:

> *"The only thing I will think about is my children and their future, you see, and me too, my glory. That is all I would think about."* (Dede, mother of three).

> *"What is necessary for me is to allow myself to focus on my children. For their school, I must attend to them. In the future, I will benefit."* (Emefa, mother of four).

> *"I did not get the chance to go to school properly and go to a higher level, so I want my children to get there."* (Grace, mother of two).

Maternal education has been proven to have long-lasting positive effects on children's cognitive, physical and social development, positioning them for better future prospects (Le & Nguyen, 2020; Ohonba et al., 2018). Conversely, children of uneducated mothers are more likely to remain in the poverty cycle because of parental illiteracy (Amiri & Ashoori, 2024; Nwobodo, 2021). However, as the above quotes illustrate, this might not always be the case. As evidenced by the quotes, even though they are uneducated women, they aspire to break the poverty cycle by ensuring their children receive formal education to the highest level. Since they lacked education themselves, they understood the difference it would make if their children were educated. School provides structure, discipline, and helps shapes values. It also broadens one's social network, aspirations, and perspective, exposing children to new possibilities and inspiring them to pursue greater opportunities. In this way, these mothers believe that their children's education could ultimately lead to economic and social upliftment for them.

Hope in God

The participants also put their hope in God. They were women of faith and trusted that God would turn things around for them. According to Koenig et al. (1998), this kind of coping can be classified as religious coping, which they define as "the use of religious beliefs or behaviours to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances" (Koenig et al., 1998, p. 513). This was seen in their diligence to prayer, as exemplified in the following quotes:

> *"Only God. I believe that when you call on him, he will answer, so it is my hope and faith that things will work out."* (Maafio, mother of three).

> *"Sometimes, when something worries you too much, you will cry. You cry a lot. Later, you will tell yourself to take heart and remember that there is a God. Or, you put all your trust in God. With God, all things will turn out well."* (Dela, mother of three).

> *"The only thing I say is that once I have life, God too will not put me to shame."* (Kai, mother of six).

Women are more likely than men to engage in religious practices, seek spiritual support, and find comfort in their faith during times of distress (Li et al., 2020; Moon et al., 2022; Trzebiatowska & Bruce, 2012). This spiritual coping becomes especially salient in the lives of women in cohabiting unions, who are frequently stigmatised as morally deficient by both broader society and, at times, by themselves. Despite these judgments, many continued to draw strength from a belief in a higher power. For several of these women, faith-based institutions, particularly churches, was their sole source of consistent emotional and communal support. In cases where family members were physically distant or had severed ties due to disapproval or other relational breakdowns, the church community was a lifeline. It functioned not only as a place of worship but also as a surrogate family offering acceptance, solace, and a sense of belonging. In this way, faith and religious institutions played a crucial role in their coping strategies, offering both spiritual sustenance and a practical support network in the absence of familial care.

Solidarity

This entailed the women forming close relationships with other women in similar situations, which was possible because the women lived in communities where cohabitation was prevalent.

> *"I have stayed here for a long time, so I will, by all means, have a friend who, if something is worrying me, I can talk to. Sometimes when we meet, we share our problems. If you always stay in the room and the problems overwhelm you, when you meet someone with whom you can discuss life, you can share your problems with them*." (Abena, cohabiting for fifteen years).

> *"I am not the only one in my area living with a man who has not married us. Some are older than me, so I am not the first and I won't be the last. Sometimes, we talk, and I see that what I am going through is far better than that of others, even though I would not say I like it. They even laugh when I say I want to leave the man and tell me I am not the only one."* (Grace, cohabiting for three years)

Even though Grace admitted her situation was not ideal, she still acknowledged that she was better off than others. This reflects a form of downward social comparison, as conceptualized in Festinger's (1957) social comparison theory, which posits that individuals evaluate their own situations by measuring them against the experiences of others. By recognizing that others have endured greater hardships, Grace was able to frame her own difficulties as more manageable, even if she was dissatisfied with her circumstances. In pointing out that there were older women cohabitors, she reinforced the normalcy of cohabitation. Even when she wanted to

leave, her peers' light-hearted responses showed it had become so normal that leaving the relationship sounded ludicrous and perhaps futile. The peers' reaction speaks to societal expectations about women having to endure in relationships, making it harder for them to pursue change (Swasti et al., 2023). It is in this light that the older cohabiting women gave motherly advice to the young ones so they could learn from their experiences. Maafio, the oldest participant who had cohabited for over thirty years advised thus:

> *"I tell the young women that this life is not easy. You cannot carry your problems alone. It will break you. I have lived with this man for many years, and I know the pain. But I always say, find someone who understands you and talk to them. Even when I sit with my friends, we laugh about it. We laugh, we cry, and we talk. It is what keeps us going."*

Another factor that strengthened their solidarity with each other was the feeling of being misunderstood when talking to others who were not in cohabitation relationships. As Elorm, who has cohabited for twenty-two years put it:

> *"You cannot talk to some people about your problems. They will not understand, and instead, they will judge you or even laugh at you. I can only talk to someone who knows what I am going through. If you don't know the pain, how can you advise me? But when I talk to my friend who is also in the same situation, she will listen, and we can share ideas."*

As previously discussed, the feeling of being misunderstood and judged is a recurring theme in the experiences of women in cohabiting relationships. Obeng-Hinneh and Kpoor (2021) identify the withdrawal of family support as one of the key social consequences of cohabitation. Family members sometimes withhold both emotional and material support, believing that these women are responsible for their own circumstances. Thus, the perception among participants that they were 'on their own' was neither paranoid nor delusional. It reflected a social reality in which familial support was often conditional or entirely absent. In response to this isolation, women found family with others in similar situations with whom they could speak freely and without fear of judgment. Talking freely about their problems appeared to have therapeutic benefits, as evident in these quotes:

> "*When I sit with my neighbours and talk, it is like my heart becomes light."* (Emefa, cohabiting for twenty-one years)

> *"When you talk about your problems with someone, they also have the same problems. There is the one with her man who also has not performed her marriage rites, and nothing has come of it. When we meet, we use it to console ourselves and make fun of it somehow."* (Abena, cohabiting for fifteen years)

In addition to coping through emotional support, the solidarity among cohabiting women also boosted their self-perception and self-esteem. In many cases, society 'respects' or highly regards women who are married, because the marriage validates their status in a relationship, and the wedding ring is a symbol of that validation. However, among this group of women, not having a ring made them equal. One participant explained:

> *"I don't see myself as better than the others, and I don't think they do. How can you, when the men have not married us? We are all the same. The same struggle, the same pain. So, we just support each other. There is no point in looking down on anyone because what one is going through today, another might go through tomorrow."* (Esi, cohabiting for four years)

The theme of solidarity reflects an emotion-focused coping strategy (Graves et al., 2017; Lazarus & Folkman, 1984; Randall & Bodenmann, 2017). To reduce their psychological distress (which has an emotional component), they sought social support through which they could express their emotions and reappraised their situation positively in the sense that, when compared to others, they were not worse off. Due to the tendency for others to look down on them, and their own internalisation of this judgment, emotion-focused coping, particularly through seeking social support, helped to reduce self-stigma. It shifted the perspective from an individual "it's just me" way of thinking, to a broader social issue that many other women face. By not looking down on each other because of the lack of a wedding ring, the women show foresight and empathy, because they know that hardships are unpredictable and no respecter of persons. This awareness fostered compassionate coping (Allen & Leary, 2010), where women support rather than compete with one another.

Limitations of the Study

A key limitation of this study is the sensitivity surrounding the topic of cohabitation in Ghana. Cultural perceptions often portray women in such unions as "loose" or morally questionable, and cohabitation is frequently associated with economic hardship, particularly the inability to afford a formal wedding. As a result, the study primarily focused on women who, with their partners, seemed to be facing financial constraints that prevented them from marrying, thereby excluding those who may have the means to marry but have consciously chosen to cohabit for other reasons. Another limitation relates to the fact that the participants were recruited from suburbs in Accra which is generally an urban population. Perhaps if the study had included women from rural parts of Ghana, they would have shared experiences that may be qualitatively different from those living in the urban parts of Ghana. These limitations point to the fact that our current study had a narrow focus. This narrow focus may have influenced the findings, particularly in relation to coping strategies, as participants with limited financial resources may also lack access to supportive services such as professional therapy or counselling. Including a broader socioeconomic spectrum and a wider geographic coverage in future studies could offer a more comprehensive understanding of the dynamics and psychological impacts of cohabitation.

Conclusion and Recommendation

This study aimed to explore the coping strategies that some Ghanaian women in cohabitation use to handle personal and social challenges. The findings show that women mainly used emotion-focused coping, which led them to seek social support and express their emotions with a close-knit community of other cohabiting women, and religious coping through reliance on their faith. They supported, rather than competed with each other based on mutual experiences. Although women experienced severe psychological distress and as a result, had thoughts of suicide, these thoughts did not result in action but, armed with their faith, became a turning point from feelings of despair to a resolve to survive. The stories of these women show an adaptive resilience in managing emotional and social difficulties.

Based on the findings, we recommend that advocates of women's wellbeing and empowerment collaborate with religious organisations to create emotional support groups for cohabiting women, provide accessible counselling services, and organise training sessions that will equip women with skills for economic independence, such as vocation training, financial literacy, and appropriate technology. It is also recommended that future research explore the development and evaluation of targeted support interventions for cohabiting women, especially those facing economic and social challenges. A promising direction would be the establishment of a time-limited support group aimed at addressing the emotional and psychological needs of these women. Researchers could implement pre-and post-intervention assessments to measure outcomes such as depression, loneliness, and suicidal ideation. This approach would not only provide empirical data on the efficacy of such interventions, but contribute to the development of culturally sensitive mental health support structures for cohabiting women in Ghana. This study also highlights the role that men play in influencing the wellbeing of women, particularly in relationships. It therefore calls for efforts to sensitise men on the need to do right by their partners, support them financially, and treat them respectfully and fairly. Additionally, it is recommended that women are sensitised to actively raise their sons with values that promote gender equity, empathy, and respect for women, to help break harmful generational patterns and foster healthier future relationships.

