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Karen J. White, Ph.D. & Heidi A. Zetzer, Ph.D.

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We mark the calendar at about a year since the high beams of a pandemic came into our rear view mirror, filling it with a pointed brightness that directed us down a road with very few, if any, off ramps. In our efforts to find our way, we relied on the kindness of other APTCers on the road. The pandemic (from the Greek pandemos "pertaining to all people") has had its effect on all of us, but not uniformly. Like an x-ray, the pandemic revealed the unstable, broken, and misshapen-structures underpinning our shared existence, especially in American society. This issue of the APTC Bulletin focuses on efforts to understand diversity issues in the service of social justice initiatives in training clinics. We endeavor to see more clearly our responsibility to recognize each other and to learn from our clients, students, and colleagues. We acknowledge the thoughtful contributions of our authors in their explorations of diversity, equity and efforts toward more socially just implementations of psychological science.

Our current president urges us to embrace a curiosity and "radical openness" in our interactions with those of different identities, walks of life, and political persuasions. We are encouraged to consider that when we allow others to see us when we do not know; they may recognize the value of their own questioning stance. This issue features the work of clinic directors who have developed model programs that train graduate students to address the needs of those who are incarcerated or those forced to flee their home countries. Careful planning and training with an emphasis on interdisciplinary collaboration allows students to develop a sense of confidence in service delivery and to experience empathy for those whose fates are unimaginable. Attention to the decolonization of our knowledge base causes us to take stock of how teaching even a "basic" skill like conceptualization of psychological test results requires us to strive toward cultural humility. Other contributions call us to appreciate the harm incurred when we are not aware of biases against those who are disabled or overweight or otherwise judged as having an "unacceptable" appearance. The summary of the APTC Diversity Survey outlines the wide range of efforts to enrich the training of our students and acknowledges areas for further self-examination and development. Our contributors underscore that empathy for others and ourselves emerges as the key ingredient to transformation and recovery. We encourage you to read slowly with deliberate attention. There is much to appreciate in this collection of clinic directors' efforts to enhance clinical training in the service of social justice.

Diversity Statement

The Association of Psychology Training Clinics is dedicated to furthering cultural awareness, competency, and humility through supportive learning opportunities and environments. We are committed to engaging in training activities which increase an understanding of individual and cultural diversity, and focus on the inter-play between contextual factors and intersectionality among all people. We respect and celebrate awareness, appreciation, and sensitivity toward all and encourage an appreciation of how political, economic, and societal influences affect individuals' behaviors, particularly those from disadvantaged and marginalized groups.

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President's Message

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Here's hoping that by the time this essay goes out in our bulletin, that 2021 has settled down a bit. With the ongoing pandemic and continued civil unrest in our country, many of us have barely had time to recover from the trials of 2020. Yet, in March, 2021 we still find ourselves having to tend to our students, our communities, our families (and hopefully, ourselves) with continued compassion, grace and strength. Internship interviews must still go on, admissions interviews must still happen, and the citizenry continues to seek services from clinics like ours at a staggering rate. Remote work continues at an uneven pace for many of us, with services affected by resources, broadband accessibility and other institutional allowances or barriers. With the recent homegrown attacks on the United States Capitol, everyone is on edge, and even people with high levels of resilience are finding their internal resources wearing thin.

I see two major challenges for APTC members as we go into the new year, both of which are daunting and yet unavoidable. The first challenge is: how do we proceed as training clinics, given the continued challenges of COVID-19? The virus, which continues to mutate, looks to be with us for at least the next year, given the slow and uneven rates of vaccinations and the seemingly lax abidance of mask and social distancing mandates among many of our citizens. Many of us have successfully onboarded remote systems for test administration and therapy, as well as systems for collecting fees, signing intake documents, etc., and feel a little more prepared for the second round of remote work that may begin come summer or fall. Some of us have not been so lucky, and are still struggling to get pieces of remote systems up and running relatively smoothly. When will we be able to resume business as usual? Will we still be drafting even newer "hybrid" or "transitional" models for our training and service provision into next year? Will everyone feel "safe" to return? If not, how will we handle these differences in capacity? What will our students have gained through this year, what will they have lost, and how will we remediate effectively? We know that things have changed irrevocably for our field, but until the dust has settled, it's still unclear just what has changed, and to what extent.

The second challenge, which is harder to quantify and thus harder to resolve, relates to the continuing polarization of the US, where most (but not all) of our clinics are based (other countries are experiencing similar trends). Depending on where our clinics are in this country, we may see greater or fewer numbers of people who self-identify as conservative-leaning, people who believe that the changing political and social mores of the country are "going in the wrong direction." Contrast that with the fact that many (though not all) graduate students and clinic directors self-identify as liberal-leaning and social-justice minded, and we have recipes for tension, if not disaster. Our second challenge is: how do we teach our student therapists to work effectively with and help patients who espouse values, attitudes and beliefs with which therapists may virulently disagree? Patients whose worldview may even specifically degrade the therapists' own gender/racial/ethnic/religious identity or sexual orientation? How do we as directors hold both the patients', the students' and the community's needs in mind, even as their relative values may directly oppose each other's, and/or our own? What are our roles as directors, teachers, mentors, and community advocates in this tense environment? Do our roles intersect or conflict with each other, and how do we navigate these conflicts? I have struggled personally regarding these issues with my younger students and colleagues, where my own stance in these matters is perhaps seen as more incremental, and less revolutionary than desired. The pressing question of "What is enough?" echoes constantly in my mind. If I do not know the answers to these questions, what do I communicate to my students, and they to their patients?

This may be a rationalization… but I think that "not knowing" can be a useful stance for a clinic director. I think of the common but fitting refrain for today, "if it were easy, we'd have figured it out by now." The fact is, the place we find ourselves today as graduate trainers is NOT easy to understand or navigate—just as technology has changed, the hues, threads and patterns of our country's social fabric has also changed over time. As viruses mutate, so does our culture. Whether we label these changes as positive or negative, as progress or backsliding, change is a certainty. As clinic directors, we are in positions to help our students and clients pivot to meet the challenges brought by change, whether it be to fight, adapt to, or accept what comes next. Our ability to practice humility with our students and patients-- to admit not knowing or having doubt—can be powerful and therapeutic, and is all too rarely encountered at this time. Although we are leaders, we still need others to help make sense of our changing world. Our students and clients can also help us develop new ways of thinking, feeling and acting in our shared community.

