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Developing clinical psychology as an experimental-behavioral science

Newsletter

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Inside The Issue

Presidential Column

J. Davila.....2

Diversity Corner

*"And Then There Was COVID": Understanding the Graduate Student
Experience from the Perspective of an African American Student During
COVID-19*

D. McDuffie.....6

Clinician Perspective

*Client Attitudes Towards Telemental Health and What We Can Do to
Address Them*

H. Brockstein.....9

Early Career Perspective

*"It Won't Cost You Much, Just Your Voice!": On Rediscovering A Human
Voice in Academia*

C. Rodriguez-Seijas.....12

Student Perspective

Telehealth in Clinical Psychology: Challenges and Future Directions

H. Willis.....15

Introductory SSCP Diversity Blog.....19

Awards & Recognition.....20

Student Special Feature.....29

Updates from Student Representatives

A. Klein & A. Rabasco.....31

Articles published in *Clinical Science* represent the views of the authors and not necessarily those of the Society for a Science of Clinical Psychology, the Society of Clinical Psychology, or the American Psychological Association. Submissions representing differing views, comments, and letters to the editor are welcome.

PRESIDENTIAL COLUMN

Joanne Davila, Ph.D.
Stony Brook University



I will start this Presidential column by saying that this has not been the year I thought it was going to be. Indeed, I never could have predicted what would happen during my SSCP Presidency and how science could be affected. I wrote this column in early September, as I was reflecting on a very difficult six months. And even in the weeks between when

I prepared this column and its publication just now, events happened, the timing of which I could not have predicted.

One of those was the passing of Scott Lilienfeld.

Though I could not have predicted when we would lose Scott, it was not unexpected. Sadly, when I stepped into the role of President in January, I knew that it was coming. What I didn't know was coming last January was that Scott would resign and sever his relationship with SSCP later in June. That was completely unexpected. I never would have predicted it, nor the content and intensity of the listserv debate that he initiated. Regardless of your take on that debate, I suspect that most of us would agree that the debate changed SSCP in some ways. I also believe that we can find another point of agreement. Whatever your feelings about Scott, I think we can all agree that Scott made extensive, significant contributions to clinical psychological science, and challenged the field to think critically in novel ways. This is why Scott received the SSCP Visionary Award (formerly the Scott Lilienfeld Visionary Award). Though the award no longer bears his name (on his request), that he was the inaugural recipient of it will always be a part of SSCP history. In addition, as you may know from the listserv, the SSCP Board is discussing, in consultation with stakeholders, the best way to honor Scott in the context of his resignation and request.

So, now I will continue on with what I wrote in early September, reflecting on other unexpected events of the year and their effect on science. I'll start by telling you a non-scientific story that sets the

stage for how I have been thinking about what's happened, and SSCP's role going forward. Back in September 2019, when I was President-Elect, Tom Olin (our prior APS Convention organizer) told me that I would need to give a Presidential address at APS. Somehow, I hadn't realized that. I actually like giving talks, but I didn't know what I wanted to talk about and the idea of a Presidential address felt somewhat daunting. So I said to Tom, "Ugh, do I have to? I really don't want to... Would I be totally out of line if I didn't do this?" Tom was quite surprised by this, knowing me, and he was very kind in response (and basically said "yes, you have to"), but I continued to fret (privately) about my talk. Well, then came the COVID pandemic, the cancellation of APS, and, of course, the cancellation of my talk. Fortunately, I'm enough of a scientist to know that I didn't cause the pandemic with my wish to not give a talk, but it certainly is one of those "be careful what you wish for" situations! Anyway, not to let passive avoidance take over, I wrote my Presidential address and delivered it as an SSCP VCL. And, of course, now I really wish that I had been able to give the talk at APS.

I've had a number of moments this past year when I wished for things, in addition to those related to my Presidential address. I wished the pandemic had never happened. I wished George Floyd (and all the others) had never been murdered. I wished that we could just go back to the time before all of this. But, of course, we can't. And I quickly came to see that we shouldn't, even if we could, because these events must be used to teach us about science. The COVID pandemic, and how it has been handled, reinforces the importance of science, the importance of using science to make informed decisions, and the importance of promoting science to everyone. The blatant racist police brutality in the US has drawn our attention to, among other things, the structural and systemic racism that exists, including in science and academia. Although it's easy to wish this wasn't true, we would be abandoning our roles as scientists if we did so.

A key aspect of science is questioning. When I was growing up, I was told not to question things, and particularly not to ask people too many questions. But I had a lot of questions, and, although it was hard for me to ask them (you can only imagine the first time I did therapy!), I wanted to, and I

knew I had to. My training reinforced this. So now, I bring this questioning to my own science and to the endeavor of science itself in light of calls to look at structural and systemic racism. If we, as scientists, don't question our own science – including, how it developed, what we value and why, our assumptions, the theories and methods and samples we use – then we're not being good scientists.

“If we, as scientists, don't question our own science – including, how it developed, what we value and why, our assumptions, the theories and methods and samples we use – then we're not being good scientists.”

My Presidential address was all about questioning. Although not focused on issues related to racism, it was focused on other aspects of diversity in relationship science, including sexual and gender orientation, and diversity in relationship types. In the talk, I questioned key assumptions on which the field had been operating, with the hopes of encouraging new ways of thinking about and approaching relationships. Relationship science also needs to pay greater attention to diversity with regard to race/ethnicity as well, though I am heartened by the work that does exist. Indeed, there is a growing body of literature on relationship functioning and interventions with underserved couples (e.g., Doss et al., 2020; Parker & Campbell, 2017; Salivar, Roddy, Nowlan, & Doss, 2018; Wischkaemper et al., 2020), particularly African American couples (e.g., Barton et al., 2018; Fincham, Ajayi, & Beach, 2011; Lavner, Barton, Bryant, & Beach, 2018; McNeil, Fincham, & Beach, 2014; Mickle & Dorie, 2019), as well as approaches to understanding and working clinically with diverse couples and families (e.g., Halford & Van De Vijver, 2020; Rastogi & Thomas, 2009).

One thing that stands out for me is data showing that associations between satisfaction in romantic relationships and mental and physical health are consistent across a range of racial/ethnic groups in the US (McShall & Johnson, 2015a; 2015b). Although, we must be very cautious in generalizing from romantic relationships to other relationships, if we look at the literature on interpersonal factors more generally, meta-analytic data support the association between social support broadly defined and health (e.g., Holt-Lunstad, Smith, & Layton, 2010). Broadening further, and pertinent to us, meta-analytic data also support the association between perceived workplace racial discrimination and (poorer) health (e.g., del Carmen Triana, Jayasinghe, & Pieper, 2015). The point I want to make here is that data generally support the notion

that the quality of the relationships we have with people, and the extent to which we feel supported and not discriminated against (including in our workplace), is related to our well-being, and this appears to be true across racial/ethnic groups.

My reflections on what has happened in our world since March 2020 and on the state of relationship science (broadly speaking) reinforced two key things that I believe we, as individuals, as an organization, and as a field, need to do. One is to examine ourselves and our science because, as I noted earlier, questioning is a foundation of science. The other is to build supportive relationships with others, because science tells us how critical relationships are to healthy functioning, across diverse individuals. Importantly, both of these are central to developing cultural humility and to creating an inclusive environment. At the core of doing so is self-examination and awareness, the examination and awareness of structures in our life that we have taken for granted, and being other-oriented in a way that conveys understanding, value, and respect, and allows for the building of collaborative relationships (e.g., Duan, 2020; Hook, Davis, Owen, & DeBleare, 2017).

In the context of this, let me reflect on my SSCP Presidency thus far. In my February 2020 column, I outlined three goals that I intended to pursue.

The first was for SSCP to uphold our focus on science. There are some who believe that I have not done so. SSCP has continued this year to promote science in all the ways it has always done. But there is one way in which we have deviated from what SSCP has always done. And this has been by opening the door to the explicit promotion of a more inclusive science, and to the questioning of ourselves and our science in ways that we typically have not done before as an organization. Furthermore, in doing so, the organization has supported the building of relationships that are more inclusive as well. The SSCP board believes this is an important step for the organization.

Among our organizational achievements in these regards are:

- Including resources on racism and anti-racism on our website
- Providing reflection questions that may assist SSCP members in developing strategies to become anti-racist
- Creating a blog, hosted by our Diversity Committee, that will provide a forum for discussing issues relevant to clinical psychological science
- Launching an initiative to utilize our Virtual Clinical Lunch (VCL) mechanism as a shared

and centralized venue to compile talks by BIPOC scholars and/or about diversity related issues

- Creating an additional set of awards dedicated specifically for BIPOC scholars and/or about diversity related issues. As you know, we recently launched a successful fundraising campaign with the aim of consistently funding a fourth Varda Shoham Clinical Science Training Initiative award focusing on Diversity and Inclusion. We will be creating additional awards, within our existing award mechanisms, going forward.

As another aspect of my Presidential goal to uphold science, I encouraged all of us to do so at the individual level as well as the organization level. In particular, here is a quote from my February column:

“There are things I think we all need to do as individuals as well to continue to promote a scientific approach. One is to think about how we conduct and disseminate science. I have been thinking about something that was discussed at the CAAPS (Coalition for the Advancement and Application of Psychological Science) meeting at ABCT this past November, which was also clearly articulated by Bethany Teachman in a November posting to the SSCP listserv. It’s not surprising, but it highlights one of the ways in which we are failing. Specifically, if we want to truly make an impact and reduce the burden of mental illness, we need to better engage with the people and communities we want to serve and understand their needs in context. Sounds obvious, but we are not successfully doing this. I encourage all of you to think about how you, personally, can conduct research, engage in prevention and intervention efforts, and generally promote science in a way that connects with and reaches those we most need to reach.”

At the time I wrote this, I had no idea we’d be where we are in the US with regard to the anti-racism movement. Indeed, I myself did not fully recognize how negligent we had been as a field despite my personally being actively engaged in diversity, equity, and inclusion efforts since graduate school. As I reflect back on my own words, they resonate even more strongly for me now. In addition, although I framed this as an individual endeavor, this is now, clearly, a necessary organizational and field level endeavor.

The second goal that I intended to pursue this year was to promote collaborative relationships with others to reach shared goals. SSCP was able to accomplish this goal in a very specific way that I had intended. We created an alliance between our External Boards and Awards Committee (EBA) and the Academy of Psychological Clinical

Science’s Collaboration and Partnerships Committee (CPC) to work together to increase clinical science representation in the major organizations and leadership roles in psychology. The joint mission of these committees will be to publicize and help elect clinical scientists to leadership positions (and the EBA will retain its other functions as well). Our thanks go to the Chair of EBA, Eugene Botanov, and the Executive Committee of the Academy, led by President Cindy Yee-Bradbury, for facilitating this.

“SSCP has continued this year to promote science in all the ways it has always done. But there is one way in which we have deviated from what SSCP has always done.... And this has been by opening the door to the explicit promotion of a more inclusive science, and to the questioning of ourselves and our science in ways that we typically have not done before as an organization.”

We were also able to accomplish this goal in a way that I could not have predicted when my term began. Specifically, I assisted in initiating and maintaining a collaboration among the leaders of SSCP, the Academy, CAAPS, CUDCP (Council of University Directors of Clinical Psychology), and CCTC (Council of Chairs of Training Councils) to stay informed and, where sensible, to work jointly on anti-racism efforts in the field. At a time where so many organizations are engaging in self-assessment, organizing committees and task-forces to make anti-racism action plans, and calling on BIPOC colleagues to assist, it is important that our leading organizations share resources, work together, distribute workload, and engage in novel activities – and support one another in doing so. I thank Bethany Teachman, Mitch Prinstein, Mandy Jensen-Doss, Cindy Yee-Bradbury, Jason Washburn, and Debi Bell for their engagement in this collaborative and supportive process.