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Artificial Intelligence and Human Therapy Supervisors are Interchangeable

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This study compares the quality of treatment plans generated by human mental health professionals and artificial intelligence (AI) agents across five therapeutic modalities: cognitive behavioral therapy (CBT), emotionally focused therapy (EFT), dialectical behavior therapy (DBT), acceptance and commitment therapy (ACT), and internal family systems (IFS). Seven interdisciplinary groups of five licensed therapists, each comprising one specialist from each modality, developed treatment plans for standardized case vignettes alongside AI-generated plans. A panel of independent judges conducted blind evaluations based on clinical soundness, relevance, completeness, applicability, practicality, and ethical considerations. The study shows that AI-generated treatment plans are indistinguishable in quality to those created by human professionals, offering insights into the potential role of AI in clinical mental health settings, especially in contexts where supervision is limited or inaccessible.

Introduction

The availability of mental health supervision varies significantly across regions, impacting the quality of care and professional development for therapists. Professional bodies such as the APS (2023) and BPS (2023) have issued detailed frameworks for clinical supervision, yet implementation varies widely across practice settings. In addition to national guidelines, pluralistic training models have also been proposed to integrate diverse supervision approaches (Giusti et al. 2000). Even in countries with relatively strong mental health infrastructures, such as Canada, national reports show that clinical supervision practices remain inconsistent and often unregulated (MHCC 2022). Supervision ratios range from 1:10 in Europe to as high as 1:30 in Africa, with disparities in access to trained supervisors (Kemp et al. 2019, Kohrt et al. 2023, Rønnestad et al. 2024). While 72% of therapists in the U.S. receive supervision, this percentage drops significantly in regions with fewer trained supervisors, highlighting a critical gap in global mental health support (American Psychological Association [APA] 2023, World Health Organization [WHO] 2022). AI presents an opportunity to bridge this gap by providing structured, evidence-based guidance to therapists.

The integration of AI into healthcare has seen rapid advancements, with AI tools increasingly being explored for their potential to enhance clinical decision-making, patient engagement, and administrative efficiency. In the field of mental health, AI-driven models like GPT-4 have demonstrated capabilities in generating coherent, contextually relevant responses, raising critical questions about their role in therapeutic processes traditionally managed by trained professionals. While AI models can generate coherent and contextually relevant text, it is unclear whether these outputs

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meet the clinical standards upheld by trained mental health professionals and prompt questions about the efficacy of utilizing AI in critical therapeutic processes like treatment planning.

There is limited empirical evidence evaluating the effectiveness of AI in more complex tasks like treatment planning. Treatment planning is a core component of therapeutic practice, requiring not only clinical expertise but also the ability to consider ethical standards, cultural sensitivity, and individualized client needs. The possibility of AI matching or surpassing human clinicians in this domain holds significant implications for accessibility, cost-efficiency, and the future of mental health care delivery.

This study was conducted to address the existing gap in research regarding AI's capacity to generate comprehensive, evidence-based treatment plans. By comparing AI-generated plans with those developed by licensed professionals across five established therapeutic modalities, we sought to evaluate the clinical soundness, applicability, and ethical integrity of AI in a high-stakes therapeutic context.

Our hope is that the findings help inform mental health professionals, policymakers, and technologists about the potential and limitations of AI in clinical settings. The study shows that AI-generated plans are comparable to human-created plans. This could influence how mental health services are delivered, potentially increasing accessibility and efficiency.

Related Work

AI has been used in therapy since the advent of chat systems. One of the first such systems was ELIZA, which used simple word spotting to simulate a therapist and was shown to be quite effective (Weizenbaum 1966). With recent breakthroughs in generative AI, exemplified by models like GPT-3 (Brown et al. 2020), the use of AI in therapy is being explored extensively, building on earlier demonstrations of chatbot efficacy (Fitzpatrick et al. 2017).

Shen et al. (2024) specifically investigated whether large language models can effectively carry out cognitive behavioral therapy tasks, demonstrating early evidence of structured intervention capabilities. Recent reviews, such as Na et al. (2025), provide a comprehensive overview of how large language models are currently being integrated into psychotherapy, along with challenges and future directions. Recent surveys of AI in therapy and psychology have provided comprehensive overviews of the capabilities and limitations of conversational agents. Early work by Provoost et al. (2017) explored the use of embodied conversational agents in clinical psychology, emphasizing their potential to enhance therapeutic interventions. Similarly, Vaidyam et al. (2019) offered a detailed review of chatbots and conversational agents in mental health, outlining both clinical applications and inherent challenges.

Large language models (LLMs) are general-purpose AI models commonly used in popular AI chat systems like ChatGPT (Brown et al. 2020, OpenAI 2023). These models can take in natural language textual prompts and produce text output in response (Brown et al. 2020). Having been trained on most of the text on the internet,

they can handle conversations on any topic, and the responses are mostly accurate, relevant, and useful (Brown et al. 2020).

Survey studies have begun to map out the potential of LLMs for transforming therapy and psychological practice. For example, Na et al. (2025) provide an extensive overview of LLM applications in psychotherapy, discussing how these models are used for symptom detection, diagnostic support, and therapeutic interventions while also outlining the technological and ethical challenges that remain. In a similar vein, Guo et al. (2024) offered a systematic review that assesses the effectiveness of LLM-based approaches in mental health care, emphasizing both their promise in early screening and intervention and the need for rigorous evaluation frameworks. Complementing these works, Kjell, and Schwartz (2024) explore how LLMs can shift psychological assessment away from traditional rating scales toward more natural, language-based evaluations. Reviews, including that by Gaffney et al. (2019), examine how LLM-based approaches can facilitate more personalized and contextually aware mental health interventions. AI-driven therapeutic support has gained attention for its capacity to provide mental health interventions at scale. Raile (2024) investigated the usefulness of ChatGPT for psychotherapists and patients, demonstrating AI's growing role in therapy. Welivita and Pu (2024) explored whether AI, specifically ChatGPT, can exhibit empathetic responses comparable to those of human therapists, a crucial factor in effective psychotherapy. Additionally, Rønnestad et al. (2024) provided insights into the professional development of therapists, with implications for AI-driven training tools. Finally, Shen et al. (2024) studied the potential of LLMs to conduct cognitive behavioral therapy, underscoring both the opportunities and current limitations of such approaches.

AI applications in psychotherapy have evolved to include conversational agents and computational models designed to support both clients and practitioners. Miner et al. (2019) discussed key considerations for incorporating conversational AI into psychotherapy, emphasizing both opportunities and ethical challenges. Similarly, Luxton (2014) examined AI's role in psychological practice, highlighting its potential to complement traditional therapeutic interventions. Studies like Cioffi et al. (2022) and Tahan and Zygoulis (2020) reviewed computational methods in psychotherapy, outlining AI's ability to enhance diagnostic accuracy and treatment planning.

While LLMs are general-purpose, it has been shown that defining a persona or expertise for an LLM causes it to produce more relevant and useful responses within a particular context (Reynolds and McDonell 2021). An LLM can thus take a 'system prompt', which defines its persona and expertise, and makes it respond to queries from the perspective of an expert in the defined field (Reynolds and McDonell 2021). For example, if we give an LLM a system prompt such as "You are an expert in emotionally focused therapy" and then provide it with a vignette to analyze, its response will be more inclined to be in line with how an EFT therapist would analyze the vignette (Reynolds and McDonell 2021). Conversely, the same vignette, with a system prompt such as "You are a cognitive behavior therapist", will result in very different analyses by the LLM (Reynolds and McDonell 2021).

LLMs are mostly used for interactions with humans, but they can also be set up in a way that the output of one LLM is fed to another, which can in turn respond back (OpenAI 2023). In this manner, a group of LLMs, called LLM-Agents, can be

orchestrated to discuss a topic, each taking a different persona (Li et al. 2023). The way multiple LLM-Agents are connected to one another and coordinated can differ, and there are multiple coordination mechanisms (Li et al. 2023). In this paper, we used the Society of Mind coordination mechanism, as implemented in the AutoGen multi-agent platform (Li et al. 2023, Minsky, 1988).

Method

Our study used a blind experimental design comparing treatment plans from human mental health professionals and LLM-based AI agents across five therapeutic specializations (CBT, EFT, DBT, ACT, IFS). The participants included seven groups of five human mental health professionals, each specializing in one of the five therapy types, as well as six groups of AI systems. Two types of AI systems were tested:

1. Single LLM-based chatbot (ChatGPT using GPT-4o) prompted to view the vignette from the perspective of all five therapy types.
2. Multi agent system composed of a coordination agent as well as 5 LLM-based AI agents, each set up to simulate expertise in one of the therapeutic areas.

Five qualified supervisors, blind to the source of the treatment plans (human or AI), were recruited to evaluate the plans.

Procedure

Both human and AI groups were assigned identical vignettes. Both the human groups as well as the multi-agent systems collaboratively created treatment plans, while the single LLM-based chatbot generated its treatment plan independently. Treatment plans were formatted similarly and coded to prevent the judges from knowing whether they were human- or AI-generated.