Speaking of fresh perspectives, I recently had the great pleasure of meeting several new clinic directors on a Zoom call, former students themselves who represent the new generation of APTC. I was delighted to converse with a diverse group of "pioneers," gamely grappling with seemingly overwhelming circumstances in their new positions- the more things change, the more they stay the same. I saw our organization's future in their faces, and it shone very brightly. They will teach us fresh ways of thinking about how we train our students in both face to face and online environments, and how to serve our clients in today's increasingly embattled society.

Although we may still be dealing with dark and uncertain times, my optimism remains strong. The challenges for clinic directors remain daunting, but as long as we remain "radically open" (to borrow psychoanalyst Anton Hart's phrase) to each other and to new ways of seeing our future, we'll come through this period wiser and better prepared for what comes next…whatever that may be.

Post-script: Since writing this essay, we were again faced with an episode of mass violence, this time towards Asian community members. There remains so much more work to do, and we must remain dedicated to doing it.

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Diversity, Ethics, Competence, and Social Justice: Training Clinics Serving Justice-Involved Clients

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Individuals who are involved with the criminal justice system have substantial behavioral health needs that are not consistently met (Treatment Advocacy Center, 2017), creating gaps in service that could be addressed, in part, by psychology training clinics (PTCs). By establishing the specialized partnerships and programs needed to address such gaps, PTCs could provide needed behavioral health services to some of the more than 600,000 individuals returning annually to their communities following incarceration (Prison Policy Initiative, 2019), enhance trainees' multicultural humility, address their interests in social justice, and strengthen community-university relations. In this brief article, we outline how PTCs can both meet the needs of clients and prepare trainees for specialized practice by building the competencies needed to work with justice--involved (JI) clients.

A Programmatic Model Serving JI Clients

We begin with an example of how a specialized JI project might be established within a university-based psychological services clinic. The Psychological Services Clinic (PSC) at Drexel University includes a doctoral-level practicum rotation that provides these services called the Drexel Reentry Project (DRP). (Contact the first author to receive the DRP manual.) The program began with a collaboration with a federal reentry court in Philadelphia (Supervision to Aid Reentry, or STAR; see https://www.paep.uscourts.gov/re-entry-court) that serves individuals appraised at a particular risk for criminal recidivism as they return to the community following incarceration. More recently, the DRP has begun accepting referrals from the Pennsylvania Innocence Project for the treatment of individuals exonerated for criminal offenses and released from prison.

Such services are intended to help JI individuals to build skills, improve decision-making, change thinking patterns, and avoid problematic situations with two broad goals: reducing the risk of subsequent offending and improving their overall adjustment during reentry by addressing behavioral health needs. The services are also intended to address a social justice need in the community, arising from the limited availability of behavioral health interventions for JI individuals who are often BIPOC and poor. Many individuals returning from prison lack social and financial resources and the capacity to seek services on their own. The DRP provides stable, inexpensive, de-stigmatized, and culturally aware treatment to clients while training the next generation of psychologists in specialized multicultural and social justice competencies.

Meeting Client and Student Trainee Needs

The DRP can serve as a model for PTCs that partner with courts, parole and probation, and legal organizations such as the Innocence Project; that have trainees in clinical psychology, counseling psychology, forensic psychology, or correctional psychology; and that seek to provide services that are particularly relevant in addressing social justice-relevant needs of the underserved in partnership with the community.[1] To meet client and trainee needs, the PTC supervisor should have the appropriate expertise to build such a program and these partnerships as this is an interdisciplinary project requiring competent leadership and supervision (see APA, 2017; SAMHSA, 2019).

Meeting Client Needs

Ethical clinical treatment begins with careful consideration of the ability to meet the client's needs. In this section, we briefly discuss some of the most commonly-experienced needs of JI clients.

Cost and Finances

For many returning to the community from prison, money is tight, and they may not have a job; those who do are more likely

1 The authors of this article are available to provide consultation and resources to interested parties. Please contact PSC Director Jennifer Schwartz, PhD (jls636@drexel.edu).

to be working without stable hours or income (Looney & Turner, 2018). Limiting the cost of services to clients may be addressed through contracts, grant or foundation funding, or considering the overall cost of services to be justified by the training value. At the DRP, court-ordered clients are served without cost under an agreement between the program and the reentry court. This eliminates ethical dilemmas associated with having the court encourage or compel treatment for clients with limited means to pay; furthermore, our clients are incentivized to attend by receiving "points" that decrease their required time under court-related supervision. For exonerated DRP clients, flexibility and grant-funded coverage of costs have been important, especially for clients who have not received compensation for their wrongful conviction.

Risk-Reduction

One important goal in providing services to JI individuals involves assessing the individual's risk for subsequent criminal offending, identifying risk-relevant needs, and delivering services that are both empirically supported (*general responsivity*) and tailored to the individual's capacities (*specific responsivity*) (Bonta & Andrews, 2017). PTCs that provide programmatic services to JI clients should be well-versed in specific interventions for risk-reduction treatment. Partnerships can also help to provide sources of support for clients whose specific areas of need are beyond the bounds of behavioral health services (e.g. job-seeking, money management). For exonerated clients, risk-reduction may not be primary; evidence suggests that about half of exonerees have had no justice involvement prior to their wrongful conviction (Shlosberg et al., 2014). However, the stigma of a wrongful conviction and experiences while incarcerated may provide other needs that are relevant to either quality of life or reoffending risk.

Trauma-Informed Care

Many individuals with involvement in the legal system have experienced a trauma at some time in their lives (Piper & Berle, 2019). Although the focus of treatment may not be to address trauma stemming from their experience with violence, institutional and interpersonal racism, or grief over the life they might have lived might arise as themes to be addressed in treatment. PTCs should anticipate this possibility, allowing the opportunity for clients to work on such concerns when indicated. Exonerees may require additional trauma-specific treatment in addition to general reentry support (Heilbrun et al., 2020). In this case, the trainee's supervisor(s) should be familiar with both types of treatment. For example, the DRP has separate supervision for trainees treating exonerees, provided by two different supervisors who combine to provide expertise in each area.

Training Competent Clinicians

PTCs have commitments to their trainees as well as to their clients. They must be able to teach the specific competencies necessary for students to succeed in providing clinical services under supervision (APA, 2017). We offer brief descriptions of some of the highest-priority competencies in the following sections.