This leads to the third goal that I intended to pursue, which was to encourage service so that our shared goals can be reached. Service is needed now more than ever with the field’s emphasis on anti-racism. This emphasis involves many new and expanded service activities – activities that should be done by everyone. Not just BIPOC individuals, and not just organization leaders, but all of us. And with that, I am thrilled to say that we have a number of new SSCP Board members joining us as we continue to support and promote clinical science, and as we work to support greater inclusivity in our field. Please welcome:

- **President-Elect:** Marisol Perez, Associate Professor, Department of Psychology, Arizona State University
- **Member-at-Large:** Sarah Hope Lincoln, Assistant Professor, Department of Psychological Sciences, Case Western Reserve University
- **Division 12 Representative:** Shari Steinman, Assistant Professor, Department of Psychology, West Virginia University
- **Student Representative:** Rachel Walsh, Graduate Student, Department of Psychology, Temple University

I also want to take this opportunity to thank our out-going Board members:

- Ana Rabasco (**Student Representative**)
- Bob Klepac (**Division 12 Representative**)
- Katie Baucom (**Member-at-Large**)
- Carolyn Becker (**Past-President**)

Their dedication to SSCP was tremendous and unending, and their contributions were significant. Indeed, the entire SSCP Board this past year worked extremely hard and was the epitome of collaborative, committed teamwork. The organization has benefitted greatly from, and I thank them deeply for, their service. I particularly want to thank our out-going Past-President, Carolyn, for her strong leadership and wise guidance.

I look forward to continuing my Presidential initiatives in the remaining months of my Presidency, and I thank you all for your support. Although not the year I thought it was going to be, it was an honor to serve as President of SSCP.

References

- Barton, A.W., Beach, S.R.H., Wells, A.C., Ingels, J. B., Corso, P. S., Sperr, M. C., Anderson, T. N., & Brody, G. H. (2018). The Protecting Strong African American Families Program: A Randomized Controlled Trial with Rural African American Couples. *Prevention Science*, 19, 904–913. <https://doi.org/10.1007/s11121-018-0895-4>
- del Carmen Triana, M., Jayasinghe, M., & Pieper, J. R. (2015). Perceived workplace racial discrimination and its correlates: A meta-analysis. *Journal of Organizational Behavior*, 36, 491–513.
- Doss, B. D., Knopp, K., Roddy, M. K., Rothman, K., Hatch, S. G., & Rhoades, G. K. (2020). Online programs improve relationship functioning for distressed low-income couples: Results from a nationwide randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 88(4), 283–294. <https://doi.org/10.1037/ccp0000479>
- Duan, C. (2020). Serving the underserved: Delivering culturally appropriate psychotherapy to racial and ethnic minorities. In J. Zimmerman, J. E. Barnett, & L. F. Campbell (Eds.), *Bringing Psychotherapy to the Underserved* (pp. 69–07). NY: Oxford.
- Fincham, F. D., Ajayi, C., & Beach, S. R. H. (2011). Spirituality and marital satisfaction in African American couples. *Psychology of Religion and Spirituality*, 3(4), 259–268. <https://doi.org/10.1037/a0023909>
- Georgia Salivar, E. J., Roddy, M. K., Nowlan, K. M., & Doss, B. D. (2018). Effectiveness of the online OurRelationship program for underserved couples. *Couple and Family Psychology: Research and Practice*, 7(3–4), 212–226. <https://doi.org/10.1037/cfp0000110>
- Halford, W. K. & Van De Vijver, F. (2020). *Cross-Cultural Family Research and Practice*. Academic Press.
- Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, 7, e1000316. <http://dx.doi.org/10.1371/journal.pmed.1000316>
- Hook, J. N., Davis, D., Owen, J., & DeBleare, C. (2017). *Cultural Humility: Engaging Diverse Identities in Therapy*. Washington DC: APA.
- Lavner, J. A., Barton, A. W., Bryant, C. M., & Beach, S. R. H. (2018). Racial discrimination and relationship functioning among African American couples. *Journal of Family Psychology*, 32(5), 686–691. <https://doi.org/10.1037/fam0000415>
- McNeil, S. N., Fincham, F. D., & Beach, S. R. H. (2014). Does spousal support moderate the association between perceived racial discrimination and depressive symptoms among African American couples? *Family Process*, 53(1), 109–119. <https://doi.org/10.1111/famp.12054>
- McShall, J. R. & Johnson, M. D. (2015). The Association Between Relationship Distress and Psychopathology Is Consistent Across Racial and Ethnic Groups. *Journal of Abnormal Psychology*, 124, 226–231.
- McShall, J. R. & Johnson, M. D. (2015). The Association Between Relationship Quality and Physical Health Across Racial and Ethnic Groups. *Journal of Cross-Cultural Psychology*, 46, 789–804.
- Mikle, K. S. & Gilbert, D. J. (2019). A systematic review of culturally relevant marriage and couple relationship education programs for African-American couples. *Journal of Ethnic & Cultural Diversity in Social Work: Innovation in Theory, Research & Practice*, 28, 50–75.
- Parker, M. L., & Campbell, K. (2017). Infidelity and attachment: The moderating role of race/ethnicity. *Contemporary Family Therapy: An International Journal*, 39(3), 172–183. <https://doi.org/10.1007/s10591-017-9415-0>
- Rastogi, M., & Volker, K. T. (2018). *Multicultural Couple Therapy*. Thousand Oaks, CA: Sage.
- Wischkaemper, K. C., Fleming, C. J. E., Lenger, K. A., Roberson, P. N. E., Gray, T. D., Cordova, J. V., & Gordon, K. C. (2020). Attitudes toward relationship treatment among underserved couples. *Couple and Family Psychology: Research and Practice*, 9(3), 156–166.

Diversity Corner

“And Then There Was COVID”: Understanding the Graduate Student Experience from the Perspective of an African American Student During COVID-19

Danielle McDuffie, MA University of Alabama



“Rona”, as I colloquially call the virus when in conversation with friends and loved ones, has caused a complete upheaval of my life professionally and practically. In this column, I will discuss some of the implications from COVID-19 as a graduate student of color and personally. I will then provide some recommendations for students and for faculty members on how best to support their

students from marginalized populations, including a positive initiative I have seen take place within my own organization.

COVID-19:

The Good, the Bad, and the Semi-Ugly

Before all of the associated changes from COVID-19, I can admit that I was trying to accomplish too much this semester and was risking burning out. There is literature to suggest that ethnic minority students in graduate programs face stressors including racial discrimination, racial prejudice, feelings of isolation, and different cultural expectations that negatively impact their academic experience (Dyrbye et al., 2007). As a result, ethnic minority students had higher rates of burnout and depressive symptoms, and a reduced quality of life. Not only was I on a trajectory towards burnout by virtue of being one of the few minorities in my program, I was also actively (unintentionally) pushing myself to that point.

COVID-19 slowed me down dramatically. Professionally, almost all of my obligations were abruptly put on hold. I ended up cancelling my Spring Break plans and entered into immediate self-isolation. However, I did not realize how much I had been pushing myself until about a week into my Spring Break (my University extended Spring Break an extra week) when I realized I had barely opened my laptop and was checking my email at the rate of once every few days (I typically check my email multiple times in one day). I felt free, but I also felt an inkling of guilt at not being productive. To com-

pound these feelings, New Jersey quickly emerged as the second epicenter of COVID-19 in the U.S. While I am currently living in Alabama for school, I am from New Jersey and many of my family members still live there. My parents and my grandmother are all either older or have some health complications that would make them vulnerable to the virus. My mother is also a certified nurse midwife, making her an essential worker. On top of my guilt at being unproductive, I was developing growing anxiety for my family. I made the decision not to fly home in early March for fear that I might catch something on the plane and give it to my parents (imagine the irony). It was a hard notion to contend with for many of the early weeks of the pandemic.

Moreover, my larger struggle was in challenging the rhetoric of the “Strong Black Woman”. The Strong Black Woman race-gender schema holds that Black women must be strong, self-reliant, resistant to negative mental health outcomes regardless of the circumstance, and willing to take care of others even at her own personal expense (Abrams, Maxwell, Pope, & Belgrave, 2014; Black & Peacock, 2010; Nelson, Cardermil, & Adeoye, 2016; Watson & Hunter, 2015). For the Strong Black Woman, breaks are not even thought of. This is a not a role I actively sought, but it is absolutely one that I have fallen into. For this reason, after my second week of doing nothing, the feelings of peace quickly shifted to blame, guilt, and some self-chiding. The grace that I had given myself during the weeks prior had dissolved into negative self-talk suggesting that I should be doing more and that my productivity should have doubled (or even tripled) with the increased time at home. I was unduly hard on myself. I had to have some candid conversations with loved ones, engage in journaling, and find others who seemed to understand my struggle (see the citation for the New York Times piece: “Stop Trying To Be Productive”) in order to let myself off the hook and find a happy medium between self-care and productivity during COVID-19.

I am not at all an expert on the marginalized student experience during COVID, but I want to share a couple of things that I have found helpful personally that could help you if you are a student from a marginalized population, or if you are seeking to help your students from marginalized populations.

Recommendations for Students from Marginalized Populations During This Time

- **Take a break from social media!** My personal break from social media actually came months before the onset of COVID-19; however, it became glaring how much less anxious I was feeling compared to loved ones who were still on social media. From what I have heard from friends who remained on social media, there is a mild spirit of panic across popular social media platforms. I have a very close friend living in New York who has expressed to me how anxious she sometimes feels when seeing all the COVID-19 conversation on social media. She has never been particularly anxious, and she should/could be the most-well informed on the outbreak as someone living, working (from home), and supporting herself in the U.S. epicenter of the pandemic. While I am not saying “delete your social media”, try taking a day or two away. And when you DO go back, do not try to scroll back and see everything you missed from the prior day or two. Go in with fresh eyes and a fresh mind.
- **Remember that it is okay to say NO!** I am a huge victim of not being able to say “no”. This was what got me into a lot of stress before the onset of COVID-19, and what caused a lot of distress for me in the early weeks of unproductivity. However, it is OKAY to not be at your maximum productivity right now! Graduate students of color often have this narrative that we have to do over and above what we are currently slated to do. In Black culture, there is a saying: “you have to do twice as much to get half as far”. However, in the midst of a global pandemic, adopting this mindset can cause more harm than good. Take the time to be intentional about what you are devoting your time to, even if that is a day spent watching television and communicating with loved ones. It is okay to be intentional with your mental and psychological health and to give yourself some grace, especially now.
- **Make realistic to-do lists.** I am a to-do list aficionado. I make a list for everything: packing for trips, daily tasks, things I need to do around the house, e v e r y t h i n g. I have found that during this time, making realistic, attainable to-do lists has helped me feel productive while not pushing me too far to the edge. Items on your to-do list could be as simple as writing one page of a manuscript, cooking one healthy meal, or going for a walk. But the feeling of checking something off your list is a reward that is unmatched (in my humble opinion).

- **Ask for the help you need.** I have wonderful research and clinical mentors, and one of the things I think helped me most during this time is my mentor allowing me to figure out what my life should look like right now. We would have weekly check-ins not only about my academic or clinical progress, but also about my mental health and things I was engaging in to promote health and wellness. Within these meetings, I was given the space to tell my mentor that I needed some time for myself, particularly after my heavy first half of the semester and concerns for my family. Even if what you need at the time is time, advocate for yourself and the space that you need.

Recommendations for Those Aiding Students from Marginalized Populations During This Time

- **Allow students a healthy amount of space and time.** The best thing my mentor did for me was give me just enough space while still keeping me aware of my goals. My mentor did not push me to be working on anything specific. Instead, she checked in on my mental health, how my family was doing, and if I was taking care of myself. She would provide subtle nudges and suggestions during our check-in calls, but she never made it imperative that I complete a task. She allowed me to make my own decision for what I could handle. For students from marginalized populations who might not be handling the shift due to COVID well, or who might not know how/when to say no, I think it is important to create that space for them to take a break and to have that not be the end of the world.
- **Think about starting an anonymous Student Support Network for students of color you may know.** At my University, I have been pleasantly surprised by the unity and outreach from professors to the students from marginalized backgrounds across graduate programs. In an initiative spearheaded by the head of the Gender & Race Studies department, an email went out to faculty soliciting anonymous donations for a fund that would support graduate students from marginalized populations who might be disproportionately struggling during these times. In the email, it was stipulated that graduate students in need had to only reach out to one person (the head of Gender & Race Studies), and that their names would be kept on a protected document that only he would have access to. There then would be a text message correspondence set up between the student and their one faculty shopper to arrange what items were needed and how/where to drop them off.