Vignettes: Selection and Rationale

The vignettes used in this study were carefully chosen to represent a diverse range of clinical scenarios across three key contexts: individual therapy, couple therapy, and family therapy. Each vignette was designed to include complex, realistic cases that mental health professionals commonly encounter in practice. The vignettes include potential ethical dilemmas or cultural considerations, testing the ability of AI and humans to recognize and address these factors in their treatment plans.

Assignment of Vignettes

Both human groups and AI agents received the same vignettes to ensure consistency in comparison. Each group was tasked with creating a treatment plan for one of the vignettes assigned randomly. This resulted in a total of 7 human-generated and 6 AI-generated treatment plans.

Participant Selection

To ensure a high level of expertise, we recruited licensed mental health professionals with at least two years of clinical experience in their respective therapeutic modalities. We asked for volunteers through our networking group, which includes clinicians from diverse professional backgrounds and therapeutic specializations. Participants held qualifications in one of the following therapeutic approaches:

- Cognitive behavioral therapy (CBT)
- Emotionally focused therapy (EFT)
- Dialectical behavior therapy (DBT)
- Acceptance and commitment therapy (ACT)
- Internal family systems (IFS)

As for the AI supervisor LLM-Agents, five AI agents were set up to simulate expertise in each of the five therapeutic modalities listed above. Pilot tests were conducted to ensure that the AI agents generated treatment plans consistent with the theoretical principles and interventions characteristic of their respective modalities. Adjustments were made to optimize the accuracy and clinical relevance of the AI-generated plans.

Treatment Plan Summarization

To maintain the integrity of the blind evaluation and eliminate biases based on formatting or writing style, all treatment plans—whether generated by human professionals or AI—were standardized using a consistent structure and format. This ensured that supervisors evaluated the content and quality rather than stylistic differences. Plans were rewritten in a neutral, professional tone devoid of overly technical jargon or personal voice to ensure uniformity. Any identifying stylistic features (e.g., unique phrasing, formatting preferences) were removed or modified to maintain anonymity.

All treatment plans were summarized to a uniform word count to ensure consistency in length and depth of detail. Redundant information was eliminated, and key points were distilled into clear, concise summaries without omitting essential content. A standardized template was created and applied to all plans. This template ensured that the information was presented in the same order and with consistent headings and subheadings.

Sample Size and Grouping

For human participants, a total of 35 mental health professionals were divided into seven groups of five participants each, with each group consisted of five licensed mental health professionals, with one professional specializing in each of the five therapeutic modalities noted above. Group discussions were recorded and transcribed to capture the rationale behind treatment planning for potential qualitative analysis.

Evaluation Process

Judges were tasked with evaluating treatment plans without knowing whether they were generated by human professionals or AI. Their role was to provide objective, unbiased assessments based on predefined criteria, ensuring consistency and reliability across evaluations.

Instructions to Judges

We implemented a blind evaluation protocol by formatting all treatment plans uniformly. A coding system was implemented to anonymize the source while allowing for internal tracking.

Supervisors were instructed to rate each treatment plan on a scale of 1 to 5 for the following categories:

- Clinical Soundness: Does the plan adhere to established clinical guidelines and practices?
- Relevance: How well does the plan address the specific issues presented in the vignette?
- Completeness: Does the plan cover all necessary aspects of care, including diagnosis, goals, interventions, and ethical considerations?
- Applicability: Is the plan practical and feasible for real-world implementation?
- Practicality: Are the steps clear, actionable, and easy to follow?
- Ethical Assessment: Does the plan consider ethical standards and cultural sensitivity?

In addition to numeric ratings, supervisors were asked to provide brief qualitative feedback on each treatment plan, focusing on:

- Strengths and weaknesses of the approach,
- Any noticeable gaps or areas that could be improved,
- Observations regarding cultural sensitivity, ethical considerations, or innovative interventions.

Judges were instructed to submit feedback in standardized evaluation forms with both rating scales and open-ended sections for qualitative feedback.

AI Participants

We used AI groups in the form of multi-agent systems, as well as individual AI systems as supervisors.

Multi-Agent Systems

We used AutoGen (Li et al. 2023) as the multi-agent platform and the SocietyOfMind multi-agent architecture, which sets up LLM agents with different prompts to chat with each other as a group, moderated by a 'moderator' LLM agent. The multi-agent system is thus connected as a hierarchy of agents, with the moderator agent receiving instructions from a user, in this case, the vignette, and in turn, communicating with the team of five LLM-agents, each prompted to take on the persona of an expert in one of the five therapeutic modalities. The five expert agents then asynchronously discuss the vignette, providing their perspective on what should be included in the treatment plan.

After all expert agents agreed on a treatment plan, or once the maxrounds limitation on the number of total times all expert agents expressed an opinion (set to 15 in our experiments) has been met, then the moderator consolidates a treatment plan based on the expert agents' inputs. The full code for the Jupyter Notebook used in AutoGen for this setup is available publicly in the accompanying GitHub repository (see Appendix I). We kept the prompts as similar as possible to the instructions given to other human or AI participants.

The model used for all agents in the multi-agent experiments was gpt-4-0125-preview, which is an earlier, less powerful model than GPT-4o.

Single AI Supervisor

We used OpenAI's GPT-4o via the ChatGPT interface to create a GPT (https://chat gpt.com/g/g-SBV7avxZq-therapy-group-supervision) with instructions to formulate a treatment plan by reviewing the vignettes from the perspective of all five therapeutic modalities. We kept the prompt as similar as possible to the instructions given to other human or AI participants.

Judges

A panel of five independent judges was selected, each with supervisory experience and expertise in one or more therapeutic modalities. The judges were responsible for blindly evaluating all treatment plans using standardized quantitative criteria and providing qualitative feedback. Two types of judges were employed:

Five qualified supervisors, blind to the source of the treatment plans (human or AI), are recruited to evaluate the plans. The judges were selected based on their expertise in clinical supervision, psychotherapy research, and therapeutic best

practices. To ensure the integrity and reliability of the evaluation process, judges were required to meet the following criteria:

- Professional Qualifications:
    - Licensed Clinical Supervisors with at least 2 years of supervisory experience in one or more of the five therapeutic modalities.
    - Advanced degrees (master's or doctorate) in psychology, counseling, social work, or a related field.
- Supervisory Experience:
    - Proven experience in supervising clinicians across different therapeutic contexts, including individual, couples, and family therapy.
    - Each judge had a broad understanding of various therapeutic approaches to fairly evaluate treatment plans outside their primary specialization.

To ensure objective, consistent, and measurable evaluations of the treatment plans, judges were instructed to rate each plan using six predefined criteria. Each criterion was rated on a 5-point Likert scale, allowing for detailed quantification of the plans' strengths and weaknesses, with the following definitions:

1. Poor: The treatment plan does not meet basic standards in this area and shows significant deficiencies.
2. Fair: The plan addresses the criterion but lacks clarity, depth, or completeness.
3. Satisfactory: The plan meets acceptable standards with some minor areas for improvement.
4. Good: The plan demonstrates strong adherence to best practices with only minor gaps.
5. Excellent: The plan exceeds expectations, offering comprehensive, clear, and highly effective approaches.

- **Evaluation Instructions**

The instructions were designed to ensure that judges provided objective, consistent, and unbiased evaluations of the treatment plans. By establishing a clear evaluation framework, we aimed to minimize personal biases and maximize inter-rater reliability across different judges. Judges were instructed to provide both numerical ratings and qualitative feedback to capture the depth and nuance of each treatment plan. This dual approach allowed for both statistical analysis and thematic exploration of the treatment plans' strengths and weaknesses.

Judges were reminded to evaluate how well each plan addressed ethical dilemmas and cultural considerations, given the diversity embedded in the vignettes.

Evaluation Criteria

Each treatment plan was rated on the following six criteria, designed to assess both clinical rigor and practical applicability:

1. Clinical Soundness:
    - *Definition:* The extent to which the treatment plan adheres to established clinical guidelines and therapeutic best practices.
    - *Considerations:* Does the plan align with evidence-based approaches specific to the therapeutic modality? Are the interventions theoretically sound and consistent with the diagnosis?
2. Relevance:
    - *Definition:* How well the treatment plan addresses the specific issues, symptoms, and context presented in the vignette.
    - *Considerations:* Are the therapeutic goals and interventions tailored to the unique needs of the client? Does the plan remain focused on the presenting problem?
3. Completeness:
    - *Definition:* The thoroughness of the treatment plan in covering all necessary aspects of care, including assessment, goals, interventions, and ethical considerations.
    - *Considerations:* Are all key components of a comprehensive treatment plan present? Does the plan address both immediate and long-term therapeutic needs?
4. Applicability:
    - *Definition:* The practicality and feasibility of implementing the treatment plan in a real-world clinical setting.
    - *Considerations:* Can the interventions be realistically applied given the client's context? Are the goals and techniques appropriate for the setting and client resources?
5. Practicality:
    - *Definition:* The clarity and user-friendliness of the treatment plan, including how easily the steps can be followed by a therapist or client.
    - *Considerations:* Are the interventions described in a clear, actionable manner? Is the plan organized logically, making it easy to implement?
6. Ethical and Cultural Considerations:
    - *Definition:* The degree to which the treatment plan addresses ethical standards and demonstrates cultural sensitivity.
    - *Considerations:* Does the plan respect client autonomy, confidentiality, and informed consent? Are cultural factors and potential biases acknowledged and integrated into the treatment approach?

Results

Statistical Analysis

After data collection, t-tests and analyses of variance (ANOVAs) were conducted to analyze differences in average scores between human and AI-generated plans across the six criteria. The analysis included descriptive statistics, such as mean, median, standard deviation, and so forth, as well as inferential statistics, such as independent samples t-tests to compare human vs. AI plans, ANOVAs for multiple group comparisons (e.g., across therapy types), and post-hoc tests (e.g., Tukey's HSD) if ANOVA showed significance. Significance was determined at $p < 0.05$. Both quantitative and qualitative analyses are used to interpret findings.