Multicultural Humility

Beyond racial and gender differences (Carson, 2020; Cope et al., 2016), there are likely to be differences in socioeconomic status, sexual identities, and life experiences between student trainees and their JI clients. Trainees should be prepared to consider issues related to multicultural identities—addressing how they may influence treatment with their clients. PTCs should be prepared to make issues related to diversity and social justice an ongoing component of student training and supervision. To encourage dialogue, reflection, and seeking information, student clinicians at the DRP present and lead a discussion on issues related to diversity, multiculturalism, and social justice every other week in supervision.

Working with Legal Actors

If actively working with legal actors such as probation officers or judges, clear expectations of the role of the clinician should be outlined. PTCs and supervisors should also anticipate the possibility of receiving a subpoena or court order for JI client documents. Depending on the jurisdiction, exonerated clients may be required to initiate legal action to receive compensation from the state for their wrongful conviction (Gutman & Sun, 2019). In these cases, the likelihood of lawyers requesting clinical notes is high. Combining the roles of forensic expert and treatment provider can create substantial ethical problems (see APA, 2013, 2017) and should be avoided. It is important to anticipate that an expert opinion may be sought by a client's attorney—and to clarify in advance that any information provided will simply be factual (e.g., treatment notes) and will not incorporate an expert opinion (e.g., "the client's PTSD was causally related to his false conviction"). Student trainees should be made aware of these distinctions and supported in providing the former while avoiding the latter.

Confidentiality

Specific issues regarding confidentiality are likely to arise when working with JI clients. First, if the PTC is receiving referrals from a legal actor, the limits of confidentiality should be made explicit and clear among the clinician, the client, and the referral source. Additionally, for some high-profile JI clients and most exonerees, clinicians may have to be particularly cautious to protect the identities of their clients in public communications such as conferences, academic presentations, and professional interviews. Information such as charges and length of sentence, for example, might be sufficient to allow the client to be identified. Trainees should be guided in how to protect confidentiality as well as the applicable law on when it is necessary to break confidentiality, such as in the case of potential harm to identifiable third parties (APA, 2017; Johnson et al., 2019).

Conclusion

The particular ethical and social justice concerns that arise when student trainees work with JI clients provide one good reason why PTCs and their trainees *should* work with such clients. When PTCs provide such services, their clients, trainees, and the larger community can all benefit. Clinicians in training develop important competencies related to multicultural and socially aware practice. Local policies may be influenced. Opportunities for research partnerships may grow. We have seen these benefits and observed some of our community's most vulnerable receiving excellent care in our work with the DRP.

References

American Psychological Association. (2013). *Specialty Guidelines for forensic psychology*. https://www.apa.org/pubs/journals/features/forensic-psychology.pdf

American Psychological Association. (2017). *American Psychological Association ethical principles of psychologists and code of conduct*. https://www.apa.org/ethics/code/ethics-code-2017.pdf

Bonta, J & Andrews, D. A. (2016). *The psychology of criminal conduct* (6th ed.) Routledge. https://doi.org/10.4324/9781315677187

Carson, E. A. (2020). *Prisoners in 2019*. Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/p19.pdf

Cope, C., Michalski, D. S., & Fowler, G. A. (2016). *Summary report: Student demographics.* American Psychological Association. https://www.apa.org/education/grad/survey-data/2017-student-demographics.pdf

Gutman, J. & Sun, L. (2019). Why is Mississippi the best state in which to be exonerated? An empirical evaluation of state statutory and civil compensation for the wrongfully convicted. *Northeastern University Law Review, 11*(2), 694-789. https://ssrn.com/abstract=3422474

Heilbrun, K., Fishel, S., Lankford, C., & Ratkalkar, M. (2020). Therapy with exonerated clients: Review and recommendations. *The Journal of Forensic Practice, 22*(2), 123-135. https://doi.org/10.1108/JFP-02-2020-0004

Johnson, R., Persad, G., & Sisti, D. (2019). The *Tarasoff* rule: The implications of interstate variation and gaps in professional training. *Forensic Psychiatry: Focus on Malpractice and Risk Management, 17*(4), 435-442. https://doi.org/10.1176/appi.focus.17402

Looney, A. & Turner, N. (2018, March). *Work and opportunity before and after incarceration*. The Brookings Institution. https://www.brookings.edu/wp-content/uploads/2018/03/es_20180314_looneyincarceration_final.pdf

Piper, A., & Berle, D. (2019). The association between trauma experienced during incarceration and PTSD outcomes: A systematic review and meta-analysis. *The Journal of Forensic Psychiatry & Psychology, 30*(5), 854-875. https://doi.org/10.1080/14789949.2019.1639788

Prison Policy Initiative. (2019). *Annual releases from state prisons and local jails, by sex and state*. https://www.prisonpolicy.org/data/releases_sex_state.xlsx

Shlosberg, A., Mandery, E. J., West, V., & Callaghan B. (2014). Expungement and post-exoneration offending. *The Journal of Criminal Law and Criminology*, 104(2), 353-388. https://www.jstor.org/stable/44113392

Substance Abuse and Mental Health Services Administration. (2019). *Principles of community-based behavioral health services for justice-involved individuals: A research-based guide*. https://store.samhsa.gov/sites/default/files/d7/priv/sma19-5097.pdf

Treatment Advocacy Center. (2017, September). *Treat or repeat: A state survey of serious mental illness, major crimes and community treatment*. https://www.treatmentadvocacycenter.org/storage/documents/treat-or-repeat.pdf

We Have Weighted Long Enough. It is Time!

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The "Too Fat Polka" was a hit song in 1947. Opening with the lyrics, "I don't want her, you can have her, she's too fat for me," one can only imagine the fat shaming words that followed. As horrific as these lyrics sound to us now, one could make the case that back in the days when the term "politically correct" (first widely recognized in 1970) was not part of our vernacular, before the Women's Liberation Movement of the 60's, 70's, & 80's; the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; the Voting Rights Act of 1965; the Equal Pay Act of 1963; Title IX in 1972; the Age Discrimination Act of 1975; the Pregnancy Discrimination Act of 1978; and the Equality Act of 2015 such a song was a sign of the times. In the 1940's, discrimination was woven into the fabric of our society and insensitivity to diversity was commonplace. However, the sad truth is that things have not changed much when it comes to weightism. In 2013, Louis Peitzman wrote a *Buzzfeed* article, titled "It is okay to come out…as long as you are not fat" in which he admitted that years after coming out as gay, he still felt anxious about identifying as fat. According to Bento et al. (2012), weightism is the new racism. Attitudes about weight in 2021 run parallel to attitudes about race in 1941. Our current laws protect people based on race, color, religion, sex, national origin, disability, genetic information, or age, but not weight. Although legislation does not necessarily change attitudes, it would be a step in the right direction. We have weighted long enough! It is time!