I think this initiative is one of the best I have seen proposed by graduate departments, and very sensitive to populations of graduate students who might have come into their graduate programs at a financial disadvantage.

Limitations of My Experience

While I acknowledge that COVID-19 has presented additional hurdles for all graduate students regardless of race, ethnicity, or cultural background, I would be remiss if I did not highlight a special group that could be disproportionately disadvantaged at this time: students of Asian descent and/or international students from Asian countries. There is a portion of the rhetoric surrounding COVID-19 that is placing blame on Asian countries for the creation and spread of COVID-19. Some of the implications from this have been hate crimes and mistreatment of selected groups of people/students. I cannot fathom what students of Asian descent/from Asian countries might be going through at the moment, and I will not try to speculate about or dictate their narratives for them.

References

- Abrams, J. A., Maxwell, M., Pope, M., & Belgrave, F. Z. (2014). Carrying the world with the grace of a lady and the grit of a warrior: Deepening our understanding of the "strong black woman" schema. *Psychology of Women Quarterly*, 38, 503–518.
- Black, A. R., & Peacock, N. (2011). Pleasing the masses: Messages for daily life management in African American women's popular media sources. *American Journal of Public Health*, 101, 144–150.
- Dyrbye, L. N., Thomas, M. R., Eacker, A., Harper, W., Massie, F. S., Power, D. V., ... Shanafelt, T. D. (2007). Race, ethnicity, and medical student well-being in the United States. *Archives of Internal Medicine*, 167, 2103–2109.
- Lorenz, T. (2020). Stop trying to be productive. Retrieved from <https://www.nytimes.com/2020/04/01/style/productivity-coronavirus.html>
- Nelson, T., Cardermil, E. V., & Adeoye, C. T. (2016). Black women's perceptions of the "Strong Black Woman" role. *Psychology of Women Quarterly*, 40, 551–563.
- Watson, N. N., & Hunter, C. D. (2015). Anxiety and depression among African American women: The costs of strength and negative attitudes toward psychological help-seeking. *Cultural Diversity and Ethnic Minority Psychology*, 21, 604–612.

About the Author

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Reflection Questions from the SSCP Diversity Committee

For Those Engaged in Conducting Clinical Science:

Engaging in Appropriate Self-Education

1. In what ways am I considering the role of racialized experiences in my research?
2. What work have I done to better understand systems of oppression and how they impact clinical psychological science? How do I describe race or other identity factors in relation to psychopathology?
3. How am I operationalizing identity factors in relation to psychopathology (e.g. am I being attentive to biological versus social constructions)?
4. In what ways am I being attentive to oppressive factors that might disproportionately align individuals from diverse backgrounds with certain psychopathologies?
5. In what ways am I consulting relevant literature from stakeholders and diversity science experts to mitigate bias in interpretation and discussion of results?
6. How representative are my research samples? If my research samples are not representative of the population that I am studying, how may I expand my recruitment efforts to obtain a more representative sample?

Seeking Appropriate Consultation

7. When conducting research focused on BI-POC samples, in what ways am I including BIPOC collaborators with expertise in my area of interest?
8. In what ways am I critical of my citation practices? In what ways am I intentionally citing BIPOC authors with expertise in my area?
9. As a reviewer or editor, have I consulted relevant literature from stakeholders and diversity science experts to try and reduce bias in reviewing?

Clinician Perspective

Client Attitudes Towards Telemental Health and What We Can Do to Address Them

Hannah Brockstein, B.S., Alvord, Baker & Associates, LLC



The COVID-19 global pandemic has increased the need for telemental health services worldwide as offices are closed due to state and local guidelines. Clients are feeling isolated and lonely while quarantined to their homes, they are lacking in social interaction and support, and are feeling anxious about the uncertainties that have come along

with a global pandemic. We know based on previous research that telemental health is effective across ages for a variety of disorders including anxiety (Berryhill et al., 2019), depression (Osenbach et al., 2013), PTSD (Frueh et al., 2007), and ADHD (Myers et al., 2015). There has been minimal research conducted on how clients perceive these services. As employees and clinicians of a private psychology practice, we sought a better understanding of the attitudes of clients and potential clients towards telemental health services before and during COVID-19 in order to help clients feel more comfortable with this technology.

The Study

We devised a survey asking a variety of questions related to the demographic information of the respondents, their comfort and experience with technology and video conferencing, their experience with mental health services, and their greatest concerns and potential benefits of telemental health services. This survey was then disseminated during the month of June using social media, word of mouth from the clinicians in our practice, listservs, and neighborhood groups. In total, we had 185 survey respondents. Unfortunately, our participants were not very diverse. Due to limitations of COVID-19, the survey could only be distributed through online platforms and word of mouth. Of the 185 participants, 76.2% identified as female, 88.6% were White, 90.8% had a Bachelor's degree or higher levels of education, and 77.8% live in suburban areas. The average age of participants was 42.6 years \pm 15.4. We only collected data from consented adults ages 18 or older.

What did participants say?

What is appealing about telemental health?

The majority of responses focused on the convenience of telemental health including reduced travel, optimal hours, ability to continue therapy when sick or unable to leave home, and the opportunity to continue therapy from a remote location.

What are your biggest concerns about telemental health?

The two most common concerns that participants had were less in person interaction and worries about their ability to build a relationship with their therapist. Some other concerns included worries about their ability to communicate virtually, the confidentiality of virtual platforms, worries about dealing with change and unfamiliar modes of therapy, and feeling socially uncomfortable with virtual communication. Most of our participants were not concerned about access or ability to use the technology needed as the vast majority had some video conferencing experience and were relatively comfortable with using technology. Additionally, our participants were highly educated and reside in suburban areas and as a result have greater access to the technology needed (high speed Internet and computer access). In populations with limited financial resources and/or in rural areas, this could be a concern that needs to be addressed with clients.

How has COVID-19 influenced attitudes towards telemental health?

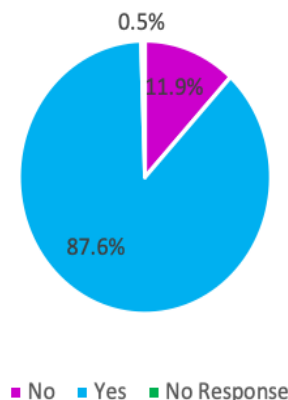
Would you be interested in therapy via (video) telemental health if you wanted/needed therapy?

Overall, 87.5% of people surveyed were interested. Two-thirds of respondents stated that COVID-19 had made them more open to using telemental health.

Please explain how/why COVID-19 influenced or changed your perspective on the use of (video) telemental health?

The overall themes of these comments show that people have begun to see the place for telemental health and how it can be advantageous to access necessary services. People who were previously

Would you be interested in therapy via (video) telemental health if you wanted/needed therapy?



reluctant have now tried it themselves and agreed that it is very useful for when they are unable to make their appointment or see their clinician in person. Many who had experienced telemental health in the past noted that they still prefer their in-person sessions to virtual sessions.

Now what?

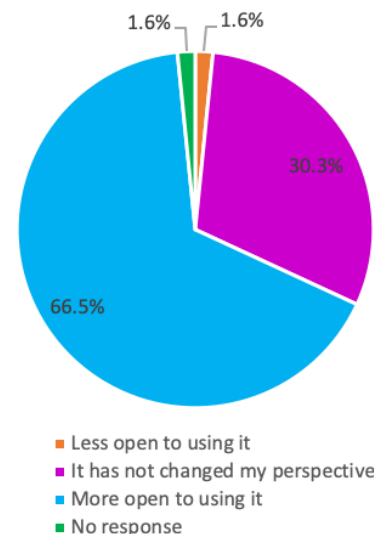
It is promising that the conditions of COVID-19 have made clients more open to telemental health services. With increasing willingness to try virtual sessions, we have the ability to reach more individuals, especially in communities that have less access to mental health services. It is also important to understand how important access to and comfort with technology are to the willingness to try telemental health. These factors may be important prerequisites for positive attitudes towards telemental health, so it is important for clinicians to advocate for better access for their clients. We can also take this information about client concerns and work to better address them with our own clients.

With input from licensed clinical psychologists at Alvord, Baker, & Associates, LLC, I have eight tips to share about what we can do to address these concerns with clients.

1. Be careful with your assumptions regarding technology comfort.

It is easy to assume, especially now, that clients are experienced and comfortable using technology. However, there are still many people who are not ready to jump into virtual sessions because they do not feel comfortable with the platforms or devices that they need. Offer to practice with your client. You can walk through the steps together (over the phone or in person after COVID-19) until they feel ready to get online themselves.

Has COVID-19 influenced or changed your perspective on the use of (video) telemental health?



2. Make sure you have informed consent for telehealth use.

In our practice, we have a specific telehealth agreement form that states the risks of telemental health as well as outlines an emergency plan if you are disconnected or need immediate care.

3. Have a conversation about how telemental health may or may not be different.

Have an open discussion about doing virtual sessions and what might feel different to your client. You can also discuss what might feel the same in order to ease your client's transition to a virtual platform.

4. Invite clients to bring up their concerns.

Make sure to allow your client to voice their own concerns about transitioning to telemental health. If you can directly address their worries, it may be easier to gain their willingness to try it.

5. Share some of the benefits.

Speak with your client about some of the positive aspects of telemental health. You can use some of the benefits discussed above or come up with some of your own that you have seen with your own clients. Help them see it in a positive light!

6. Ensure privacy.

It is important to discuss confidentiality with clients as well as the parents of a client if they are a child. For example, our clinicians discussed clients having their session in the car with others present or parents who want to eavesdrop on their child's

session now that it is happening in their home. You can address these concerns before they become an issue.

7. Have a backup plan!

We all know that technology sometimes fails, and have probably experienced our fair share of it during this pandemic. Talk to your client about what you will do if something goes wrong. You can make sure you have a phone number to reach each other at if one of you loses internet service or the platform that you use stops working. Having a plan in advance with a client can help ease worries that clients may have about their virtual sessions and can help you think on the spot when something goes wrong!

8. Spend time on the relationship.

One of the main concerns that many of our survey participants had was building or keeping a relationship with their therapist. If you are working with a child, it may be hard to do this so our clinicians suggested having the child screen, draw on the virtual whiteboard, or show you things in their room that they like. There are many virtual games and activities you can find online, or you can get creative and make them yourself!

Never in history has there been such a great need for telemental health. It is positive that most of our participants were willing to try this format for therapy sessions. We believe with the right precautions and collaboration amongst clinicians, telemental health can be an effective way to deliver therapy services to clients in need.

References

- Berryhill, M.B., Halli-Tierney, A., Culmer, N., Williams, N., Betancourt, A., King, M., & Ruggles, H. (2019). Videoconferencing psychological therapy and anxiety: a systematic review. *Family Practice*, 36(1), 53-63. <https://doi.org/10.1093/fampra/cmy072>
- Frueh, B.C., Monnier, J., Yim, E., Grabaugh, A.L., Hamner, M.B., & Knapp, R.G. (2007). A randomized trial of telepsychiatry for post-traumatic stress disorder. *Journal of Telemedicine and Telecare*, 13(3), 142-147. <http://dx.doi.org.proxygw.wrlc.org/10.1258/135763307780677604>
- Myers, K., Vander Stoep, A., Zhou, C., McCarty, C.A., & Katon, W. (2015). Effectiveness of a telehealth service delivery model for treating attention-deficit/hyperactivity disorder: a community-based randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 54(4), 263-274. <http://dx.doi.org.proxygw.wrlc.org/10.1016/j.jaac.2015.01.009>
- Osenbach, J.E., O'Brien, K.M., Mishkind, M., & Smolenski, D.J. (2013). Synchronous telehealth technologies in psychotherapy for depression: a meta-analysis. *Depression and Anxiety*, 30(11), 1058-1067. <https://doi-org.proxygw.wrlc.org/10.1002/da.22165>

About the Author

Hannah is a clinical research coordinator at Alvord, Baker & Associates, LLC, a large group private practice located in Rockville, MD. She graduated from the University of Maryland, College Park in 2019 with a double degree in psychology and family science. Hannah is applying to clinical psychology doctoral programs and is interested in studying the development, implementation, and outcomes of accessible, evidence-based interventions for children and adolescents with ADHD and anxiety disorders.