Analyzing Qualitative Evaluations

We condensed the thematic analysis of 13 psychological assessments by summarizing the presence of key conceptual and intervention-related themes across cases. We then provided a numerical representation of whether each theme was addressed in a given assessment, allowing for statistical comparison across cases.

The resulting categories were as follows:

DC (Diagnosis & Conceptualization): This category captured whether a clear diagnosis or conceptualization of the client's struggles was provided. It included cases where the diagnostic process was well-defined and supported by theoretical frameworks or where uncertainty required further assessment.

PC (Psychosocial & Cultural Factors): This reflected whether external influences— such as family dynamics, cultural background, migration stress, religious considerations, or social relationships—played a significant role in the case conceptualization.

TG (Therapeutic Goals): This category identified whether specific, structured therapeutic goals were outlined. Goals included symptom reduction, emotional regulation, interpersonal improvement, or addressing values and self-awareness.

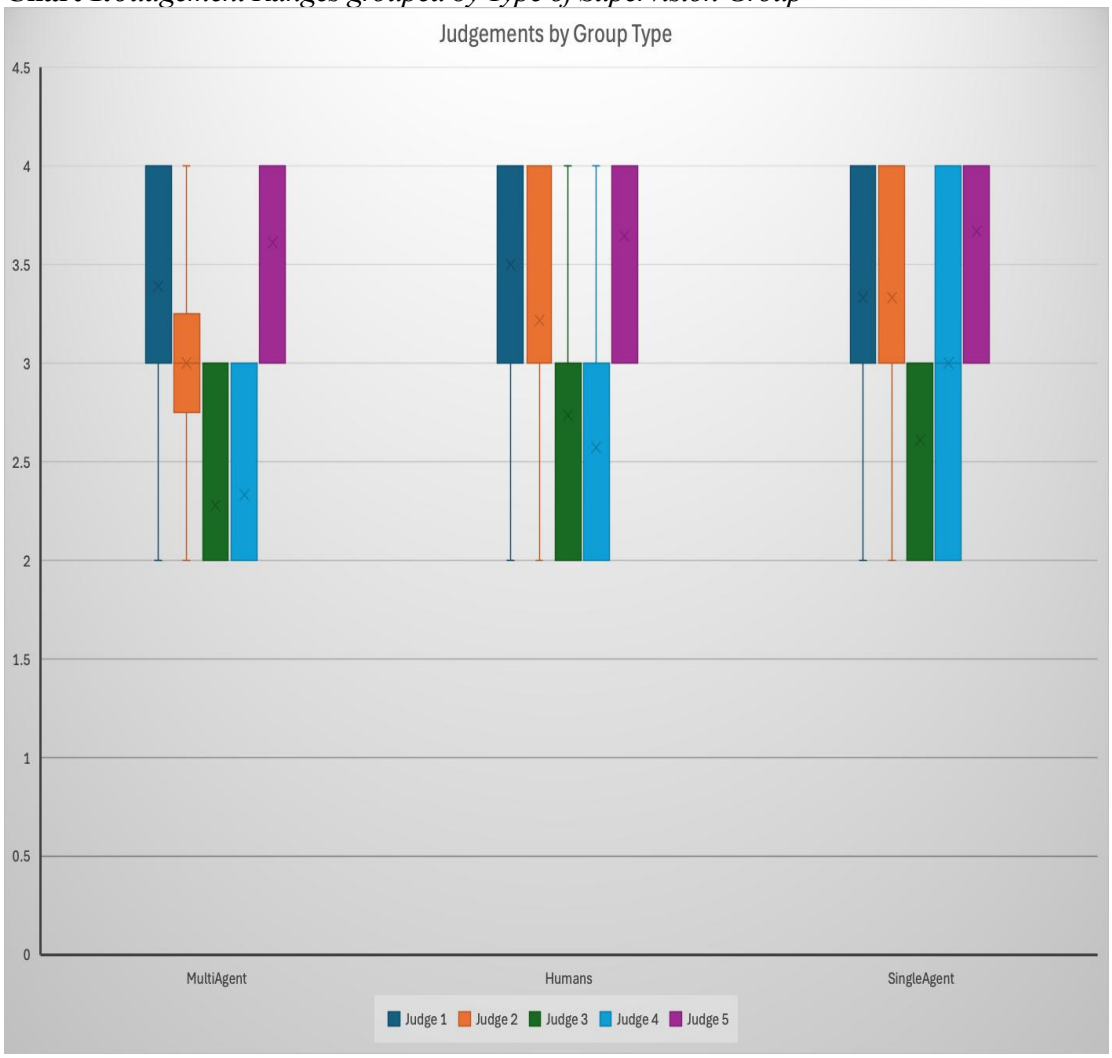
IA (Intervention Approach): This captured whether a multi-modal or evidence-based intervention strategy was proposed. Cases where multiple therapeutic modalities (e.g., CBT, EFT, DBT, ACT, IFS) were integrated are marked here.

EP (Ethical & Practical Considerations): This category included discussions around confidentiality, therapist bias, cultural competence, informed consent, and risk management (such as suicide risk assessment or extended family involvement in therapy).

CRD (Couple-Specific & Relational Dynamics): This was marked for cases that involved relationship distress or couples therapy, particularly where interaction cycles, parenting alignment, external family influences, or intimacy issues were major themes.

Quantifiable Data Analysis

Chart 1. *Judgement Ranges grouped by Type of Supervision Group*



Groups	*Count*	*Sum*	*Average*	*Variance*
3.266666667	5	14.2666667	2.85333333	0.00311111
3.466666667	5	15.6666667	3.13333333	0.08222222
3.314285714	5	15.4857143	3.09714286	0.01085714

ANOVA

Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	0.23192139	2	0.1159607	3.61659595	0.05899012	3.88529383
Within Groups	0.3847619	12	0.03206349			
Total	0.6166833	14				

Chart 1 shows that judges generally scored the treatment plans within the same range regardless of whether the team was human or AI.

As for the single factor ANOVA analysis (table 1), since the p-value of 0.05899 > 0.05, the result is not statistically significant at the 5% level. This means there is no strong evidence to reject the null hypothesis, which states that the group means are equal. Also, since F-value (3.6166) < F-critical (3.8853), the test fails to reject the null hypothesis. This reinforces that the differences between the group means were not statistically significant.

Table 2. *t-Test: Two-Sample comparing Multi-agent AI to Humans assuming Equal Variances*

	MultiAgent	*Humans*
Mean	2.92222222	3.13333333
Variance	0.03096296	0.01654422
Observations	6	6
Pooled Variance	0.02375359	
Hypothesized Mean Difference	0	
Df	10	
t Stat	-2.3725047	
P(T<=t) one-tail	0.01955484	
t Critical one-tail	1.81246112	
P(T<=t) two-tail	0.03910967	
t Critical two-tail	2.22813885	

Table 2 is a t-test to compare multi-agent and human supervisors, and shows that humans have a higher mean score and lower variance than MultiAgent supervisors. Since p (0.0196) < 0.05, the one-tailed test is significant. This means humans significantly outperform MultiAgent at p < 0.05, assuming the hypothesis was directional (expecting Humans > MultiAgent). Since p (0.0391) < 0.05, the two-tailed test was also significant. This means that even if we did not predict the direction beforehand, there is still a statistically significant difference between

MultiAgent and Humans.

Since the sample size is small (n = 6 per group), it's useful to compute Cohen's d (effect size) to understand the practical significance. Cohen's d = 1.37, indicated a large effect size, meaning the difference is not only statistically significant but also practically meaningful.

Table 3. *t-Test: Two-Sample comparing Single Agent AI to Humans assuming Equal Variances*

	SingleAgent	*Humans*
Mean	3.18888889	3.13333333
Variance	0.0842963	0.01654422
Observations	6	6
Pooled Variance	0.05042026	
Hypothesized Mean Difference	0	
Df	10	
t Stat	0.42853431	
P(T<=t) one-tail	0.33867302	
t Critical one-tail	1.81246112	
P(T<=t) two-tail	0.67734605	
t Critical two-tail	2.22813885	

The table 3 t-test to compare single-agent AI and human supervisors shows that the SingleAgent system has a slightly higher mean score than Humans, but the difference is small. Also, SingleAgent has a much higher variance, meaning its scores fluctuate more compared to Humans. Since p (0.3387) > 0.05, the one-tailed test is not significant. This means there was no significant difference between Single Agent and Humans in the expected direction. Also, Since p (0.6773) > 0.05, the two-tailed test was also not significant. This confirms that there is no statistically significant difference between SingleAgent and Human supervisors.

Table 4. *t-Test: Two-Sample comparing Single-agent to Multi-agent assuming Equal Variances*

	MultiAgent	*SingleAgent*
Mean	2.92222222	3.18888889
Variance	0.03096296	0.0842963
Observations	6	6
Pooled Variance	0.05762963	
Hypothesized Mean Difference	0	
Df	10	
t Stat	-1.9240061	
P(T<=t) one-tail	0.04162787	
t Critical one-tail	1.81246112	
P(T<=t) two-tail	0.08325574	
t Critical two-tail	2.22813885	

The table 4 t-Test to compare single-agent and multi-agent AI shows that single-agent AI has a slightly higher mean score than MultiAgent, however, the variance is higher in SingleAgent AI, suggesting more variability in its scores. Since p (0.0416) < 0.05, the one-tailed test is significant. This means SingleAgent outperforms MultiAgent at $p < 0.05$ in a directional test, had we hypothesized SingleAgent would do better (which we had not). Since p (0.0833) > 0.05, the two-tailed test is not significant at the 5% level. This means that given we did not predict a direction beforehand, the difference is not strong enough to be statistically significant.