In an age when most Americans will decry any overt sign of prejudice, there persists an unspoken permission to judge people based on body size, with weight being among "the most socially acceptable prejudices to endorse" (Blaine et al., 2002; Collisson et al., p. 536; Damm, 2012). Scott Reeder, a veteran statehouse journalist and freelance reporter noted that it was acceptable for news reporters and media personalities to ridicule political figures based on body size. Examples he gave included calling Governor Chris Christie, Governor Krispy Kreme; stating Governor J.B. Pritzke had a problem with co-morbidity; and telling "Fat Donald" jokes about Donald Trump, also referred to as President Plump. Sadly, Governor Christie subsequently told reporters, "When you're overweight, fair or unfair, there's going to be those who make really awful comments about you and there are going to be people who make jokes about it. That's the way it goes." Reeder, unwilling to accept resignation to bullying for being fat as a viable option, chastised his colleagues in the media when he commented, "After more than 30 years of covering politicians, I can say usually those who joke about obesity are folks who have never struggled with it themselves." He then challenged reporters and journalists to leave body size out of the political equation. And, I might add, out of the late-night talk show hosts' monologues. We have weighted long enough! It is time!

Speaking of the media, we have made some progress in introducing cast members of color and cast members of varying sexual orientations, but little or no progress increasing the numbers of cast members who are overweight or obese, unless they are the object of jokes about their weight, comedic somewhat lonely characters, or outcasts. Rarely are they romantic leads, action stars, lawyers or doctors (Whyte, 2010). In fact, only 25% of men and 5-7% of female characters are above average weight, with the majority being below average weight and outwardly beautiful (Blaine et al, 2002; Harriger & Thompson, 2011; Whyte, 2010). Thus, people who are overweight or obese are underrepresented in shows or sitcoms. Shows like *Orange is the New Black*, The *Mindy Project*, and *Drop Dead Diva* are a step in the right direction. We have weighted long enough! It is time!

Anti-fat prejudice has increased over the past ten years with an implied acceptance of the stereotype of fat people being overweight, lazy, self-indulgent, unhappy, hedonistic, friendless, sedentary, stupid, or worthless (Bento et al., 2012; Foster-Gimbel & Engeln, 2016). Concurrently, the prevalence of obesity has increased in the United States. According to the Centers for Disease Control and Prevention (2017; 2021), in 1950, 14% of adults were considered obese, 27% in 1999, and 40% in 2018; in 1950, 45% of adults were considered overweight, 61% in 1999, and 71% in 2018. Age, another one of the final frontiers of prejudice, may, however, work in one's favor with regard to weightism. Apparently, people tend to judge older people less harshly (those over 50) than younger cohorts (20's and 30's) with regards to weight, with the age effect especially liberating for women who are released from the standard of the unrealistically thin ideal as they grow older (Bento et al., 2012).

One cannot hide being obese. As Peitzman (2013) aptly stated, "I never had to come out as fat." He indicated that he knew he was fat because people told him he was fat. Whether overtly or subtly, the message was the same, and has continued all of his life. An astute observer, Peitzman noted that people who make a gay slur are considered homophobic; those who make a racial slur, are considered racist, but those who ask questions like, "Why don't you lose weight?" or "Have you seen this new diet?" slip under the radar. Yet is this not weightism and should we not label people who make weight-related slurs *weightists*?

Comments such as these reflect ignorance of the causes of obesity. The idea that weight is controllable for all permeates society (Bento et al., 2012). Shows like *The Biggest Loser* and cover stories about weight loss in *People* magazine only perpetuate the idea that weight is controllable and weight loss possible for everyone who is overweight or obese. What they neglect to say is that maintaining weight loss is virtually impossible, with 90% of people who lose weight gaining it back plus more within 5 years. Blaine et al. (2002) observed that the way weight loss products are marketed also implies anyone can lose weight, especially women. Thus, weight loss actually has a paradoxical effect by reinforcing the concept that weight

is manipulable. Science tells us that weight is a much more complex phenomenon. Half of the cause of obesity is genetics and the other half is variables such as environment and individual choices (Bento et al, 2012).

Types of Weightism

This article highlights the deleterious effects of judging people based upon weight or body size. Weightism includes weight-based stigma, stereotypes, prejudice, and discrimination and can affect people at either end of the weight spectrum—under or over (Bento et al., 2012). Anyone who has experienced anorexia or was "super skinny" as a kid can attest to the insensitivity of others communicated through looks, jokes, or comments about being too thin. Because the numbers of people at the "skinny" end of the spectrum are much smaller, this article focuses on the overweight/obese population's experience, however, weight bias affects extremely thin people as well. Weightism can take a variety of forms including aversive weightism, complimentary weightism, internalized weightism, and workplace weightism.

Aversive Weightism

Aversive Weightism is when people outwardly express acceptance of bodies of every size, yet subtly favor members of the "normal-weight" group. People in this group may avoid or feel uncomfortable around obese people even to the point of avoiding association with normal weight people who have obese friends (stigma by association) (Bento et al., 2012).

Complimentary Weightism

Complimentary Weightism is when people make comments about appearance, specifically compliments about weight gain or loss that appear innocent, yet have a negative impact on a person's body image, causing increased self-objectification, body surveillance and body dissatisfaction, depending upon the perceived impact of the comments for the individual. Although the compliments may initially feel good or uplifting, Calogero et al. (2009), in a study of 220 women, found that these commendations remind women that evaluation is often based upon appearance and comparison to the ever elusive thin, but not too thin, ideal. I have heard repeatedly in my practice, both people with anorexia and people who are at high weights, desperately wish that they could alter their weight, whether it be weight gain or loss, in secret, without anyone making a comment. It is as though the implied scrutiny in the seemingly innocuous comments is a violation that steals away ownership of their own bodies. Valuing competence over appearance seems to moderate the impact of this type of comment on the receiver, however, I agree with Calogero et al. (2009) when they wrote, "Indeed, to say something nice may be worse than saying anything at all when the content of the comments is about appearance of women's weight or shape" (p. 130).