Reflection Questions from the SSCP Diversity Committee

For Those Engaged in Clinical Supervision:

1. What are ways I may encourage my supervisees to take a multicultural perspective in case conceptualization and treatment?
2. Am I comfortable discussing issues related to race with my supervisees, including racial differences between therapists and clients as well as between supervisors and supervisees?
3. Am I making a concerted effort to seek out consultation, peer-support, and self-reflection when I, or my supervisees, are overwhelmed or confused about how to navigate multicultural issues?

For Those Providing Clinical Services:

1. When using an EBP or psychological test with Black clients, have I taken the time to examine the evidence base? If there is little or no research about the topic, how will I incorporate a multicultural, anti-racist view in use of the EBP or test administration/interpretation?
2. Am I pathologizing Black clients' experiences?
3. Am I labeling and discussing the role of white privilege in mental health?
4. Am I adequately providing my patients with extra space to process, grieve, and express their thoughts and emotions related to racism?
5. When patients discuss issues related to race or racism, am I showing them that I am interested in what they have to say and how these experiences have impacted them?

Early Career Perspective

It Won't Cost You Much, Just Your Voice!

On Rediscovering A Human Voice in Academia

Craig Rodriguez-Seijas, Ph.D. University of Michigan



Am I Qualified to Write This?

Absolutely Not! Here It Is.

When I was asked to write this early career perspective, I was honored to contribute my viewpoint to the SSCP membership. And then ... excitement quickly blossomed into glowing anxiety, sparkling self-consciousness, and preemptive embarrassment. Naturally, I put off writing this until

the day before it was due (Happy International Coming Out Day Everyone!). What's working without imminent-deadline-angst anyway? To write this is to stand in front of a crowd of academics extemporizing. Unlike any conference or symposium I'd ever attended, there are no notes at my disposal. No citations or references to hide behind. No previous scholarship in which to ground my words. Instead, here I am given free reign to say whatever I want to say. To use my voice in a way that feels much more vulnerable to me. What could I say that would be helpful? What can I say that won't land me in some abstract trouble that we, as junior scientists, often worry about? And that's how I settled on writing a piece about my own personal journey to finding a stronger voice within academia. Forgive the needlessly verbose introduction, but I rarely get to write independent of the strict confines and rules of academic scholarship. I'm capitalizing on this opportunity for a more "colorful" approach, as my advisor would have called it.

Initial Soft Whispers

A brief history is worthwhile to provide context of some ways in which I learned to self-silence. It's the quintessential story of academic coming-of-age. Boy grows up on a tropical island in the Caribbean. Boy typically excels at the top of his class. Boy eventually decided to go to medical school because boy perceived it to be the career boy should aspire to. After two years, boy abandons medical training

to restart his undergraduate degree in psychology. And as I trace my professional journey, I realize that this would be the point in my life where I began using my own voice. At this point, I began the process of trying to say and do things consistent with how I actually felt. The decision to leave medical school for a career in psychology was met with several comments of "you're going the wrong way" and "nobody leaves medicine for psychology". However, my resolve to switch fields was mostly driven by the close group of friends, my mother included, who spoke truth to my inner experiences. Never in my life did I want to pursue medicine, but I thought that I *should* since I had the grades to do so, and it was expected of me by my teachers and mentors at that time. Growing up in the proverbial closet means learning, early on, to do, say, and eventually study the things that one perceives will buy approval, affirmation, and acceptance.

I felt liberated studying psychology and everything related to it. Readers might be shocked to learn this, but I quickly became one of the more vocal students in my classes.

Well Hello Again Self-Silence!

Fast forward four years, and I was moving from the warmth of the Caribbean to Long Island, USA, for graduate school at Stony Brook University. As I began graduate training away from friends and family, my voice was held hostage by a much louder internal voice -- one which every graduate student knows all too well -- that second guessed everything I do, did, or contemplated doing. Parts of that voice are common to the graduate experience I believe: we're in a situation where we are still learning, building expertise, and so never know if we actually know enough to have a truly informed opinion. Other examples seemed more unique to my personal circumstances. As an immigrant, I felt somewhat an outsider. Typical social references used among peers and faculty flew over my head. Knowing that I had initially been waitlisted before eventual acceptance to my graduate program consistently echoed that I was not as smart as my peers. The feeling that I had to ensure that I was maximally productive, more so than some peers, was ever present; I needed to justify my worth to overcome the extra "work" that would befall any institution hiring an immigrant as myself. Leaving

the relative safety of Stony Brook, navigating new dimensions of sexual orientation concealment within the professional sphere arose. Should I remove my earrings during the internship interview process, lest some subconscious bias or concern about a perceivably gay therapist's effect on potential patients land me in a suboptimal internship placement (or none at all)? It wasn't much consolation to hear from female friends that they had similar struggles in deciding if to wear their wedding rings during internship interviews.

I have had the privilege of being mentored by a host of compassionate and understanding scholars throughout my professional career, starting with my advisor. Fortunately, I was always provided the space to process and discuss perceived injustices within academia. For example, I extensively discussed that decision to proceed on internship interviews without earrings (though I still insisted on at least wearing a pink shirt or tie) with him. I resolved that I needed to engage in some concealment to get myself in the door. Thereafter, I could wreak havoc ... I mean ... be my authentic self! I believe that much of academia is spent, especially for the most vulnerable, covering one's mouth and telling oneself that eventually, in a safer place, in the not too distant future, one can do more. One day I will be more vocal. In the future, I will change the way things were, so that those coming after might have an easier time. And I personally believe that these internal dialogues keep junior voices silenced within academia (at least within clinical psychology which is my sole familiarity).

Even now, as I reread what I've written thus far, I worry that others will interpret my words as some sort of virtue signalling or hyperbolic description of academia. I worry that readers will view this as some search for sympathy and need for admiration from others. A "woe is me" sort of trope. Perhaps this tidbit most effectively illustrates that voice of self-doubt and expectation of rejection about which I speak.

Now I Can Hardly Shut Up!

This past year has really been a decade! Personally, I have found myself speaking up more than ever before. I realize that, or perhaps I'd like to believe that, I have (re)discovered my voice. I have found myself more willing to invite the extensive distress and anxiety that comes with speaking up into my life (such as a week of sleepless nights worrying about how others might interpret my responses on a professional listserv and if this could result in some long standing negative effects on my professional career). I believe that a major catalyst for this has been my exit from the relative protection I pos-

sessed as a graduate student who was fortunate to work with mentors who consistently protected my time, energy, and wellbeing. Academics who studied, and lived with attention to, issues related to stigma and its impact on health. Most importantly, mentors who did the speaking up on many occasions. Having seen these models in my formative professional years really normalized dissent for me.

I wanted this piece to do two things. My major reason for writing this was to voice some small portion of my own continuing struggle to come to terms with the desire to speak openly in academic circles and the desire to exist in relative obscurity. I wanted to voice the normalcy of any and all of *waves hands wildly* this, especially for vulnerable students, early career researchers, and those who fit into one of the many underrepresented bins within academia. Secondly, as I've reflected on the factors that impacted my own eagerness to be more vocal, I figured that they could be helpful for everyone who has felt the desire to speak up, but ultimately been unable to for various reasons. To this second point I turn now: The factors that have given me my own professional voice.

1. Relative Professional Safety

I have been one of the lucky few to be hired at the faculty level. Personally, and I will go out on a limb here saying similarly for many/most/all graduate students, I feel that it is now safer for me to be a voice of even more dissent. One of the primary reasons for silencing has been the whisper that we all hear about where some senior faculty member(s) invariably sabotages the prospects of junior folks due to dislike or disagreement with some seemingly innocuous question or comment that was made by the student/postdoc/ECR. Tenure is still up for grabs, but I feel like there is sufficient relative career safety to justify being more outspoken at this point in my life. I am in the most tremendous awe of the courage of even more junior folks who speak openly, with seemingly so much more to lose than I. Affirm them! When you see it, send a back-channel email. Enter the conversation to support them. Let them know how much you appreciate their willingness to invite discord into their professional-emotional lives. They will appreciate it.

2. Tiredness

I began graduate school in 2013. After seven or so years of hanging back I truly feel tired of staying silent. Even before the relative safety of a faculty position, I'd begun speaking out more. I'd be lying if I didn't mention that the sociopolitical climate, one which feels like a continued affront to populations with whom I share several individual attributes, simply means that I've been left with a shorter rope.

I feel less able to let things just slide by without comment. I might not be able to do as much to enact change in any individual way on a wider global level, but speaking up can help shift the narrative in the more circumscribed academic society in which I exist. However, tiredness has translated to increased action largely because of the other factors I point to above and below.

3. Guilt

I have privilege. My relative privilege extends to academia. First and foremost, as a cisgender, non-disabled man I am lauded for speaking out. I've been socialized to admire the outspoken male academics within my circles. The adjective "outspoken" invariably conveys only the most positive connotation when describing men yet often takes a more derogatory tone when referring to women. I'm less likely to be disregarded as "emotional" if I voice any concerns. Another example: though I am of mixed descent, my ethnic ambiguity means I can often pass for white or white of Hispanic descent. I believe that I, then, have a responsibility to utilize said privilege in ways that can be beneficial. Having seen numerous women and BIPOC academics be vocal, I've gained much contact courage from them, and have felt like I have little excuse to stay silent much longer. That I've admired the mentors who spoke up regularly, thereby allowing me to remain silent, I've decided that I want to be one of those persons, and again I have a wealth of privilege on my side which permits me to actively do this. I think it imperative to point out that silence does not equate cowardice; speaking up does not equate bravery.

4. Social-Professional Support

Several factors related to social support fundamentally increased over the last three years, directly impacting my willingness to speak more frankly and openly. First, beginning my internship at Brown University found me within a 25-person cohort of very vocal, social-justice oriented colleagues. Ask them at Brown ... we routinely caused (good) trouble! Second, becoming more involved in academic twitter helped me realise that most of the people whom I admired, and by whom I was most intimidated, are largely an interesting band of dad-joke-posting, sourdough-baking folks. Seeing this more human side within academia meant I saw senior academics as less intimidating. Third, when I have ventured to speak out I have largely been met with back-channel support and encouragement, resulting in my own increased resolve to remain vocal (see point 3 above, especially when the support has come from graduate students or those with more to lose than I had for speaking out).

In Conclusion: Proceed with Caution

What is this piece **not** meant to do? Guilt anyone who has chosen/been forced to stay silent or ignore any inner compulsions to speak up within academia. Further, in no way do I suggest that the onus for change remains at the individual level. Instead, all those folks in academia who hold powerful positions have collectively dropped the ball in creating an appropriately inclusive environment for junior research scientists. I simply present my individual decision-making process. Psychological science leaders hold the lion's share of the responsibility for change.

What would I like anyone to take home from this? Deciding to be more vocal in any atmosphere is going to be a personal decision. I wanted to outline the processes that go into my own choice of whether or not I can handle the stress that comes with speaking frankly and openly within some academic circles. We're trying to survive historic injustices that show little sign of abatement, academia, a global pandemic, and so much more. I'll end with a sentiment that I've often used in therapy with young sexual minority clients when discussing the decision to be "out": There is no blanket rule when it comes to speaking out in academia. Staying silent can be necessary self-preservation. Hopefully you can find some professional environment(s) where you can be your authentically-voiced self.