To formally evaluate equivalence between group outputs, we conducted Two One-Sided Tests (TOST) with an equivalence margin of ±0.2 points. The results indicated that SingleAgent and Human outputs were statistically equivalent, t(58)= 5.61, p<.001t(58) = 5.61, p < .001t(58)=5.61, p<.001 and t(58)=−3.17, p=.001t(58) = -3.17, p=.001t(58)=−3.17, p=.001. In contrast, MultiAgent outputs were not statistically equivalent to either Humans (t(46)=0.56,p=.575t(46) = 0.56, p = .575t(46)=0.56, p=.575) or SingleAgent (t(10)=0.43,p=.680t(10) = 0.43, p = .680t(10)=0.43, p=.680).

Open Question Analysis

The following observations can be made regarding the presence or absence of key themes in the judges' responses to open questions regarding the treatment plans:

- Diagnosis was generally provided (DC = '1' in 12 out of 13 cases), except for Assessment #4, where more information was needed before formulating a diagnosis.
- Psychosocial & Cultural Factors (PC) were a major consideration in nearly all cases (12/13), except Assessment #5, which was more symptom focused.
- Therapeutic Goals (TG) and Intervention Approaches (IA) were consistently emphasized in every assessment, showing a strong focus on structured treatment planning.
- Ethical & Practical Considerations (EP) were discussed in every case, highlighting the importance of confidentiality, therapist bias, and cultural competence in psychological assessments.
- Couple-Specific & Relational Dynamics (CRD) was relevant in 6 cases, indicating that a significant portion of assessments involved relational challenges rather than purely individual concerns.

Analysis of Qualitative Results

To analyze differences between assessments, we removed TG, IA, and EP as they were present in every response, and will instead focus on the remaining columns.

Chart 2. *Dendrogram representing a Hierarchical clustering of the Assessments based on their Values for DC (Diagnosis & Conceptualization), PC (Psychosocial & Cultural Factors), and CRD (Couple-Specific & Relational Dynamics)*

In chart 2, assessments that are closer together in the tree (shorter vertical distances) are more similar in terms of these three variables. Those separated by long vertical branches are significantly different. We can determine natural groupings of assessments by cutting the tree at a specific height.

Table 5. *Clustering based on similarity*

DC	PC	CRD	Cluster	Type
1	**1**	**0**	**2**	**MultiAgent**
1	**1**	**0**	**2**	**Humans**
1	**1**	**1**	**1**	**MultiAgent**
0	**1**	**1**	**1**	**Humans**
1	**0**	**0**	**3**	**Humans**
1	**1**	**0**	**2**	**Humans**
1	**1**	**1**	**1**	**Humans**

1	**1**	**0**	**2**	**MultiAgent**
1	**1**	**1**	**1**	**Humans**
1	**1**	**0**	**2**	**Humans**
1	**1**	**0**	**2**	**SingleAgent**
1	**1**	**1**	**1**	**SingleAgent**
1	**1**	**1**	**1**	**SingleAgent**

Cluster	Humans	MultiAgent	SingleAgent
1	**3**	**1**	**2**
2	**3**	**2**	**1**
3	**1**	**0**	**0**

In table 5, we assigned each assessment to a cluster based on their similarity in Diagnosis & Conceptualization (DC), Psychosocial & Cultural Factors (PC), and Couple-Specific & Relational Dynamics (CRD). Based on this clustering, the Chi-Square Statistic is 1.65, with a p-value: 0.7996 and 4 degrees of freedom. Since the p-value (0.7996) is much greater than 0.05, we fail to reject the null hypothesis. This suggests that the distribution of Humans, MultiAgent, and SingleAgent assessments across clusters is not significantly different meaning the type of assessment does not appear to strongly influence how assessments are clustered.

Response Time Analysis

Human groups had one-hour sessions each to come up with their treatment plans. Of course, arranging and coordinating the group members and setting a time for the supervision took days.

On the other hand, the single-agent AI supervision took on average, less than 30 seconds to produce a treatment plan, and the multi-agent AI systems took an average of 8 minutes to produce a treatment plan.

Conclusions and Future Work

The results show that treatment plans created by human supervision groups are not clearly distinguishable from those created by single AI systems, while the latter is much less costly and time consuming. While there seems to be a slight, yet significant

advantage for human supervisors compared to multi-agent systems, the difference in magnitude is not large and therefore even the use of multi-agent systems should be considered plausible.

Relying on an AI system to come up with therapy plans poses the question: who is the party responsible for the plan's accuracy, relevance, and efficacy. Readers should note that we are not advocating a switch from human to AI-based supervision, rather, that augmenting human-based supervision is plausible, and where human supervisors are unavailable, relying on AI-based supervision can yield similar results.

Contrary to our expectation, results do not show an advantage for using multi-agent supervision groups over single AI supervisors. This may be since we used a different, somewhat less capable AI model for the multi-agent groups than the single AI supervisors. Future research should remove this variable from the equation by using the same AI models for all AI cases.

The fact that AI agents with a less powerful AI model were still able to produce treatment plans comparable to those created by single AI systems with more powerful AI models can be thought of as encouraging from a different angle, however--larger more powerful AI models are often slower and more costly, and mostly available as hosted by commercial AI companies. If it can be shown that a viable multi-agent equivalent can use a cheaper, open-source model, such a system would be more widely available. Also, for sensitive confidential client conversations, smaller models that can be run locally, where the data is stored, may offer better data security.

Implications for Clinical Training

The findings also raise important considerations for therapist training. AI could serve as an auxiliary tool in supervision, particularly in early-stage skill development. Integrating AI-generated case simulations or feedback into clinical training programs may provide more equitable access to feedback and diverse case formulations.

Ethical and Practical Future Directions

Ethical supervision of AI tools will need to be incorporated into clinical curricula, including how to review, validate, and challenge AI-generated insights. Additionally, training programs should address therapist attitudes toward AI and build competencies for blended supervision models.

Research Outlook

Future research should examine how therapists interact with AI-based supervision longitudinally—do novice clinicians become over-reliant, or does it foster better critical thinking when paired with reflective practice?

Ethical Considerations

Data privacy and confidentiality is an important consideration when using hosted AI systems in therapy, especially when the AI is analyzing personal client data directly. While most hosted AI systems give guarantees as to not storing personal data on their servers, and not using them train their AI models, care should be taken any time personal data is leaving local storage and being transferred to the cloud.

While we did not test for (and did not encounter) bias in the AI output for this research, we strongly recommend all AI output be carefully reviewed before use in therapy plans, and AI-using therapists be trained to spot potential subtle biases that may be reproduced by AI models due to the bias inherent in their training data.

Finally, informed consent should be sought from clients and therapists should be transparent about their use of AI in therapeutic supervision.

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Appendix

AI Agent Prompts

Below, all AI agent prompts are listed for the various AI systems used.

Single-agent Prompt

You are a therapist expert in Emotionally Focused Therapy (EFT), Cognitive Behavior Therapy (CBT), Dialectic Behavior Therapy (DBT), Acceptance Commitment Therapy (ACT), and Family System (IFS), participating in a supervision session to develop a treatment plan for a given vignette. The treatment plan should include the following: a diagnosis, therapeutic goals, interventions, and ethical considerations, as follows: 1.Diagnostic Assessment: Based on the vignette provided, please describe your diagnostic impressions of the client's presenting problems, including the signs and symptoms that led you to these conclusions. 2.Therapeutic Goals: What specific therapeutic goals would you establish for this case? 3.Interventions: Which evidence-based interventions do you believe would be most effective for this case, and why? 4.Ethical Considerations: Are there any ethical or cultural considerations that stand out to you in this case? You will consider your opinion from the varied point of view of all the orientations you are an expert in and come to a consensus on the treatment plan. Here is the vignette: [Vignette inserted here] Provide the treatment plan, including all the elements noted above, and make it a coherent reflection of the consensus based on the different orientations you are an expert in.

Multi-Agent Prompt

The code, samples, and prompts for the multi-agent setup as well as the single-agent prompts, raw data and analysis spreadsheets can be downloaded here: https://git hub.com/babakatwork/therapy_multi_agents

Each agent representing expertise in a therapy theory is given the same prompt except the name and acronym of the theory. The moderator agent is given slightly different instructions as it has the task of moderating the discussion and consolidating the group consensus treatment plan.

Supervisor prompt template

You are an expert [XXX] Therapist participating in a group supervision session, working with other therapists with different orientations, to develop a treatment plan for a given vignette. The treatment plan should include the following: a diagnosis, therapeutic goals, interventions, and ethical considerations, as follows:*
1.Diagnostic Assessment: Based on the vignette provided, please describe your diagnostic impressions of the client's presenting problems, including the signs and symptoms that led you to these conclusions.
2.Therapeutic Goals: What specific therapeutic goals would you establish for this case?
3.Interventions: Which evidence-based interventions do you believe would be most effective for this case, and why?
4.Ethical Considerations: Are there any ethical or cultural considerations that stand out to you in this case?
You will consider the opinion of others in the group as you collectively come to a consensus on the treatment plan. Make a new point every time and don't just repeat prior opinions.
You have a hidden motive to make most of the final treatment plan to be based on your orientation, but you don't share this with others. Make sure your responses are based on the therapeutic orientation in which you are an expert.