Internalized Weightism

Internalized Weightism is a tragic consequence of the fat prejudice in our society. People who are overweight or obese who internalize our culture's negativity toward people with high weights think of themselves as lazy, stupid, lacking willpower, self-indulgent, unlovable, or worthless. These beliefs create debilitating self-loathing, self-fulfilling prophecies or self-limitations that limit success in life and romantic relationships (Foster-Gimbel & Engeln, 2016). Complimentary weightism frequently fuels internalized weightism, with those innocent, well-meaning comments lighting the match of self-hate.

Workplace Weightism

Workplace Weightism is a twenty-first century reality at every stage of employment including hiring, placement, compensation, promotion, discipline, and termination, with the wage penalty for obesity being higher for women than for men (Bento et al., 2012). Aversive weightism in the workplace can result in subtle discrimination, intentional or unintentional, with explanations that seem believable, yet in reality, are based in weight bias.

In summary, all types of weightism have serious negative consequences for the objects of weight bias. Again, this begs the question, why do we not call out those who display weightism? Are they not, in the purest sense of the word, weightists?

Weightism and Populations

Here is where things get really interesting. Weightism affects groups of people in different ways.

Race

Weight stigma is predicted to be more negative for white women than African-American or Hispanic women, where higher weights are more culturally acceptable (Bento et al., 2012). Adult Asians experienced a plot twist. Given that currently 71% of the U.S. population is overweight or obese and given that Asian immigrants are less likely to be overweight than Asian Americans born in the U.S., Asian Americans who are overweight are perceived more "American" by other Americans and less likely to have their citizenship questioned. Ironically, for Asian Americans, the social benefits of being overweight may outweigh the health risks (Handron et al., 2017).

Adolescents

Bucchianeri et al. (2013) studied the prevalence of harassment among 2,800 adolescents on the basis of socioeconomic status, weight, race/ethnicity, or sexual orientation. They found that weight-based harassment was the most prevalent, followed by race. Those adolescents who were overweight or obese experienced disproportionately higher rates of all types of harassment than normal or underweight peers. Golden et al. (2016) reported up to 40% of overweight girls and 37% of overweight boys are teased about their weight by peers or family members. Weight teasing had a toxic effect, making things worse for the young people who were studied by engendering weight gain, binge eating, or extreme weight control measures.

Health Care Professionals

Those of us in the health care professions are not exempt from weightism. McClure Brenchley et al. (2020) found that higher-weight health care providers, regardless of gender, may experience prejudice by prospective clients/patients especially when their specialty was relevant to weight. Weightism affects the likelihood of a client/patient choosing the provider, the trust in the provider, and the chance that they will follow the provider's recommendations. Apparently, the feeling is mutual, since a survey of physicians reported more than 50% believed obese patients to be awkward, unattractive, and noncompliant with treatment (Whyte, 2010).

Gay Men

Gay men struggle with weightism. Peitzmen (2013) wrote, "I was never really bullied for being gay, but instead got made fun of for being fat on a daily basis." Peitzman wrote about his experience of coming out as a gay man. He expected to be welcomed by the gay community and offered "a seat at the table" only to have his expectations dashed by a loud and clear message of exclusion that said, "No, you can't sit with us!" From his perspective, there is no room for fat men in the gay community; being fat does not fit the preferred image. Sadly, Peitzman continued to feel like an outcast over ten years after he came out. Is his experience unique? According to a study by Foster-Gimbel and Engeln (2016), it is not. They found that there is a pervasive anti-fat bias in the gay community and a virtually unattainable muscular, yet thin body ideal that is the gold standard for gay men. They noted that gay men show levels of body shame and dissatisfaction much like heterosexual women, with great emphasis placed on physical appearance, particularly in the context of approaching a romantic partner. Additional findings were that gay men expected rejection and rude treatment if overweight, that overweight gay men questioned their appeal as a romantic partner frequently blaming weight for rejection, and that the anti-fat bias in the gay community has led to body dissatisfaction and increased likelihood of eating disorders. Consequently, many gay men find themselves in the very unfortunate position of both experiencing and promoting anti-fat bias.

Mixed-Weight Relationships

Lastly, are the results of a fascinating study of mixed-weight relationships by Collisson et al. (2016). I had never thought about mixed-weight relationships before—at least not consciously. There appears to be an unwritten code that romantic partners need to be similar,

at least outwardly. Noting that mixed-race couples used to be questioned but are now more accepted, and mixed-age couples are still often viewed askance (cougar, gold digger, cradle robber), they wondered about attitudes toward mixed-weight couples. What they found is that people are very prejudiced against mixed-weight couples and concluded that mixed-weight relationships may be "a new and understudied socially acceptable target of prejudice" (Collisson et al., 2016, p.536).

Concluding Thoughts

Weightism is not a respecter of persons—it affects people of all races, ages, sexual orientations, political affiliations, and socioeconomic strata. In 2019, talk show host Bill Maher stated that fat shaming needed to make a comeback and made derogatory comments about fat people. Talk show host James Cordon's response to Bill Maher's statements was heartfelt, personal, and to the point. I highly recommend every reader of this article watch this YouTube video of his response, https://www.youtube.com/watch?v=Ax1U04c4gaw. In this video, he stated, "If making fun of fat people made them lose weight, there would be no fat kids in schools and I would have a six pack right now!" James's YouTube response is brilliant, yet sadly even he poked fun at being fat, using humor as he talked about the pain. Weightism hurts.