About the Author

Craig Rodriguez-Seijas, Ph.D. is an Assistant Professor in the Clinical Science area within the Department of Psychology at the University of Michigan. He currently directs the Stigma, Psychopathology, & Assessment (SPLAT) Lab which focuses on understanding dimensional models of psychopathology and, in particular, factors related to the expression, assessment, conceptualization, and treatment of psychopathology among populations that contend with stigma, discrimination, and denigration.

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Student Perspective

Telehealth in Clinical Psychology: Challenges and Future Directions

Henry A. Willis, M.A., University of North Carolina at Chapel Hill



I am a doctoral candidate from the University of North Carolina at Chapel Hill, and a current psychology intern at Montefiore Medical Center/Albert Einstein College of Medicine. My dissertation, defended just a few months before the start of the COVID-19 pandemic, explored culturally adapting mobile-health (mHealth) and telehealth technologies for use among African American youth and young adults. At the time of my defense, the widespread use of telehealth and mHealth in clinical psychology seemed like a far-off reality. Yet, in light of the COVID-19 pandemic, the field was forced to immediately adapt to telehealth, and mental health professionals experienced a sudden, mass migration to delivering services online. Despite my own foundation and passion for telehealth, I still found that utilizing technology to deliver psychological services to be a jarring experience. Though some aspects of delivering psychological services via telehealth seemed straightforward, both my research and personal experiences have exposed the challenges that face clinicians and student therapists, especially when we treat those from vulnerable populations (i.e., people of color, those from low-income backgrounds, etc.). In this perspective, I discuss challenges that may arise when utilizing telehealth as a student clinician, considerations for using telehealth with vulnerable populations, and potential future directions for telehealth and mHealth.

1. Possible Challenges of Utilizing Telehealth as a Student

Delivering psychotherapy via telehealth has its many advantages (i.e., reaching clients that may have transportation challenges, who may live in rural areas, etc.) but as a student, I've found that I was often faced with many practical challenges that impeded early attempts to deliver services effectively. The first challenge is access to working devices and effective internet. Faculty members and supervisors may assume that students have access to a camera-enabled mobile device and high-speed internet due to our status as graduate students, but delivering psychotherapy via telehealth often requires additional resources. For instance, even if one has the necessary "hardware" (i.e., a computer with a working camera and microphone), there can sometimes be difficulties with devices being able to effectively handle the various programs required for telehealth (i.e., Zoom, Microsoft Teams, etc.). Initially, I often found that my home internet was not "fast enough" to handle telehealth sessions, and this is often a challenge for students who do not live alone and may have others utilizing the same internet/WiFi. This can be distressing to student therapists as it leads to constant disconnections or visual/audio difficulties that impacts our ability to deliver services effectively. Moreover, student therapists may not have the resources to create an environment that is conducive to delivering treatment. For instance, students who are parents, live with family members or roommates, and/or who have limited space within their homes are at a particular disadvantage.

Lack of access to reliable hardware and internet may disproportionately impact graduate students who are from low-income backgrounds and/or already feeling financially strained by their graduate student stipend. As students, in order to grapple with these challenges, it is important that training programs provide additional resources that allow us to effectively conduct telehealth sessions (i.e., funding for mobile-devices/computers, reimbursement for high-speed internet services, etc.). Even

if student clinicians have the necessary equipment to conduct psychotherapy via telehealth, our clients may need additional support to engage in telehealth effectively. Often times, I found myself in the dual role of being both a clinician and an IT specialist. For students beginning telehealth, it is important to realize that some session time may be spent helping clients connect to telehealth platforms and/or troubleshoot technological issues. This is stressful for both the student clinician and the client, as either may have varying knowledge of technology and software platforms. Again, this is a situation in which it is important that institutions and training programs provide ample resources, trainings, and support for graduate students to help them feel competent when navigating potential technological issues/difficulties.

In the “virtual” therapy room, a host of other issues may arise. First, given that sessions occur outside of the clinic, there is an increased chance that session content is overheard, either by others in the client’s home, or by others in the clinician’s home. Some solutions exist, such as the use of headphones, but do not entirely ameliorate the difficulty in ensuring confidentiality when therapy takes place virtually. Moreover, during sessions, I often found it harder to navigate leading and facilitating group therapy sessions as it’s easier for clients to talk over each other over Zoom. I also had to become more comfortable “talking over” or interjecting more forcefully during sessions with more talkative clients. In video sessions, it may also be more difficult to pick up on non-verbal cues that we might notice during in-person sessions, such as eye contact, fidgeting, etc.

Additionally, environments outside of the traditional clinical setting are expectedly more chaotic. As a student therapist, I had to become adjusted to being more comfortable with unexpected intrusions, such as loud noises from cars or neighbors, unexpected visitors, and even package deliveries. Our clients are also navigating similar intrusions and unexpected distractions while in virtual psychotherapy. These experiences may impact rapport with our clients and our own perceived effectiveness as clinicians. For example, technical difficulties (i.e., becoming disconnected or frozen) or intrusions may interrupt a client during a particularly emotional or difficult exchange. This inevitably will frustrate both the clinician and the client, and may impact how the client perceives treatment or the clinician. While navigating this, I’ve found that first, cultivating a heightened sense of empathy and self-compassion

for myself has helped to deal with the stress of these challenges. Moreover, discussing these potential intrusions/distractions with clients at the beginning of telehealth sessions helps to reduce the distress that occurs when these intrusions inevitably occur. The transition to telehealth and these new challenges also highlighted an increased need for supervisors to begin to take into account how to help students navigate the many issues raised above, and the unique challenges that arise when delivering mental health services via telehealth.

“When engaging in telehealth with vulnerable and often underserved populations, it is also important to realize that traditional systemic barriers to treatment do not magically go away because of telehealth.”

Finally, the biggest challenge I faced when transitioning to telehealth is an increased difficulty to “be present” while in sessions. As I highlighted earlier, a host of intrusions that would not normally occur in a clinical setting increases the risk that both the therapist and client become distracted. Even just being on a computer or mobile device increases the chance that one is distracted by incoming emails, messages, or calls. For those students beginning telehealth, some “best practices” include: closing/silencing mail and message applications, putting your device on “do not disturb”, and communicating any potential interruptions that may occur on your end to the client (i.e., the potential that the session is interrupted by a pet, children, or other factor). Clients should also be made aware and agree to follow these “best practices” to the extent possible. In the end, being transparent with clients about the many challenges we face when engaging in telehealth, being flexible, and applying empathy to both ourselves and our clients, can reduce anxiety related to delivering psychotherapy via telehealth.

2. Telehealth with Vulnerable Populations

Despite my passion for telehealth and mHealth, my research and clinical experiences have highlighted how telehealth is not a silver bullet in terms of resolving disparities in access to or utilization of mental health services. Simply put, existing disparities, especially in marginalized communities, will impact how people engage in tele-mental health treatments. For example, finding safe, private,

and secure locations to have therapy is already challenging given the impact COVID-19 has had on several facets of life (adults working full-time from home, children attending school virtually from home, etc.). Unsurprisingly, finding these spaces is even more challenging for those from low-income backgrounds and/or those who may be in urban areas/small households. For clinicians, this means we have to be open to being flexible on where psychotherapy takes place. In my most recent experiences, it's not uncommon for clients to attend sessions from a car, a park bench, a closet, or even a bathroom. It is also important to realize that those from low-income backgrounds may lack access to working devices, high-speed internet, and/or may not feel comfortable navigating the various software platforms we use for therapy. It's important for clinicians and supervisors to assess these factors with clients and also be able to help the client find resources in the community that may help them resolve these barriers.

“Culturally-informed clinical training becomes even more vital, as clinicians and supervisors should be prepared to have these race-related discussions during the course of treatment.”

When engaging in telehealth with vulnerable and often underserved populations, it is also important to realize that traditional systemic barriers to treatment do not magically go away because of telehealth. In fact, these obstacles may just impact telehealth in more complex ways. For example, access to childcare is often a barrier to treatment engagement among marginalized groups. Though telehealth means that now families can engage in treatment from home, lack of access to childcare during telehealth sessions can impact parents' ability to engage in therapy, especially when there is only one caregiver in the home with multiple children. Similarly, existing disparities in equitable access to resources and other determinants of health outcomes (i.e., food, housing, employment, adequate insurance, etc.) have been exacerbated by the COVID-19 pandemic, and disproportionately affect vulnerable populations such as people of color, those from low-income and/or rural backgrounds, individuals with disabilities, and more. These stressors impact the psychological well-being of clients

from these backgrounds, and are undoubtedly more stressful or debilitating during this crisis. Healthcare systems and training programs should take on the responsibility of making effective telehealth services more accessible during (and after) this pandemic for these populations.

Finally, it is also necessary to acknowledge the ongoing racial violence against African Americans and the ensuing protests occurring across the country. This, in combination with individuals quarantining and spending more time at home and online, means that there is an increased risk for African Americans and those from other racial-ethnic minority groups to be exposed to the traumatic effects of viewing videos of such violence and unrest online or in the media. My prior research highlighted how exposure to traumatic videos online that portray African American men being shot by police are linked to higher levels of posttraumatic stress and depressive symptoms for African American and Latinx youth (Tynes, Willis, Stewart, & Hamilton, 2019). This increased exposure to online traumatic videos, in combination with stress related to the pandemic, highlights the increased need for culturally-relevant tele-mental health services. Unfortunately, these at-risk communities may also have reduced access to traditional sources of support that contribute to resilience due to the pandemic and quarantine, such as community and family events, religious activities, and social support. Clinicians should address this during telehealth sessions by providing safe, affirming spaces for client's to process and develop coping strategies to navigate these race-related stressors, while also helping the client find ways to access culturally-relevant support and affirming spaces that exist online. Because of this, culturally-informed clinical training becomes even more vital, as clinicians and supervisors should be prepared to have these race-related discussions during the course of treatment.

3. Future Directions for Telehealth and mHealth

As we continue to utilize telehealth and face the challenges that accompany this delivery method, there is a sense among many that this may become the “new normal” in mental healthcare. As we move forward, despite the many advantages of telehealth, there are many ways these interventions can be improved. Primarily, I believe that the field should strive to integrate telehealth services with mHealth (i.e., the use of smartphone/mobile technology

to deliver telehealth) technologies, which could bolster treatment accessibility and engagement, especially among underserved populations. For instance, mHealth applications have the ability to help clients manage appointments and remain engaged in therapy (i.e., mobile devices can deliver text-based appointment reminders/notifications). It may increase homework compliance and accessibility by providing on-demand access to digital resources such as worksheets and psychoeducational readings and videos. mHealth technologies can also help clinicians track clients' symptoms and response to treatment, as well as improve communication between clients and therapists by providing opportunities to text via secure application messaging in-between sessions. In the end, although telehealth and mHealth aren't silver bullets for resolving existing barriers to treatment, over time, they have the potential to help clinicians increase access to effective mental health treatments, especially to those from underserved communities.

4. Conclusion: Special Considerations for Clinical Students of Color

The COVID-19 pandemic, in addition to the concurrent racial violence and injustices, have presented many challenges for students of color. I've heard varying experiences from peers about, and have personally struggled with, how to best navigate clinical training during these times. As a Black clinical psychology student, this is even more distressing in that so often, the world around me and the events that are happening have immediate and devastating effects on myself, my family, friends, and community. During this period, I have found it most helpful to engage in self-care, while seeking out safe spaces with advisors and fellow students who identify with my experiences. Most importantly, navigating this time with awareness and acceptance that things are difficult has increased my own self-compassion.

“The COVID-19 pandemic, in addition to the concurrent racial violence and injustices, have presented many challenges for students of color.”