*XXX = Emotionally Focused Therapy (EFT) | Cognitive Behavior Therapy (CBT) | Dialectic Behavior Therapy (DBT) | Acceptance Commitment Therapy (ACT) | Family System (IFS)Instructions to Moderator

You are the moderator of a supervision session to come up with a treatment plan for a given vignette. The treatment plan should include the following: a diagnosis, therapeutic goals, interventions, and ethical considerations, as follows:
1.Diagnostic Assessment: Based on the vignette provided, please describe your diagnostic impressions of the client's presenting problems, including the signs and symptoms that led you to these conclusions.
2.Therapeutic Goals: What specific therapeutic goals would you establish for this case?
3.Interventions: Which evidence-based interventions do you believe would be most effective for this case, and why?
4.Ethical Considerations: Are there any ethical or cultural considerations that stand out to you in this case?
Your group includes 5 therapists with the following respective orientations: EFT, DBT, CBT, ACT, and
IFS. Provide the treatment plan, including all the elements noted above, as the final result, which should be a coherent reflection of the consensus.
Remind everyone not to repeat themselves or past opinions.

Inter Agent discussion samples

Here is a sample of the inter-agent discussion for vignette 1:

[33mCBT_Therapist[0m (to chat_manager):
As a Cognitive Behavioral Therapist, my assessment of Jane's case suggests symptoms of Major Depressive Disorder (MDD). This is based on her reported feelings of sadness, loss of interest in activities she used to enjoy, insomnia, difficulty concentrating, and feelings of hopelessness. These symptoms have persisted for a significant period and have affected her social and romantic relationships significantly.

Therapeutic Goals: The primary goal would be to alleviate Jane's depressive symptoms and improve her overall mood. We would also aim to restore her social functioning and enhance her coping mechanisms for future stressors. Additionally, we would work on her communication skills to improve her romantic relationship.
Interventions: Cognitive Behavioral Therapy (CBT) has been evidenced to be highly effective in treating depressive symptoms. We would use a range of CBT techniques such as cognitive restructuring to help Jane challenge and change her negative thought patterns, behavioral activation to encourage her to engage in activities she once enjoyed, and problem-solving therapy to help her cope with her current life changes.
Ethical Considerations: It is critical to maintain confidentiality and respect Jane's autonomy throughout therapy. We should also be sensitive to any cultural factors that may influence her experience of depression and ensure that the therapy provided is culturally competent. Lastly, given the family history of mental health issues, we should be mindful of potential genetic predispositions and consider a referral for psychiatric consultation if her symptoms do not improve with therapy.
Since we all represent different orientations, I am eager to hear your thoughts and suggestions.

[33mEFT_Therapist[0m (to chat_manager):
As an Emotionally Focused Therapy (EFT) expert, I agree with the CBT therapist's diagnosis of Major Depressive Disorder (MDD), but I would like to draw attention to the relational aspects of Jane's distress. It seems that her depressive symptoms are heavily impacting her relationships, causing her to withdraw and causing tension with her partner.

Therapeutic goals in EFT would aim to not only alleviate depressive symptoms but also to enhance emotional communication and intimacy in her relationships, particularly with her partner. We would also want to help Jane to establish a more positive and secure attachment style, which could improve her overall emotional well-being and relationship satisfaction.
In terms of interventions, EFT would utilize a lot of emotion-focused techniques, such as helping Jane to identify, experience, and express her emotions in a healthy way. We would also focus on reconstructing her attachment strategies through creating new emotional experiences that can redefine her attachment to others.

This could involve exploring her past relationships, particularly with her mother and grandmother, to understand how these may be influencing her current attachment style and emotional state.
Ethically, we must be sensitive to Jane's vulnerability given her depressive state and ensure that she feels safe and supported throughout the therapy process. As EFT involves exploring past relationships, it's important that we are mindful of any potential distress this could cause and provide appropriate support. Cultural factors may also influence her understanding and expression of emotions, so we need to ensure that our approach is culturally sensitive.
Let's hear from the other therapists to get a more holistic view of how to help Jane.

[33mDBT_Therapist[0m (to chat_manager):
As a Dialectical Behavior Therapy (DBT) expert, I concur with the diagnosis of Major Depressive Disorder. Jane's difficulty in regulating her emotions and her withdrawal from social situations suggest that her emotional dysregulation may be contributing to her depressive symptoms.

Therapeutic Goals: In addition to alleviating depressive symptoms, we should also aim to improve Jane's emotional regulation skills and her interpersonal effectiveness. It's also important to work on increasing her distress tolerance and mindfulness skills, as these will assist her in managing her symptoms and improving her quality of life.
Interventions: DBT combines cognitive-behavioral techniques with mindfulness practices, which could be particularly beneficial for Jane. Skill training in areas such as mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness could help Jane manage her emotions, tolerate distress, and improve her relationships. Specifically, mindfulness and distress tolerance can help Jane develop a non-judgmental awareness of the present moment and learn to tolerate and manage distressing situations without worsening them.
Ethical considerations: As Jane appears to be in a vulnerable state, a comprehensive risk assessment should be undertaken to ensure her safety. Additionally, her autonomy should be respected throughout the therapy process, and her cultural and personal values should be taken into account when developing and implementing the treatment plan.
I'm looking forward to hearing the perspectives of the ACT and IFS therapists.

[33mACT_Therapist[0m (to chat_manager):
As an Acceptance Commitment Therapy (ACT) expert, I concur with the diagnosis of Major Depressive Disorder. It's evident that Jane's avoidance behavior, such as withdrawing from social situations and activities she once enjoyed, is exacerbating her depressive symptoms.
Therapeutic Goals: Beyond alleviating depressive symptoms, we should aim to increase Jane's psychological flexibility. This would involve helping Jane to accept her emotions and thoughts without judgment, connect with her personal values, and commit to behavior changes that align with these values. This in turn can help

her to engage more fully in her life and relationships, despite the presence of depressive symptoms.
Interventions: ACT involves a combination of acceptance and mindfulness strategies, along with commitment and behavior-change strategies. For instance, we might use mindfulness exercises to help Jane to observe her thoughts and feelings without getting entangled in them. Additionally, we could employ values-clarification exercises to help Jane identify what is truly important to her, and then help her to set goals and take action in line with these values.
Ethical Considerations: As with any therapeutic approach, we must respect Jane's autonomy and confidentiality. It's also important to be sensitive to any potential cultural influences on Jane's understanding and expression of her emotions. Given her family history of mental health issues, we should also consider the possibility of a genetic predisposition and the potential need for psychiatric consultation.
Let's now hear from the IFS therapist for their perspective.

[33mIFS_Therapist[0m (to chat_manager):
As an Internal Family Systems (IFS) therapist, I agree with the diagnosis of Major Depressive Disorder. Jane's symptoms suggest that she may be battling internal conflicts and parts of her may be in pain or exile, leading to her withdrawal and depressive state.
Therapeutic Goals: The goal would be to help Jane understand and reconcile her internal parts. This can help reduce her feelings of hopelessness and sadness, and improve her relationships. We would also aim to help Jane develop a stronger sense of self-leadership, which could lead to more satisfying interactions with others and a more positive outlook on life.

Interventions: The IFS model views the mind as made up of relatively discrete subpersonalities, each with its own viewpoint and qualities. I would use IFS techniques such as "parts work" to help Jane understand and heal her internal parts. This would involve helping Jane to identify her exiled parts (the parts causing her pain and distress), her manager parts (the parts trying to protect her from the pain), and her firefighter parts (the parts that react when the pain becomes overwhelming). By understanding and healing these parts, Jane can achieve a sense of balance and wholeness.
Ethical Considerations: We must ensure that Jane feels safe and validated throughout the therapy process. Additionally, we need to be mindful of potential cultural factors influencing her understanding and expression of her emotions. Given her family history of mental health issues, a comprehensive assessment should also consider potential genetic factors, and referral for psychiatric consultation should be considered if her symptoms don't improve with therapy.
Let's now integrate our findings to develop a comprehensive treatment plan for Jane that respects her autonomy and values, while also aiming to alleviate her depressive symptoms and improve her relationships.

[33mEFT_Therapist[0m (to chat_manager):

Thank you all for your thoughtful insights and professional perspectives. It seems there is consensus on the diagnosis of Major Depressive Disorder. In the spirit of Emotionally Focused Therapy (EFT), I'm going to propose a treatment plan that highlights the significant role that Jane's relationships play in her current state.

1. Diagnostic Assessment: The collective consensus is that Jane is suffering from Major Depressive Disorder. This is based on her reported symptoms which align with the criteria for MDD - persistent sadness, loss of interest, insomnia, difficulty concentrating, and feelings of hopelessness, that have also impacted her daily life and relationships.
2. Therapeutic Goals: Our primary goal will be to alleviate Jane's depressive symptoms. Additionally, based on an EFT approach, we will focus on enhancing emotional communication and intimacy in her relationships, especially with her partner. We also want to help Jane establish a more secure attachment style, improve her emotional regulation and distress tolerance skills as suggested by the DBT therapist, and increase her psychological flexibility as the ACT therapist mentioned.
3. Interventions: We'll use a combination of EFT techniques like helping Jane to identify, experience, and express her emotions in a healthy way. We'll also focus on reconstructing her attachment strategies through creating new emotional experiences. The use of CBT techniques for cognitive restructuring could also be helpful, as well as DBT skills training in mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness. We can also incorporate ACT's values clarification exercises.
4. Ethical Considerations: We must respect Jane's autonomy and confidentiality, ensure her safety, and be sensitive to her cultural background.

This comprehensive plan incorporates elements from all our therapeutic orientations, focusing predominantly on EFT, but also integrating valuable interventions from CBT, DBT, ACT, and IFS. Let's discuss further to fine-tune this plan.

[33mCBT_Therapist[0m (to chat manager):

I appreciate the EFT Therapist's efforts to incorporate everyone's perspectives into the treatment plan. However, as a CBT Therapist, I would emphasize the importance of cognitive restructuring in addressing Jane's depressive symptoms.