As educators of future mental health therapists and psychologists, we have a responsibility to champion this last frontier of prejudice. Sadly, our diversity training efforts have focused on many important areas, but basically ignored issues of body shape and size (Bento et al., 2012). Weight bias awareness needs to be an integral part of educating culturally competent therapists, thus must be taught in our clinical classes and interwoven into our clinical supervision and training. As stated by Bronchu (2019, p. 191), "Weight bias is a neglected topic in most clinical psychology training programs." Given that mental health care providers can be weightists themselves, awareness of one's own biases is essential to minimize harm to overweight or obese clients. Little things such as having chairs in offices and waiting rooms that accommodate people of all sizes are important considerations. Addressing weight bias with our students is important for another reason. Weightism is bullying and it has serious consequences. Not only can it lead to body objectification, body checking, body hate, relentless dieting, social isolation, and internalized oppression, but also frequently underlies serious mental health disorders including depression, anxiety, post-traumatic stress disorder, and eating disorders that cause emotional distress. Our students need to be able to create safe spaces in their future offices where people who have been oppressed and shamed because of their body size feel comfortable talking about the depth of their pain and can experience healing.

Sadly, we are still singing the "Too Fat Polka."[1] Sometimes it is sung very overtly as in the statements by Bill Maher, but for most of us, we sing the refrain quietly now, humming it with finesse—hidden under snide comments, subtle slights, or expressions of health concerns. Think about how often we ask, "Does this make me look fat?" without giving it a second thought. Take a moment now and give it a second thought. Next time, try saying, "Does this look good on me?" instead. Subtle changes like this will tip the scales in a kinder direction. I challenge you to address weightism with your students, reminding them as Bill Cordon (2019) reminded over 5 million viewers, "When you encourage people to think about what goes into their mouths, think a little bit harder about what comes out of yours." We have weighted long enough! It is time for mental health providers and clinical trainers to speak out against weightism!

[1] https://lyricsplayground.com/alpha/songs/t/toofatpolka.html

References

Bento, R. F., White, L. F., & Zacur, S. R. (2012). The stigma of obesity and discrimination in performance appraisal: A theoretical model. *The International Journal of Human Resource Management, 23*(15), 3196–3224. https://doi.org/10.1080/09585192.2011.637073

Blaine, B., McElroy, J. (2002). Selling stereotypes: Weight loss infomercials, sexism, and weightism. *Sex Roles: New York, 46*(9, 351-357. https://doi.org/10.1023/A:1020284731543

Brochu, P. M. (2019). Teaching clinical psychology trainees about weight bias. *Women & Therapy, 42*(1–2), 191–199. https://doi.org/10.1080/02703149.2018.1524066

Bucchianeri, M. M., Eisenberg, M. E., & Neumark-Sztainer, D. (2013). Weightism, racism, classism, and sexism: Shared forms of harassment in adolescents. *Journal of Adolescent Health, 53*(1), 47–53. https://doi.org/10.1016/j.jadohealth.2013.01.006

Calogero, R. M., Herbozo, S., & Thompson, J. K. (2009). Complimentary weightism: The potential costs of appearance-related commentary for women's self-objectification. *Psychology of Women Quarterly, 33*(1), 120–132. https://doi.org/10.1111/j.1471-6402.2008.01479.x

Centers for Disease Control and Prevention. (2017, August). *Overweight and obesity statistics*. https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity#trends

Centers for Disease Control and Prevention. (2021, February 11). *Adult obesity facts*. https://www.cdc.gov/obesity/data/databases.html

Collisson, B., Howell, J. L., Rusbasan, D., & Rosenfeld, E. (2017). "Date someone your own size": Prejudice and discrimination toward mixed-weight relationships. *Journal of Social and Personal Relationships, 34*(4), 510–540. https://doi.org/10.1177/0265407516644067

Cordon, J. (2019, September 12). James Cordon responds to Bill Maher's fat shaming take [Video]. YouTube. https://www.youtube.com/watch?v=Ax1U04c4gaw

Damm, J. E. (2012). Weightism: Can personality characteristics predict prejudice in college students? [ProQuest Information & Learning]. In *Dissertation Abstracts International: Section B: The Sciences and Engineering* (Vol. 72, Issue 12–B, p. 7714).

Foster-Gimbel, O., & Engeln, R. (2016). Fat chance! Experiences and expectations of antifat bias in the gay male community. *Psychology of Sexual Orientation and Gender Diversity, 3*(1), 63–70. https://doi.org/10.1037/sgd0000159

Golden, N. H., Schneider, M., & Wood, C. (2016). Preventing obesity and eating disorders in adolescents. *Pediatrics, 138*(3). http://doi.org/10.1542/peds.2016-1649

Handron, C., Kirby, T. A., Wang, J., Matskewich, H. E., & Cheryan, S. (2017). Unexpected gains: Being overweight buffers Asian Americans from prejudice against foreigners. *Psychological Science, 28*(9), 1214–1227. https://doi.org/10.1177/0956797617720912

Harriger, J. A., & Thompson, J. K. (2012). Hollywood and the obsession with the perfect body. *Sex Roles: A Journal of Research, 66*(9–10), 695–697. https://doi.org/10.1007/s11199-011-0076-4

McClure Brenchley, K. J., Pitpitan, E. V., & Quinn, D. M. (2020). Prejudice against higher-weight health providers: Implications for patients and providers. *Journal of Applied Social Psychology*. https://doi.org/10.1111/jasp.12655

Peitzman, L. (2013, October 10). It gets better, unless you're fat. *Buzzfeed*. Retrieved from http://ww.buzzfeed.com/louispeitzman/it-gets-better-unless-you're-fat.

Reeder, S. (2020, December 3). Fat 'jokes' unfair way to criticize politicians. *The Daily Journal*. https://www.daily-journal.com/opinion/columnists/scott-reeder-fat-jokes-unfair-way-to-criticize-politicians/article_197db74a-3365-11eb-8c39-f736cd5ffe8e.html

Whyte, J.W. (2010). Medicine and society: Media portrayal of people who are obese. *Virtual Mentor 12*(4), 321-324. *http://doi.org/10.1001/virtualmentor.2010.12.4.msoc1-1004*.

Psychology Training Clinics and Social Justice : GRADUATE STUDENTS SERVING INCARCERATED AND REFUGEE POPULATIONS

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Only recently has the field of psychology seriously embraced social justice as a critical component of clinical training. Community psychologists first proposed social justice models through humanistic and ecological lenses where social research informs social action (Prilleltensky & Nelson, 1997). In spirit, psychologists quickly adopted these more complex and contextualized frameworks; however, they have been slower to integrate these frameworks into training or clinical practice (Burnes & Christensen, 2020).