Academia often forces us into a bubble that can sometimes feel separate from the world going on around us. This isolating effect is also compounded by the pandemic and the need to quarantine in an

effort to keep those that we care about safe. As we continue to move forward in our clinical training, I hope students of color can continue to find safe ways to cultivate resilience and thrive during this difficult time. As institutions and training programs begin to provide support to graduate students that help them navigate the many changes to our education/training that COVID-19 has prompted (i.e., the switch to telehealth and virtual classes, etc.), I hope that special considerations and culturally-informed support for clinical students of color is also made a priority.

Reference

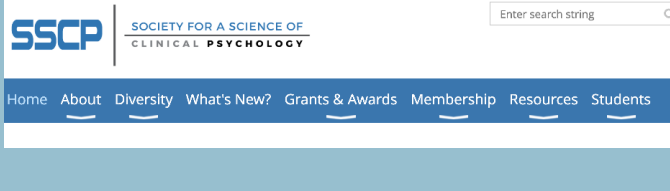
Tynes, B. M., Willis, H. A., Stewart, A. M., & Hamilton, M. W. (2019). Race-Related Traumatic Events Online and Mental Health Among Adolescents of Color. *Journal of Adolescent Health*, 65(3), 371–377. <https://doi.org/10.1016/j.jadohealth.2019.03.006>

About the Author

Henry Willis is a doctoral candidate in the Clinical Psychology program at the University of North Carolina at Chapel Hill. His current interests include exploring the relationship between online and offline racial discrimination and mental health outcomes, understanding socio-cultural protective factors (i.e., racial identity) and how they impact psychopathology (i.e., obsessive-compulsive disorder) within African Americans, creating cultural adaptations of evidence-based treatments, and utilizing mobile-health technology to increase access to mental health treatments for underserved populations. He is currently completing his predoctoral clinical internship at the Albert Einstein College of Medicine/Montefiore Medical Center in the Bronx, New York.

Visit our website to stay updated with the latest events, news, and award announcements to improve clinical science!

sscpweb.org



Introducing the SSCP Blog

Hosted by the SSCP Diversity Committee

<https://medium.com/society-for-a-science-of-clinical-psychology>

First Series: Diversity in Clinical Science

Why should clinical psychologists care about racism?

In a new study that recently made its way around Psych Twitter, Roberts and colleagues (2020) examined trends in 26,000+ cognitive, social, and developmental psychology papers published in top-tier journals between 1974 and 2018. They offer several findings, among them: (1) Articles highlighting race were rare to virtually nonexistent; (2) The vast majority of publications were edited by White editors; (3) Editorial boards that had more White members were significantly less likely to publish papers highlighting race. The authors conclude that systemic inequality is, indeed, alive and well in psychology. Clinical psychological science may have been “spared” from this particular review, but are we immune to issues of systemic inequality? Research suggests not.

In 1993, the NIH mandated that funding proposals include specific strategies to increase the diversity of research participants. And yet a review of 379 NIMH-funded clinical trials published between 1995 and 2004 found that less than half of those studies had samples where subgroup analyses by race/ethnicity and gender were possible (Mak et al., 2007). Similar patterns emerged in a review of RCTs for depression published over a 36-year-period; despite some improvements in the diversity of participants over time, it was still exceedingly rare for treatment effects to be examined across racial/ethnic groups (Polo et al., 2019). Meanwhile, a review of RCTs for panic disorder (1993–2010) found that less than half of published studies reported racial/ethnic data at all. Of those that did, about 83% of participants were White (Mendoza et al., 2012). Reporting practices lag behind in suicide research, too; longitudinal studies on risk factors for suicidal thoughts and behaviors frequently do not include ethnicity of participants, and rarely include LGBTQ status (Cha et al., 2017). These trends continue despite the fact that LGB youth are almost five times as likely to attempt suicide compared to their non-LGB counterparts (CDC, 2016), and 30–50% of transgender youth attempt suicide (Toomey et al., 2018). These shortcomings in reporting and inclusion reflect just the tip of the iceberg.

So, where do we go from here? Welcome to the official SSCP blog, hosted by the SSCP Diversity Committee. We invite you to join us as we explore systematic inequality in clinical psychology.



The SSCP Diversity Committee was established in 2014 to promote a more diverse clinical science through the pursuit of two primary goals: (1) To support and increase the diversity of the SSCP membership; and (2) To further the mission of clinical psychological science as it applies to

diversity issues. Six years later, we find ourselves in a moment of national reckoning with the systemic racism that has plagued our institutions for too long. Academia, psychological science, and, more specifically, clinical psychology, are not immune to this reckoning. We are guided by principles of clinical science in the pursuit of a more equitable, just, and anti-racist field.

The purpose of this blog is to elevate diverse voices in the field, while ensuring the widespread, sustained dissemination of diversity-related issues and content in clinical psychological science. Through a combination of narrative, reflection, and evidence-based posts written by a diverse group of graduate students, early career researchers/psychologists, and senior psychological scientists, we aim to provide consistent content pertaining to diversity in our field.

References

- Center for Disease Control. (2016). Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9–12: Youth Risk Behavior Surveillance. Atlanta, GA: U.S. Department of Health and Human Services.
- Cha, C. B., Tezanos, K. M., Peros, O. M., Ng, M. Y., Ribeiro, J. D., Nock, M. K., & Franklin, J. C. (2018). Accounting for diversity in suicide research: Sampling and sample reporting practices in the United States. *Suicide and Life-Threatening Behavior*, 48(2), 131–139.
- Mak, W. W., Law, R. W., Alvidrez, J., & Pérez-Stable, E. J. (2007). Gender and ethnic diversity in NIMH-funded clinical trials: Review of a decade of published research. *Administration and Policy in Mental Health and Mental Health Services Research*, 34(6), 497–503.
- Mendoza, D. B., Williams, M. T., Chapman, L. K., & Powers, M. (2012). Minority inclusion in randomized clinical trials of panic disorder. *Journal of Anxiety Disorders*, 26(5), 574–582.
- Polo, A. J., Makol, B. A., Castro, A. S., Colón-Quintana, N., Wagstaff, A. E., & Guo, S. (2019). Diversity in randomized clinical trials of depression: A 36-year review. *Clinical Psychology Review*, 67, 22–35.
- Roberts, S. O., Bareket-Shavit, C., Dollins, F. A., Goldie, P. D., & Mortenson, E. (2020). Racial inequality in psychological research: Trends of the past and recommendations for the future. *Perspectives on Psychological Science*.
- Toomey, R. B., Syvertsen, A. K., & Shramko, M. (2018). Transgender adolescent suicide behavior. *Pediatrics*, 142(4), e20174218.

Awards & Recognition

2020 SSCP Susan Nolen-Hoeksema Early Career Award

Sylia Wilson, PhD

Institute of Child Development at the University of Minnesota



Sylia Wilson, PhD, completed her PhD in clinical psychology at Northwestern University, clinical internship at the Minneapolis Veterans Affairs and Health Care System, and postdoctoral fellowship at the Minnesota Center for Twin and Family Research. She is currently a McKnight Land-Grant Assistant Professor at the Institute of Child Development at the University of Minnesota. Her research examines the developmental etiology of psychopathology - the underlying processes that lead to the development of internalizing and externalizing problems. Her research integrates developmental, clinical, and neuroscience methods, and takes a lifetime developmental perspective that includes the study of infants, children, adolescents, and adults. She uses study designs and populations that are causally and genetically informative, including longitudinal, high-risk family, and twin designs, and takes a multimodal approach that includes behavioral, observational, neurocognitive, psychophysiological, and magnetic resonance imaging methods. Dr. Wilson's research has been funded by the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Brain & Behavior Research Foundation.

2020 SSCP Lawrence H. Cohen Outstanding Mentor Award

Mitch Prinstein, PhD, ABPP

University of North Carolina at Chapel Hill

Mitch Prinstein, Ph.D., ABPP is the John Van Seters Distinguished Professor of Psychology and Neuroscience, and Assistant Dean for Honors Carolina at the University of North Carolina at Chapel Hill. Mitch's research examines interpersonal models of internalizing symptoms and health risk behaviors among adolescents, with a specific focus on the unique role of peer relationships in the developmental psychopathology of depression and self-injury. He has published over 150 peer-reviewed papers and 9 books, including an undergraduate textbook in clinical psychology, graduate volumes on assessment and treatment in clinical child and adolescent psychology, a set of encyclopedias on adolescent development, and the acclaimed trade book, "Popular: Finding Happiness and Success in a World That Cares Too Much About the Wrong Kinds of Relationships." He is a past Editor for the Journal of Clinical Child and Adolescent Psychology, and a past-president of the Society for the Science of Clinical Psychology and the Society of Clinical Child and Adolescent Psychology. Mitch currently serves on the Board of Directors of the American Psychological Association. Mitch's longstanding commitment to students' professional development training is reflected in dozens of invited addresses at local and national conferences, as well as several publications including the APAGS Workbook on the internship selection process, The Portable Mentor, and his uncensored advice for admission to psychology graduate programs. Mitch's most important contributions are reflected in the success and happiness of his students who have made enormous impacts by pursuing their true passions and being confident in their own abilities.



Awards & Recognition

2020 Varda Shoham SSCP Training Grant Initiative Awardees

Track: Innovation in Clinical Science Training

Winner:

“Protecting Clinical Psyence: Supporting Emerging Clinical Scientists Through the COVID-19 Research Drought” submitted by Michael Kofler, Ph.D. Florida State University

Track: Value-Added to the Program

Winner:

“Enhancing the Implementation of Clinical Science Diversity Training at the University of Maryland, College Park”, submitted by CJ Seitz-Brown, Ph.D. University of Maryland, College Park Clinical Psychology Program

Track: Conducting Science in Applied Settings

Winner:

“Expanding a Clinical Practicum Training Experience for Graduate Students to Deliver Universal DBT Skills in an Underserved Community”, Submitted by Maya Boustani, Ph.D. Loma Linda University

SSCP is excited to announce the addition of a fourth track to the Varda Shoham Training Grant Initiatives with guaranteed support for two years:

Diversity and Inclusion Track

SSCP thanks you for your support!

2020 Clinical Science Visionary Award Announcement

The SSCP Board is pleased to announce the 2020 winner of the Clinical Science Visionary Award:

Dr. Gerald Davison

**Professor of Psychology and Gerontology
University of Southern California**

Dr. Davison will be featured in the winter edition of *Clinical Science*.

Student Awards & Recognition

Congratulations to the 2019 SSCP Dissertation Award Winners!

Corinne Bart, MA

“Neural Reward Functioning in Bipolar Spectrum and Substance Use Disorders: Identifying Common Mechanisms”

Temple University

Mentor: Dr. Lauren Alloy, PhD



Jennifer Gamarra, MA

“How Powerful is Knowledge? A Mixed-Methods Approach to Evaluating Mental Health Literacy”

University of California, Los Angeles

Mentor: Bruce Chorpita, PhD

Zabin Patel, MA

“Individual, Family, and Neighborhood Effects on Anxiety and Depression in Youth”

University of Miami

Mentor: Mandy Jensen-Doss, PhD



Accepting Applications for the 2020 SSCP Outstanding Student Teacher Award

SSCP is accepting nominations for the Outstanding SSCP Student Teacher Award.

This award is intended to recognize outstanding graduate students who are providing exceptional contributions to the field of clinical psychology through their teaching. SSCP encourages candidates from all underrepresented and minority groups to apply. Winners will be selected based upon their dedication to, creativity in, and excellence in teaching in the area of clinical science. Any topic related to clinical science teaching is eligible (e.g., abnormal psychology, child psychopathology, any relevant seminar, etc.). Selected student will be featured in the Outstanding SSCP Student section of the SSCP Newsletter and receive a \$100 monetary award.

Applications must be received by December 1, 2020.

Notification of awards will be made in January, 2021.