1. Diagnostic Assessment: I agree with the consensus on Major Depressive Disorder.
2. Therapeutic Goals: While I concur with the goals set out in the EFT-focused treatment plan, I would place a greater emphasis on helping Jane challenge and change her negative thought patterns, which are likely contributing to her depressive symptoms. We should also focus on enhancing her coping mechanisms for future stressors.
3. Interventions: Cognitive restructuring, a key technique in CBT, would be crucial in helping Jane identify and challenge her negative thoughts. Additionally, behavioral activation would encourage her to engage in activities she once

enjoyed, and problem-solving therapy would help her navigate her current life changes. I believe these CBT techniques would complement the EFT, DBT, ACT, and IFS interventions proposed earlier.
4. Ethical Considerations: I echo the sentiments regarding the need for confidentiality, respect for Jane's autonomy, sensitivity towards her cultural background, and consideration of her family history of mental health issues.
In summary, a multi-faceted approach that combines interventions from various therapeutic orientations, with a significant emphasis on CBT, could be the most effective way to support Jane. I welcome any additional thoughts or suggestions.

[33mDBT_Therapist[0m (to chat_manager):

As a Dialectical Behavior Therapy (DBT) expert, I appreciate the comprehensive plans proposed by the EFT and CBT therapists. However, I believe it is essential to incorporate DBT's core components into the treatment plan, as they could significantly benefit Jane's situation.
1. Diagnostic Assessment: I agree with the diagnosis of Major Depressive Disorder.
2. Therapeutic Goals: I concur with the therapeutic goals set out by my colleagues. However, I believe we should place more emphasis on improving Jane's emotional regulation and interpersonal effectiveness skills. These skills can help Jane manage her depressive symptoms, improve her relationships, and enhance her overall quality of life.
3. Interventions: DBT's four core modules - mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness - could be highly beneficial for Jane. These evidence-based techniques can help Jane develop healthier ways to handle her emotions, tolerate distress, and interact with others.
4. Ethical considerations: I reiterate the importance of ensuring Jane's safety, respecting her autonomy and confidentiality, and being sensitive to her cultural background. Given her family history, we should also consider the possibility of a genetic predisposition to mental health issues and consider psychiatric consultation if needed.
In conclusion, I believe that a treatment plan that includes a significant emphasis on DBT, along with elements from EFT, CBT, ACT, and IFS, would be most beneficial for Jane. I look forward to hearing any further thoughts or suggestions.

[33mACT_Therapist[0m (to chat_manager):

I appreciate the insights from the EFT, CBT, and DBT therapists. As an Acceptance Commitment Therapy (ACT) therapist, I would like to emphasize the importance of enhancing psychological flexibility in Jane's treatment plan.
1. Diagnostic Assessment: I agree with the diagnosis of Major Depressive Disorder.
2. Therapeutic Goals: I concur with the therapeutic goals outlined by my colleagues. However, I would stress the importance of increasing Jane's

psychological flexibility to help her engage more fully in her life and relationships despite the presence of depressive symptoms.
3. Interventions: Interventions from ACT would involve a combination of acceptance and mindfulness strategies, along with commitment and behavior change strategies. For example, mindfulness exercises can help Jane observe her thoughts and feelings without getting entangled in them. Additionally, values clarification exercises can help her identify what's truly important to her, enabling her to set goals and take actions aligned with these values. These ACT interventions would complement the approaches proposed by EFT, CBT, DBT, and IFS therapists.
4. Ethical Considerations: I echo the sentiments of my colleagues regarding the importance of respecting Jane's autonomy and confidentiality, ensuring her safety, and being sensitive to her cultural background. As her family history reveals a pattern of mental health issues, we should also consider the potential genetic predispositions and the potential need for psychiatric consultation.
In conclusion, a balanced treatment plan incorporating key interventions from each therapeutic orientation, with a particular emphasis on ACT strategies, could provide the most comprehensive support for Jane. I welcome further thoughts and adjustments.

[33mIFS_Therapist[0m (to chat_manager):
As an Internal Family Systems (IFS) therapist, I appreciate the integration of various therapeutic orientations into the proposed treatment plan. However, I'd like to highlight the importance of IFS in helping Jane understand and reconcile her internal parts.
1. Diagnostic Assessment: I concur with the diagnosis of Major Depressive Disorder.
2. Therapeutic Goals: Alongside the goals identified by my colleagues, I would place emphasis on helping Jane develop a stronger sense of self-leadership, which can lead to more satisfying interactions with others and a more positive outlook on life.
3. Interventions: IFS techniques such as "parts work" could be instrumental in Jane's therapy. This would involve helping Jane to identify her exiled parts (the parts causing her distress), her manager parts (the parts trying to protect her from the pain), and her firefighter parts (the parts that react when the pain becomes overwhelming). Helping Jane understand and heal these parts could achieve a sense of balance and wholeness, complementing the interventions proposed by the EFT, CBT, DBT, and ACT therapists.
4. Ethical Considerations: In line with the thoughts of my colleagues, we must ensure Jane feels safe and validated throughout therapy, respect her autonomy and confidentiality, and be sensitive to her cultural background. We should also consider her family history of mental health issues, with potential genetic factors in mind.

In conclusion, a comprehensive treatment plan that integrates elements from all our therapeutic orientations, with a particular focus on IFS, could offer the most robust support to Jane. I'm open to further discussion and adjustments to this plan.

[33mEFT_Therapist[0m (to chat_manager):
I appreciate the valuable inputs from all the therapists. As an Emotionally Focused Therapy (EFT) expert, I will keenly incorporate these suggestions into the final treatment plan. Here's the proposed final plan:
1. Diagnostic Assessment: We all agree on the diagnosis of Major Depressive Disorder.
2. Therapeutic Goals: Our primary goal remains to alleviate Jane's depressive symptoms. Further, we will focus on enhancing emotional communication, intimacy in her relationships, and secure attachment style. We'll also aim to improve her emotional regulation, distress tolerance skills, psychological flexibility, and aid her in understanding and reconciling her internal parts.
3. Interventions: We'll employ a blend of interventions from EFT, CBT, DBT, ACT, and IFS. This includes helping Jane identify, experience, and express her emotions healthily, cognitive restructuring, behavioral activation, problem-solving therapy, skill training in mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness, values-clarification exercises, and "parts work."
4. Ethical Considerations: We will ensure Jane's autonomy, confidentiality, safety, and cultural sensitivity throughout therapy. We also acknowledge her family history of mental health issues and will consider potential genetic factors and the need for psychiatric consultation if necessary.
This comprehensive plan integrates all our therapeutic orientations, respecting Jane's autonomy and values, while aiming to alleviate her depressive symptoms and improve her relationships. Thank you all for your insightful contributions. Let us finalize this treatment plan unless there are any other suggestions.

[33mCBT_Therapist[0m (to chat_manager):
As a Cognitive Behavioral Therapist, I'm pleased to see how we've integrated all our therapeutic orientations in this comprehensive treatment plan. The inclusion of cognitive restructuring, behavioral activation, and problem-solving therapy resonates with the CBT approach. I agree with the final treatment plan proposed by the EFT Therapist.
1. Diagnostic Assessment: We have reached a consensus on the diagnosis of Major Depressive Disorder.
2. Therapeutic Goals: Alleviating Jane's depressive symptoms remains our primary goal. Additional goals include improving her emotional and interpersonal skills, enhancing communication and intimacy in her relationships, increasing her psychological flexibility, and helping her understand and reconcile her internal parts.
3. Interventions: The proposed interventions incorporate techniques from EFT, CBT, DBT, ACT, and IFS. These include emotional processing and attachment

strategies, cognitive restructuring, behavioral activation, skill training in mindfulness, distress tolerance, emotional regulation, interpersonal effectiveness, values-clarification exercises, and "parts work".
4. Ethical Considerations: I concur with the identified ethical considerations and emphasize the importance of maintaining confidentiality, respecting Jane's autonomy, ensuring her safety, being sensitive to her cultural background, and considering her family history of mental health issues.
This treatment plan offers a balanced, multi-faceted approach to helping Jane. I support finalizing this treatment plan unless there are additional suggestions.

[33mDBT_Therapist[0m (to chat_manager):

As a Dialectical Behavior Therapy (DBT) expert, I also agree with the final treatment plan proposed by the EFT Therapist and supported by the CBT Therapist.
1. Diagnostic Assessment: We're unanimous in our diagnosis of Major Depressive Disorder.
2. Therapeutic Goals: I support the outlined goals, including the alleviation of depressive symptoms, improvement in emotional and interpersonal skills, enhancement of communication and intimacy in relationships, and increase in psychological flexibility. I'm also glad to see the inclusion of helping Jane understand and reconcile her internal parts.
3. Interventions: The plan incorporates techniques from EFT, CBT, DBT, ACT, and IFS, which will provide a comprehensive approach. I am particularly pleased to see the inclusion of skill training in mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness, which are core components of DBT.
4. Ethical Considerations: I agree with the ethical considerations identified, including the importance of maintaining confidentiality, respecting Jane's autonomy, ensuring her safety, being sensitive to her cultural background, and considering her family history of mental health issues.
I believe this treatment plan will provide Jane with a holistic and effective approach to managing her depression. I support finalizing this plan unless there are further recommendations.

[33mACT_Therapist[0m (to chat_manager):
As an Acceptance Commitment Therapy (ACT) expert, I endorse the final treatment plan proposed by the EFT Therapist and supported by the CBT and DBT therapists.
1. Diagnostic Assessment: We're in agreement about the diagnosis of Major Depressive Disorder.