Today, there is escalating interest and focus on translating social justice into psychology training, as evidenced by the numerous articles dedicated to social justice. In May 2020, the journal of *Training and Education in Professional Psychology* (TEPP) devoted a special issue to social justice training in health psychology. Moreover, the Council of Chairs of Training Councils (CCTC, 2021) recently held a virtual conference on social responsiveness in health service psychology with dedicated topics such as decolonizing and transforming psychology curriculums. While this heightened level of interest is an exciting step for our field, engaging in social justice training and service delivery within psychology clinics can be challenging. Many psychology training clinics provide clinical services to university undergraduates (e.g., Dyason et al., 2019), and while cultural competence in doctoral training has progressed (e.g., Benuto et al., 2019), treatment delivery among marginalized populations can require specialized training. Further, barriers to receiving mental health services for groups such as incarcerated individuals or refugees may include clients' lack of finances, language discrepancies, housing instability, and stigma (e.g., Byrow et al., 2020). Despite these obstacles, implementing and delivering culturally responsive evidence-based practices to marginalized groups may benefit at-risk populations and enrich student training.

This article describes two programs conducted through a clinical psychology training clinic informed by social justice frameworks and delivered to marginalized populations. In the first program, graduate students provide treatment for substance use and co-occurring disorders to federal detainees within correctional facilities. Through the second program, graduate students work with multidisciplinary teams and provide holistic, culturally responsive services to refugees and survivors of torture.

Graduate Training in Correctional Psychology

Since its peak in the middle of the 20th century, state and county psychiatric hospital populations have declined sharply, particularly during periods of deinstitutionalization (Bassuk & Gerson, 1978). While this progressive shift built momentum towards community-based care, prisons soon supplanted psychiatric hospitals to house individuals with mental illness. Indeed, following deinstitutionalization, half of incarcerated adults meet criteria for a mental health disorder (Al-Rousan et al., 2017). This prevalence is doubly concerning given that, per 100,000 individuals, the United States incarcerates more adults than any similarly developed nation (Wagner & Sawyer, 2018). Moreover, substance use disorders (SUD) affect a quarter of those in prison (Al-Rousan et al., 2017), with additional estimates as high as 50% (Fazel et al., 2017).

Incarceration has devastating effects on physical and mental health. Downstream effects include widening inequity in the community, particularly for Black and Hispanic individuals who are vastly overrepresented in corrections (Wildeman & Wang, 2017). For example, Black men are about six times as likely as White men to be imprisoned, and Black men between the ages of 18 and 19 are 12 times as likely as similarly aged White men to be imprisoned.

This staggering and disproportionate incarceration rate has deep ties to racist policies in the United States, such as procedures stemming from the war-on-drugs era of the justice system, over-policing of low income and racial minority communities, and the disenfranchisement and dehumanization of formerly incarcerated persons (Provine, 2011). Among mental health treatment programs in prison, these disparities are not addressed; compared to White individuals, Black and Hispanic individuals with SUDs are significantly less likely to receive treatment, even when controlling for substance use severity (Hunt et al., 2015). This dearth of SUD treatment further exacerbates the risk of re-offense and incarceration among Black and Hispanic adults.

Numerous facilities have risen to the challenge of treating residents with mental illness. For example, reentry programs targeting mental illness, substance use disorders, and other psychosocial needs consistent with those outlined by the risk-needs-responsivity (RNR) model (e.g., employment; Andrews et al., 2006) have yielded reductions in recidivism (Sacks et al., 2012), substance use (Sullivan et al., 2007), and symptoms of mental illness (e.g., depression; Johnson & Zlotnick, 2012). Despite the promise of mental health treatments delivered to those incarcerated, evidence-based treatment remains scarce in prisons.

To meet the treatment needs of incarcerated groups, our training clinic has established a graduate student training program dedicated to implementing evidence-based mental health and SUD treatment for federal detainees in two local prisons. The establishment and implementation of this program comprised collaboration with a federal judiciary and our state Department of Corrections (DOC). Preliminary data from a recently approved research repository of participants treated over four years (N = 192; 89% Male; *M* age = 35) highlights the impact of the opioid epidemic on justice involvement, with 64 percent of participants having opioid use disorder (51% stimulant use, 38% cannabis use, 35% alcohol use disorder).

Pre-doctoral students participate in DOC training and SUD treatment training via coursework and supervisory didactics, emphasizing theoretical frameworks such as Cognitive Behavioral Therapy (Zlotnick et al., 2009) and Acceptance and Commitment Therapy (Lanza et al., 2014). Given that federal detainees are subject to frequent transfer between facilities, our treatment protocol comprises encapsulated, skills-based modules (group and individual formats). These modules draw from evidence-based practices and apply to both substance use and mental health disorders (e.g., functional analysis, cognitive patterns, and values; Beck, 2011; Hanley et al., 2003). Training clinics are well equipped to deliver such interventions, particularly given their emphasis on evidence-based treatments (Heatherington et al., 2012).

An essential framework in our application of SUD treatment in corrections is the use of Motivational Interviewing (MI; see McMurran, 2009). A "guiding style" implemented to elicit change talk among individuals, MI involves collaboration with the client and support of client-generated goals and methods of change (Rollnick et al., 2010). Implementation of MI is paired well with a harm reduction, instead of abstinence-based (Gallagher & Bremer, 2018), approach; clients are encouraged to identify feasible, self-generated goals. Both methods are rooted in responsivity, or attending to characteristics like client motivation, psychological impairment, skills, and supports (Andrews et al., 2006). Consequently, an emphasis is placed on client autonomy, rather than solely relying on clinician determined measures of success and goals (e.g., sobriety).

This training encourages social justice commitment via mitigation of incarceration's downstream effects through SUD and co-occurring disorder treatment (Wildeman & Wang, 2017). This training also increases an understanding of treatment needs among incarcerated groups, which are not often represented in studies such as randomized controlled trials (e.g., Pettus-Davis et al., 2016). Ultimately, the training, methods, and content of this treatment program comprise a culturally informed approach, which is also essential to working with the refugees resettled in the U.S.