Application Instructions: Please upload a 500-word biography and CV at the following link:

<https://forms.gle/8f9zdHUqA6E5yE1Q8>

Please have your recommender upload your recommendation letter to the following link:

<https://forms.gle/GUYPHkCYwVsBry756>

For more information regarding this award, please see email announcement on the SSCP student listserv or the website: <http://www.sscpweb.org/page-18121>

Student Awards & Recognition

Outstanding Student Diversity Researcher Award



Devin Banks, PhD
University of Missouri—St. Louis

Dr. Devin Banks is an Assistant Professor at the University of Missouri—St. Louis. She recently earned her Ph.D. in Clinical Psychology from Indiana University—Purdue University in 2020 and completed her predoctoral internship at the Charleston Consortium at the Medical University of South Carolina. Dr. Banks' research seeks to understand and prevent behavioral health problems that disproportionately affect racial/ethnic minority and socio-demographically disadvantaged communities. She is especially interested in the prevention of health disparities related to substance use and sexual behavior. The ultimate goal of her work is to improve behavioral health equity via culturally-relevant interventions targeting risk reduction and resiliency building during adolescence and young adulthood.

1. What are your research interests?

I study how behavioral health problems develop among racial and ethnic minorities. Specifically, I focus on understanding the development of problems related to substance use and risky sexual behavior, which are related to significant health and social disparities among communities of color (including disproportionate rates of liver disease, HIV/STI, drug-related incarceration, the list goes on...). My work aims to first, identify young people at highest risk for engaging in these behaviors and second, develop culturally relevant and accessible interventions for them. By leveraging tools that youth already have, including cultural resilience and mobile technology, I hope to help improve racial health equity across the lifespan.

2. Why is this area of research exciting to you?

The resilience of young people amazes me. But systemic racism and classism present a major barrier to their (mental) health. Helping adolescents and young adults mitigate and overcome these barriers by leveraging their potential for resilience is so rewarding to me.

3. Who are/have been your mentor(s) or scientific influences?

My mentor, Dr. Tamika Zapolski has been the biggest influence in my academic life. I am currently following in her career footsteps, not because she wanted me to, but because I have so admired her quiet perseverance. Also, she is a rockstar and wildly underrated in our field!

4. What advice would you give to other students pursuing their graduate degree?

Because of the immense pressure of graduate school, it is so easy to get caught up in the competition and metrics whether it's number of publications, amount of funding, or number of clinical hours. I encourage students to remember "your why." In other words, hold on to the reason you came to this field and make sure that is what drives your goals and behavior. For me, this looks like writing a "personal statement" for my eyes only and revisiting it regularly to ensure I'm staying true to myself and my values.

Student Awards & Recognition

Outstanding Student Diversity Researcher Award: Honorable Mention



**Tenille Taggart, M.A.
Stony Brook University**

Tenille Taggart is a doctoral candidate in Clinical Psychology at Stony Brook University. She works with Dr. Nicholas Eaton, and she is currently completing her internship at San Bernardino County's Department of Behavioral Health. She earned her B.A. in Psychology with a minor in Lesbian, Gay, Bisexual, and Transgender Studies at San Diego State University. She earned her M.A. in Psychology at Stony Brook University. Tenille's research interests primarily focus on the use of intersectional and transdiagnostic approaches to examine health disparities among marginalized populations as well as the underlying processes by which these disparities may be conferred.

Why is this area of research exciting to you?

I am personally and professionally dedicated to improving the health and wellbeing of marginalized populations, not only because of my own lived experiences with marginalization, but because no one should be afraid to live their most authentic life. When we make diversity and inclusion a priority, it makes the world a safer, better place.

Who are/have been your mentor(s) or scientific influences?

Dr. John Pachankis is someone whom I have looked up to and learned from for many years. While working with him, I had the privilege of personally witnessing the profound transformations that can take place when marginalized folx are affirmed for their unique identities and perspectives while also providing tools and techniques aimed directly at combating the negative effects of stigma.

What advice would you give to other students pursuing their graduate degree?

Some advice for my fellow graduate students: be persistent, you miss 100% of the shots you don't take, and learn to love the journey and not focus too much on the destination.

Accepting Applications for the 2020 SSCP Outstanding Student Diversity Researcher Award

Applications must be received by December 1, 2020.
Notification of awards will be made in January, 2021.

Candidates are those who have made exceptional contributions to diversity in clinical science. Applicants may be a member of a diverse group (broadly defined), engage in diversity related research, or both. Members of all underrepresented and minority groups are encouraged to apply. Only graduate students (including students on internship) and post-doctoral fellows will be considered for this award. Applicants must be student members of SSCP (student fee is \$15).

<http://www.sscpweb.org/DivAward>

Student Awards & Recognition

Outstanding Student Teacher Award



Jennifer Gamarra, M.A.

University of California, Los Angeles (UCLA)

Jennifer is a 5th-year, doctoral candidate at the University of California, Los Angeles (UCLA) Clinical Psychology program. She completed her undergraduate degree in Psychology at the University of Pennsylvania. Upon graduating, she worked as a research technician in the National Center for PTSD/Boston VA Healthcare System. At UCLA, her current research focuses on caregiver mental health literacy, and the role that caregiver knowledge of youth mental health problems plays in relation to stigma and attitudes about seeking mental healthcare for youth. At UCLA, she has been a teaching assistant for several courses, and was selected for the UCLA Teaching Practicum program, in which she taught her own Introduction to Psychology course to undergraduates. In 2019, she was selected for the inaugural class for the California State University, Northridge Teaching Fellowship. Through this program, she developed and taught an advanced undergraduate course in evidence-based clinical interventions. For three years, Jennifer has also been the lead Psychology Instructor for Oxbridge at UCLA (Oxbridge Academic Programs), an international academic summer program for high school students.

1. What are your teaching interests and/or teaching philosophy?

I absolutely love teaching psychology (especially abnormal/clinical) at the undergraduate level. It always feels easy to teach these courses because can be relatable to every student - and I think that having a personal connection to material makes students more engaged and allows them to really process what they're learning. Therefore, I strive to make all of my lessons applicable to students' lives and do my best to make real-world connections to the materials in several ways (e.g., in-class examples, assigning reading materials relevant to their daily lives).

2. What do you enjoy most about teaching?

This is a tough question because there is so much! But since I have to pick, I think the relationship you build with the students, which then influences the relationship they have with the material. I have taught classes of all shapes and sizes, but I've found that in teaching small classes/sections, where I can make individual connections with students, there is an enrichment within our conversations and how I approach teaching the lessons.

3. Who are/have been your mentor(s) or other influences on your teaching?

I have several mentors in teaching that I've had the privilege of working with and learning from. However, I always think about the first professor I ever was a teaching assistant for, who taught Introductory Psychology for a 300+ person class. He approached teaching like a performance, with the enthusiasm and charisma that you see on a Broadway stage. It was so cool! I would sit in the "audience" with the other students and would notice how captivated they were. So in truth, that's what I try to channel, because I want my students to be excited about the material (although I hope I don't overdo it).

4. What advice would you give to other students pursuing their graduate degree?

Embrace your teaching! I think many programs have teaching as an option or requirement for funding, which really frames it more like a "have to do this to get paid" opportunity rather than an honor and privilege. This discounts what I believe we can do for our undergraduates, who may be your future labmates, research assistants, or mentees. As graduate students, we are the model for what the future may hold for these students, and I don't think that's emphasized enough.

Student Awards & Recognition

Outstanding Student Teacher Award



Jessica Kansky, M.A.
University of Virginia

Jessica is a sixth-year graduate student in clinical psychology at the University of Virginia and graduated Summa Cum Laude with a B. A. in Psychology from the University of Pennsylvania. Her research focuses on psychosocial predictors and outcomes of romantic experiences from adolescence through adulthood. Specifically, she is interested in the role of romantic relationships in optimal interpersonal and individual development and well-being, recently publishing several reviews of romantic development across the lifespan. Her research published in *Emerging Adulthood* exploring the potential benefit of romantic dissolution was recently awarded Best Student/New Professional Paper of 2017. She has also received numerous accolades for her teaching, receiving University of Virginia's Psychology Department Teaching Award and the University's only Distinguished Teaching Award for Social Sciences in 2019. She will be completing her pre-doctoral internship at the Charleston Consortium in 2020-2021 where she hopes to further her training in both couples therapy and evidence-based trauma focused treatments.

1. What are your teaching interests and/or teaching philosophy?

My teaching interests have focused on courses designed around close relationships and mental health. I designed and taught a psychology seminar that centered on romantic relationships across the lifespan, including the developmental function of relationships as well as common couples therapy treatments. I have also taught courses focused on pedagogy for undergraduates interested in designing and teaching their own courses as well.

My teaching philosophy stems from the idea that the purpose of learning is to be an intelligent and curious consumer of real-world knowledge in order to give back to society in a meaningful way. I believe the best education encourages students to go out into the world and apply it, creating a sense of autonomy within their own work to serve a larger purpose beyond the classroom. I also strive to create a unique, memorable, inclusive, and supportive experience for all students. Through sharing my experiences as a relationship researcher and therapist, I model this bidirectional tenet (real world awareness to classroom learning as well as classroom learning to community outreach all in creative, engaging ways) for students. I strive to apply my own research endeavors, which assess close relationships and well-being, and clinical knowledge (i.e., providing therapy at a community clinic, behavioral medicine clinic, and hospital for those with serious mental illness) into classroom discussions to promote the real-world applicability of the psychological research, theories, and models of relationships we discuss.

2. What do you enjoy most about teaching?

One of the aspects of teaching I enjoy most is when

students engage with the material in more meaningful ways, beyond the expectations for the course, and connect course content to their personal lives. It's rewarding when students share with me that they have learned something about themselves and extended course content towards self growth. It's also exciting when students share with me additional resources they found that relate to course content to indicate my teaching has extended well beyond the classroom walls.

3. Who are/have been your mentor(s) or other influences on your teaching?

Three primary influences immediately come to mind in terms of who has shaped my teaching style and interest: UC Irvine's Stephen Schueller (formerly a graduate student instructor while I was an undergraduate at Penn) and UVa's Dan Willingham and Bob Emery. All three professors have led by example in creating a warm, supportive classroom and engaging atmosphere for students to feel comfortable grappling with material. I have also participated in several pedagogical trainings at UVa and actively incorporate backwards course design and learning-centered activities in my classes to meet the goals of my teaching philosophy.

4. What advice would you give to other students pursuing their graduate degree?

I would encourage other students to find rewarding and fun activities outside of anything related to academics and regularly engage in these activities to work towards work-life balance. I also would advise students to find supportive colleagues and friends outside of their academic circle because all of graduate school is more manageable with a strong support system by your side.

Awards & Recognition

Outstanding Student Clinician Award

Michaela B. Swee, M.A. Temple University



Michaela is a fifth year clinical psychology doctoral candidate at Temple University. Born and raised in New York, Michaela received her Bachelor of Arts in psychology from Wesleyan University. At Temple, Michaela studies under the mentorship of Dr. Richard Heimberg in the Adult Anxiety Clinic of Temple (AACT), an outpatient clinic and research laboratory specializing in social anxiety. Her clinical and research interests focus on utilizing integrative compassion- and acceptance-oriented approaches to help individuals struggling with shame, trauma, anxiety, depression, and other internalizing experiences. Michaela's dissertation study is a randomized controlled trial of a self-compassionate letter writing intervention for individuals with high levels of internalized shame. She has worked with a diverse range of clients in numerous settings, including the AACT, Temple Psychological Services Center, Swarthmore College Counseling Center, and the Center for the Treatment and Study of Anxiety at the University of Pennsylvania. She has trained in multiple cognitive-behavioral therapies (CBTs; i.e., CBT for social anxiety disorder, exposure and response prevention for obsessive-compulsive disorder, and prolonged exposure therapy for posttraumatic stress disorder), psychodynamic therapy, acceptance and commitment therapy (ACT), compassion-focused therapy (CFT), and group therapy approaches. In July, Michaela will begin her predoctoral internship at Harvard Medical School/McLean Hospital.