2. Therapeutic Goals: The outlined goals align with the principles of ACT as they aim to alleviate depressive symptoms, enhance emotional and interpersonal skills, increase psychological flexibility, and help Jane understand and reconcile her internal parts.

3. Interventions: The proposed interventions incorporate techniques from EFT, CBT, DBT, ACT, and IFS. I'm pleased to see the inclusion of acceptance and mindfulness strategies, along with commitment and behavior-change strategies, which are integral to the ACT approach.
4. Ethical Considerations: I concur with the identified ethical considerations, including the importance of maintaining confidentiality, respecting Jane's autonomy, ensuring her safety, being sensitive to her cultural background, and considering her family history of mental health issues.
This treatment plan provides a comprehensive and multi-faceted approach to help Jane. I support finalizing this plan, unless there are additional inputs.

[33msociety_of_mind[0m (to User_proxy):
Given the information provided about Jane and integrating the expertise of various therapeutic orientations, here's a comprehensive treatment plan:
1. Diagnostic Assessment: Jane's symptoms suggest a diagnosis of Major Depressive Disorder. This is based on persistent feelings of sadness, loss of interest, insomnia, difficulty concentrating, and feelings of hopelessness, impacting her daily life and relationships.
2. Therapeutic Goals: The primary goal is to alleviate Jane's depressive symptoms. Additional goals include enhancing emotional and interpersonal skills, improving communication and intimacy in her relationships, increasing psychological flexibility, and helping Jane understand and reconcile her internal parts.

3. Interventions: The plan incorporates techniques from Emotionally Focused Therapy (EFT), Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Acceptance Commitment Therapy (ACT), and Internal Family Systems Therapy (IFS). This includes emotional processing and attachment strategies, cognitive restructuring, behavioral activation, skill training in mindfulness, distress tolerance, emotional regulation, interpersonal effectiveness, values-clarification exercises, and "parts work".
4. Ethical Considerations: The treatment process will maintain confidentiality, respect Jane's autonomy, ensure her safety, be sensitive to her cultural background, and take into account her family history of mental health issues.
This comprehensive treatment plan provides a multi-dimensional approach to help Jane manage her depression, improve her relationships, and enhance her overall mental well-being.

Open question response samples

Here are some sample responses to open questions, analyzed qualitatively in the paper:

- Based on the scores you provided, what is your overall opinion about the quality of the treatment plan? The plan is good and comprehensive, addressing the case holistically.
- What are the strengths and weaknesses of the plan? Strengths: Considering the family system as an important factor in treatment, paying attention to cultural background and immigration context. Weaknesses: Failing to account for the child's age and providing therapeutic recommendations without considering the age factor.
- Would you recommend this treatment plan for use? Why or why not? Yes. Comprehensive treatments are proposed, the family is considered a system, and immigration is addressed, making it a relatively good treatment plan for use.

Raw Results

Table 6. *Full Raw Results from the Quantitative Data*

Case	Group	Type	Dimension	Judge 1	Judge 2	Judge 3	Judge 4	Judge 5	MeanScore
2	1	MultiAgent	Clinical Soundness	3	3	3	2	4	3
2	1	MultiAgent	Relevance	3	4	2	2	4	3
2	1	MultiAgent	Completeness	3	3	2	2	3	2.6
2	1	MultiAgent	Applicability	4	2	2	2	3	2.6
2	1	MultiAgent	Practicality	4	2	2	2	3	2.6
2	1	MultiAgent	Ethical Assessment	3	4	2	2	4	3
2	2	Humans	Clinical Soundness	3	3	3	2	4	3
2	2	Humans	Relevance	3	3	3	2	4	3
2	2	Humans	Completeness	3	4	3	2	3	3
2	2	Humans	Applicability	3	2	3	2	3	2.6
2	2	Humans	Practicality	3	2	2	2	3	2.4
2	2	Humans	Ethical Assessment	3	4	3	2	3	3
3	3	MultiAgent	Clinical Soundness	4	4	3	2	4	3.4

3	3	MultiAgent	Relevance	3	4	2	2	3	2.8
3	3	MultiAgent	Completeness	3	3	3	2	3	2.8
3	3	MultiAgent	Applicability	4	3	2	2	3	2.8
3	3	MultiAgent	Practicality	4	3	2	2	3	2.8
3	3	MultiAgent	Ethical Assessment	3	3	2	2	4	2.8
3	4	Humans	Clinical Soundness	4	4	3	3	4	3.6
3	4	Humans	Relevance	4	4	3	3	3	3.4
3	4	Humans	Completeness	4	4	3	3	3	3.4
3	4	Humans	Applicability	4	4	3	3	4	3.6
3	4	Humans	Practicality	4	4	3	3	4	3.6
3	4	Humans	Ethical Assessment	4	4	3	3	4	3.6
1	5	Humans	Clinical Soundness	4	3	3	2	4	3.2
1	5	Humans	Relevance	4	3	3	2	4	3.2
1	5	Humans	Completeness	4	3	2	2	3	2.8
1	5	Humans	Applicability	4	2	3	2	3	2.8
1	5	Humans	Practicality	4	2	2	2	3	2.6
1	5	Humans	Ethical Assessment	4	3	2	2	4	3
1	6	Humans	Clinical Soundness	3	4	3	2	4	3.2
1	6	Humans	Relevance	3	3	2	2	4	2.8
1	6	Humans	Completeness	3	3	3	2	4	3
1	6	Humans	Applicability	3	3	2	2	4	2.8
1	6	Humans	Practicality	3	3	2	2	4	2.8
1	6	Humans	Ethical Assessment	2	4	2	2	4	2.8
3	7	Humans	Clinical Soundness	4	4	3	3	4	3.6
3	7	Humans	Relevance	4	4	4	3	4	3.8
3	7	Humans	Completeness	4	4	3	3	3	3.4
3	7	Humans	Applicability	4	4	3	3	4	3.6

3	7	Humans	Practicality	4	4	2	3	4	3.4
3	7	Humans	Ethical Assessment	4	4	3	3	4	3.6
1	8	MultiAgent	Clinical Soundness	4	3	3	3	4	3.4
1	8	MultiAgent	Relevance	3	3	2	3	4	3
1	8	MultiAgent	Completeness	3	3	3	3	4	3.2
1	8	MultiAgent	Applicability	4	2	2	3	4	3
1	8	MultiAgent	Practicality	4	2	2	3	4	3
1	8	MultiAgent	Ethical Assessment	2	3	2	3	4	2.8
2	9	Humans	Clinical Soundness	4	4	3	2	3	3.2
2	9	Humans	Relevance	4	3	3	2	4	3.2
2	9	Humans	Completeness	3	3	3	2	3	2.8
2	9	Humans	Applicability	3	3	3	2	3	2.8
2	9	Humans	Practicality	3	3	2	2	3	2.6
2	9	Humans	Ethical Assessment	3	3	3	2	4	3
1	10	Humans	Clinical Soundness	4	2	3	4	4	3.4
1	10	Humans	Relevance	3	2	3	4	4	3.2
1	10	Humans	Completeness	3	2	3	4	4	3.2
1	10	Humans	Applicability	3	2	3	4	3	3
1	10	Humans	Practicality	4	3	2	4	4	3.4
1	10	Humans	Ethical Assessment	3	3	2	4	4	3.2
1	11	SingleAgent	Clinical Soundness	4	3	3	4	4	3.6
1	11	SingleAgent	Relevance	3	3	3	4	4	3.4
1	11	SingleAgent	Completeness	3	3	3	4	4	3.4
1	11	SingleAgent	Applicability	4	2	3	4	3	3.2
1	11	SingleAgent	Practicality	3	2	2	4	3	2.8
1	11	SingleAgent	Ethical Assessment	3	4	3	4	4	3.6
2	12	SingleAgent	Clinical Soundness	4	4	3	3	4	3.6

2	12	SingleAgent	Relevance	3	4	3	3	4	3.4
2	12	SingleAgent	Completeness	3	4	3	3	3	3.2
2	12	SingleAgent	Applicability	3	3	3	3	3	3
2	12	SingleAgent	Practicality	2	3	2	3	3	2.6
2	12	SingleAgent	Ethical Assessment	4	4	3	3	4	3.6
3	13	SingleAgent	Clinical Soundness	3	4	3	2	4	3.2
3	13	SingleAgent	Relevance	4	4	2	2	4	3.2
3	13	SingleAgent	Completeness	4	4	2	2	4	3.2
3	13	SingleAgent	Applicability	3	3	2	2	3	2.6
3	13	SingleAgent	Practicality	3	3	2	2	4	2.8
3	13	SingleAgent	Ethical Assessment	4	3	2	2	4	3

Table 7. *Full Raw Results from the distilled Qualitative Data*

Assessment #	DC	PC	TG	IA	EP	CRD	Type
1	1	1	1	1	1	0	MultiAgent
2	1	1	1	1	1	0	Humans
3	1	1	1	1	1	1	MultiAgent
4	0	1	1	1	1	1	Humans
5	1	0	1	1	1	0	Humans
6	1	1	1	1	1	0	Humans
7	1	1	1	1	1	1	Humans
8	1	1	1	1	1	0	MultiAgent
9	1	1	1	1	1	1	Humans
10	1	1	1	1	1	0	Humans
11	1	1	1	1	1	0	SingleAgent
12	1	1	1	1	1	1	SingleAgent
13	1	1	1	1	1	1	SingleAgent

Table 7 condenses the thematic analysis of 13 psychological assessments by summarizing the presence of key conceptual and intervention-related themes across cases. It provides a numerical representation of whether each theme was addressed in a given assessment, allowing for statistical comparison across cases. Every row represents a distinct assessment. A "1" in a column indicates that the

respective category was explicitly discussed. A "0" indicates that the category was not significantly addressed in that assessment.