1. What are your clinical interests?

I am passionate about helping individuals with high levels of shame lead meaningful lives that incorporate greater self-compassion, self-acceptance, and connection to self and others. Many of these individuals have experienced significant trauma in their lives. Through exploring and examining one's feelings, belief systems, and actions, I strive to help clients shift from a place of self-disparagement to a place of greater self-care, experimenting with different ways of relating that involve greater present-mindedness, vulnerability, and authenticity. I deeply enjoy doing this work in both individual and group formats. My integrative training (i.e., CBT, psychodynamic therapy, ACT, CFT, group therapy) has taught me to strive to meet clients where they are, understand their individual therapeutic wants and needs, and address them in an unprescribed, person-centered manner. I work collaboratively with clients in attending to blind spots, which is how I think I can be most valuable. It is easy for one to get stuck in the inner loopings of one's own mind. We can all benefit from the insight others help us cultivate, which is

sometimes difficult or impossible to do alone. My most treasured moments occur when clients encounter perspectives for the first time that begin to create new openings for change.

2. Why is this area of clinical work exciting to you?

I love that this work is about the power of relationships and using connection, compassion, and human understanding to move people from perceived "stuckness" and isolation to deeper connection and improved relationships with self and others. My experience doing CFT and acceptance-oriented work to address shame, in individual and group formats, is that clients are met on their own islands and offered a raft; sometimes for the first time in their lives. This raft can be offered by the therapist, by whom the client feels seen and held, or it can even more meaningfully be offered by another group member experiencing something similar who essentially says, "me too." Groups are powerful in large part because they offer individuals the opportunity to experience the common humanity of their pain and struggles and learn that they are

Awards & Recognition

not alone. It is a true gift to help facilitate understanding and connection, as these processes are powerful seeds for the kinds of change clients are seeking.

3. Who are/have been your mentor(s) or clinical influences?

When I think back, my oldest clinical influence is my psychologically minded, warm, and open family, who taught me safety in emotional honesty, vulnerability, and intimacy with others. I have tremendous gratitude for my mentor, Dr. Rick Heimberg, who has been a supportive force in my professional development and taught me how to be an effective CBT therapist. I also feel immense gratitude for Dr. Catherine Panzarella, whose confidence and belief in me taught me to trust my own clinical sense and judgment. I feel indebted to Dr. Kelly Wilson and other members of the ACT and CFT communities, who helped me learn experientially how to meet another in their suffering and show up as a compassionate, brave human in the room. My supervisors and colleagues in the psychodynamic and group therapy communities instilled in me the power of flexibility, introspection, and process—examining the ways in which my own person interacts with clients and the therapy process. Additionally, I would be remiss not to mention my own therapist, Leslie, who has helped me grow into the psychotherapist I am today through gifting me the humbling experience of sitting on the other side of the room and examining some of the same difficult human experiences with which I help my own clients engage. Finally, there are a few extremely special friends and colleagues—they know who they are—with whom I have shared hours-long conversations, offering one another guidance, support, and peer supervision on the challenges of clinical work. These conversations help me stretch and grow as a clinician and a person in ways that wouldn't happen without them.

4. What advice would you give to other students pursuing their graduate degree?

First, I would encourage anyone aspiring to become a professional psychotherapist to pursue their own therapy, as I believe the process can be as extraordinary for professional development as it can be for personal growth. Second, I urge you to

follow your heart as a guide to pursuing what matters during graduate school. There are any number of factors and pressures in our programs that can lead us astray from our passions. As difficult as it is to remember at times, this is your training and your future you are building. The courage to nurture what you value, even if it is the less beaten path, is important. For example, if you have clinical training goals that are difficult to meet within the context of your program, consider seeking external support and opportunities to supplement your training. Although graduate school can feel long and arduous, it also passes in the blink of an eye, so try to focus on the pieces that are most valuable to you. I personally have found myself happiest and more grounded when I feel connected and present to the pursuits that matter most.

Virtual Clinical Lunch (VCL) Series

SSCP's Virtual Clinical Lunch offers an opportunity for the entire field to discuss clinical science research together.

Check out our diversity-related VCLs!

<http://www.sscpweb.org/ClinicalLunch>

July 2020

Dr. Joanne Davila's SSCP Presidential Address on "Studying Relationships in Today's World."

<https://youtu.be/yCdYQ9nj6SA>

Drs. Lauren Khazem, Craig Rodriguez-Seijas, and Natalie Watson-Singleton with Dr. Rheeda Walker as discussant, "Using Clinical Science to Improve the Assessment and Treatment of Underrepresented Groups."

<https://youtu.be/344iIL1qA>

February 2020

Joseph Gone, "Is Psychological Science A-Cultural?"

https://www.youtube.com/watch?v=fO2lGxrp_6A&feature=youtu.be



Student Special Feature

Our Students Need Support: Gaps in Graduate Student Mental Health Options

Alexandra B. Klein, M.A.,¹ Ana Rabasco, M.A.,² Ellen H. Steele, M.A.,³

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Case Western Reserve University¹; Fordham University²;

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As many as 70% of graduate students in clinical psychology will experience stressors that impact their functioning, including those related to academic pressures, financial stress, anxiety, and poor work/life balance (El-Ghoroury et al., 2012). Recent literature has highlighted the importance of self-care strategies in helping graduate students effectively cope with both present and future stress. In particular, professional support systems and awareness of one's needs and reactions to stressors have emerged as two important aspects of self-care among a sample (N = 358) of clinical psychology graduate students (Zahniser et al., 2017). However, student perspectives on self-care initiatives in their programs suggest that a systematic effort to educate about, encourage, and model self-care strategies is lacking (Zahniser et al., 2017). Further, one study found that 38 to 75% of clinical psychology graduate students are likely to seek treatment for a range of issues including psychopathology and career-related stressors (Holzman et al., 1996).

“Findings from this survey reflect a clear need for clinical psychology programs to develop resource lists of affordable, empirically supported treatment options for their graduate students.”

Taken together, this small body of research suggests that graduate students in clinical psychology have a need for mental health treatment and that systematic, top-down initiatives focused on implementing clear pathways for students to obtain support and engage in self-care are lacking. Further complicating this issue is the fact that graduate student stipends may not cover the relatively high cost of psychotherapy, though this assumption is anecdotal and requires empirical testing. Additionally, providers in the community may serve as supervisors and lecturers within clinical psychology programs, limiting the number of providers

with whom students can initiate care. Therefore, the SSCP Student Committee conducted a survey to better understand the resources currently available to assist graduate students in SSCP with accessing mental health treatment. Findings from this survey and initiatives being implemented to address this issue are discussed below.

SSCP GRADUATE STUDENTS' PATHWAYS TO MENTAL HEALTH CARE

DOES YOUR GRADUATE PROGRAM PROVIDE CLEAR INFORMATION FOR YOUR OWN MENTAL HEALTH CARE?



WHAT IS THE PROCESS OF ACCESSING CARE IN YOUR PROGRAM?



*Note: responses in this category included going to campus health center, speaking with fellow graduate students, being unsure if resource list was up to date or listed potential practicum supervisors, etc.

A total of 73 students completed the anonymous survey, which was administered via the SSCP student listserv. The results suggest that over half of students (52.1%; n = 38) do not have a clear way

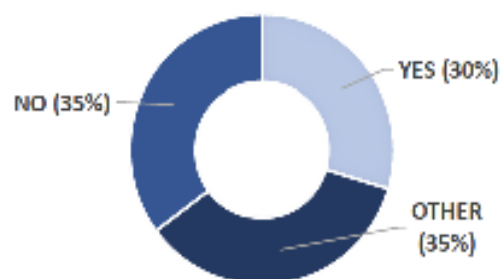
within their graduate program to obtain information about mental health treatment that may be available to them. The majority (54.8%, $n = 40$) reported that if they were to seek care, they would look for resources on their own rather than through their advisor, DCT, program, or university. Of the programs where a DCT does keep a list of available resources, the majority of students reported that the lists were either not up to date (21.3%; $n = 13$) or they were unsure if the resource list was up to date (65.6%, $n = 40$).

SSCP Graduate Students' Pathways to Mental Health Care

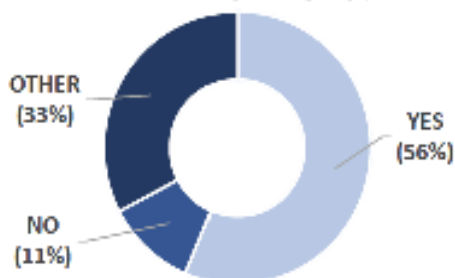
IF YOUR PROGRAM KEEPS A RESOURCE LIST, ARE THE OPTIONS UP TO DATE?



IF YOUR PROGRAM KEEPS A RESOURCE LIST, ARE THE OPTIONS AFFORDABLE?



IF YOUR PROGRAM KEEPS A RESOURCE LIST, ARE THERE EMPIRICALLY SUPPORTED TREATMENT OPTIONS?



Further, while the majority of students reported that the resource lists included clinicians providing empirically supported treatments (56.4%, $n = 31$), over a third reported that the treatment options are not affordable (35.2%, $n = 19$). Taken together, findings from this survey reflect a clear need for clinical psychology programs to develop resource lists of affordable, empirically supported treatment options for their graduate students, or when such resources are not available in the local community, options that are accessible via telehealth. Additionally, students need a clear avenue for obtaining these resources and seeking treatment.

“Students need a clear avenue for obtaining these resources and seeking treatment.”

In an effort to assist graduate students and programs with obtaining and advertising mental health resources, the SSCP Student Committee will be engaging in three ongoing initiatives. First, the committee plans to publish findings from this brief survey in a peer reviewed publication in order to bring awareness to this issue and encourage future research. Secondly, we will develop a high-level list of resources to help students navigate finding mental health resources that will be effective for them. Finally, we plan to form partnerships with other professional organizations in order to: 1) assist DCTs with compiling resources, and 2) engage providers in offering services to graduate students at a reduced rate. As graduate students are the future of scientific research and practice in clinical psychology, opportunities for treatment and care will prove a valuable initiative for the future.

References

- El-Ghoroury, N. H., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology*, 6(2), 122.
- Holzman, L. A., Searight, H. R., & Hughes, H. M. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. *Professional Psychology: Research and Practice*, 27(1), 98.
- Zahniser, E., Rupert, P. A., & Dorociak, K. E. (2017). Self-care in clinical psychology graduate training. *Training and Education in Professional Psychology*, 11(4), 283.

Updates from Student Representatives

Alexandra Klein, M.A., Case Western Reserve University
Ana Rabasco, M.A., Fordham University

As your student representatives, we would like to take this opportunity to update you on a couple of opportunities and resources for our members.

Updates and Resources

Student Website:

Our student website has moved! You can find updated information about SSCP students at: <http://sscpweb.org/students>

Student Mentorship Programs:

Our Student Committee has compiled a list of student mentorship programs across a variety of organizations related to psychology. You can find the list on our resources page: <http://sscpweb.org/page-18231>

SSCP Student Mental Health:

We recently surveyed our SSCP student members about the mental health resources available to them. You can find our report with the findings, titled, "Our Students Need Support: Gaps in Graduate Student Mental Health Options," in this newsletter!

Internship Hotel/Transportation Match:

We will not be organizing the Internship Hotel/Transportation Match this year because internship interviews will be held remotely by the vast majority of programs. We hope that it will be safe to hold in-person internship interviews next year and that the Internship Hotel/Transportation Match will return then!

SSCP Student Committee:

Want to get more involved with SSCP students? Consider joining the SSCP Student Committee! We add new members every January. SSCP Student Committee members participate in initiatives to increase student membership and awareness of SSCP, help to create resources for student members, and attend quarterly meetings. Email us at sscp-student@gmail.com for more information.

Professional Training and Employment Resource:

Check out the Professional Training and Employment page to find your next job! There are faculty positions and postdoctoral fellowships listed: <https://societyforscienceofclinicalpsychology.wildapricot.org/page-18108>

Contact Us!

We would love to hear from you with any suggestions, comments, questions, or concerns regarding SSCP student membership or resources for students, so feel free to email us!

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