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Graduate Training in Refugee and Survivor of Torture Populations

As Emma Lazarus's 1883 words inscribed in bronze on the pedestal of Lady Liberty state, "*...Give me your tired, your poor, your huddled masses yearning to breathe free. Send these, the homeless, tempest-tost to me.*" This poem illustrates the United States' long-standing social justice ideals for welcoming marginalized populations. However, while the world witnesses unprecedented, forced displacement of refugees, U.S. policies have shifted to accepting the lowest resettlement numbers since the Refugee Act of 1980 (*UNHCR*, 2020). Perpetuated by ethnic and religious discrimination (Silove et al., 2017), the recent U.S. administration authorized the resettlement of 15,000 refugees in FY2021 compared to 110,000 in FY2017 (Federal Register, 2016; 2020).

Each stage of the refugee journey (e.g., pre-migration, migration, and post-migration) can present horrific traumatic experiences (Schweitzer et al., 2011). Pre-migration often constitutes brutal war conflict, physical and psychological trauma, with studies showing approximately 20% of refugees experiencing torture in their homelands (e.g., beating, deprivation, witnessing the murder of family members, sexual assault; Steel et al., 2009). During migration, the hardships of escaping, living in dangerous refugee camps, and losing family members due to malnourishment can further traumatize refugees (Mollica, 2008). Finally, although resettlement and post-migration are often met with a sense of joy and safety, there are remaining challenges. Some studies have shown that post-migration living difficulties, such as lack of housing, unemployment, and poverty, significantly predict greater adverse mental health outcomes than past trauma (e.g., Schweitzer et al., 2011). Resettled refugees experience disproportionate levels of posttraumatic stress, anxiety, and depression (Ghumman et al., 2016). Despite the arduous process of obtaining refugee status and resettling in a new country, the over three million refugees currently living in the U.S. (UNHCR, 2021) exhibit remarkable resilience.

Connecting Cultures (Fondacaro & Harder, 2014) was established in 2007 to serve the mental health needs of resettled refugees, asylees, and survivors of torture through a multidisciplinary, holistic, strength-based, and culturally responsive approach (Fondacaro & Mazulla, 2018). For the first two years of the program, extensive outreach to ethnic communities and organizations was essential to gaining refugee trust. As trust increased, refugee clients began to seek services within the training clinic. When graduate students initiated psychological intervention for refugee clients, it became apparent that basic needs of food insecurity, housing, employment, and legal requirements were also unmet. Eventually, the university social work internship and a local law school clinic became integrated with psychology. Services now include psychological intervention, social work assistance, psychiatric consultation, physical therapy services, and medical referrals. Older adult refugee clients currently receive treatment in their homes, and refugee children receive school services. Additionally, Connecting Cultures has a satellite office within a partner ethnic community organization. Clients typically obtain in-person services; however, during COVID-19, we have expanded to telehealth services.

Graduate students learn to work with interpreters, receive individual and group supervision, along with didactics of trauma treatment, and cultural knowledge and sensitivity by professionals and ethnic partners. They also receive training in the Chronic Traumatic Stress Framework (Fondacaro & Mazulla, 2018). Finally, graduate students are engaged in research projects and provide local and national presentations on refugee mental health. The program has grown into one of 36 national Survivor of Torture programs.

Although well over one thousand refugees from over 30 countries of origin have received services through Connecting Cultures, our first research repository includes 178 refugee clients; (N = 178; 52% Female; *M* age = 42). Over half of this sample either "never attended school" or attended "some" secondary school. The five countries with the highest representation include Bhutan, Somalia, Bosnia, Iraq, and Burma. Seventy-nine percent of participants lived in a refugee camp before arrival, and the majority were survivors of torture. The four most common religions were Islam, Christianity, Hinduism, and Buddhism. Another Connecting Cultures study found psychological flexibility was a resiliency factor in that it mediated the relationship between torture status and mental health symptoms (Gray et al., 2020). The knowledge gained from these studies guides the ongoing development of the program.

This clinical-research program inspires a commitment to social justice through working with marginalized populations who often do not have access to such services. Graduate students show dedication to this work, gain experiential and research knowledge, and express gratitude for this unique opportunity. The refugees in our community gain access to mental health intervention through extensive outreach services, and graduate students learn to engage with ethnic communities.

Conclusion

While stemming from clinical psychology, both of the presented treatment programs emphasize the importance of cultural responsiveness and cross-disciplinary collaboration in the facilitation of evidence-based practice. The mental health treatment of federal detainees and refugees will not, on its own, resolve the issues of systemic racism and discrimination. However, graduate trainees can bolster a rehabilitative justice system, enhance the process of successful refugee resettlement, and help to mitigate systemic inequity. In addition to benefiting federal detainees and refugees, participation in these treatment and training programs enables pre-doctoral students to engage with diverse systems. As suggested by assessing cultural competency following participation in conceptually similar programs (Nilsson et al., 2011), the culturally informed training that accompanies graduate involvement with these populations will give rise to cohorts with a commitment to social justice.

REFERENCES

Al-Rousan, T., Rubenstein, L., Sieleni, B., Deol, H., & Wallace, R. B. (2017). Inside the nation's largest mental health institution: A prevalence study in a state prison system. *BMC Public Health, 17*(1), 342. https://doi.org/10.1186/s12889-017-4257-0

Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency, 52*(1), 7–27. https://doi.org/10.1177/0011128705281756

Bassuk, E. L., & Gerson, S. (1978). Deinstitutionalization and mental health services. *Scientific American, 238*(2), 46–53. https://doi.org/10.1038/scientificamerican0278-46

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond (2nd ed.)*. Guilford Press.

Benuto, L. T., Singer, J., Newlands, R. T., & Casas, J. B. (2019). Training culturally competent psychologists: Where are we and where do we need to go? *Training and Education in Professional Psychology, 13*(1), 56–63. https://doi.org/10.1037/tep0000214

Burnes, T. R., & Christensen, N. P. (2020). Still wanting change, still working for justice: An introduction to the special issue on social justice training in health service psychology. *Training and Education in Professional Psychology, 14*(2), 87. http://dx.doi.org/10.1037/tep0000323

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review, 75*, 101812. https://doi.org/10.1016/j.cpr.2019.101812

CCTC (2021, February 5). Social responsiveness in health service psychology training: Recalibrating our collective mission. Virtual Conference of the *Council of Chairs Of Training Councils (CCTC)* Virtual Conference.

Federal Register (2020, November 6). Presidential determination on refugee admissions for Fiscal Year 2021. *Presidential Documents*, 85, No. 216.

Federal Register (2016, October 11). Presidential determination on refugee admissions for Fiscal Year 2017. *Presidential Documents*, 81, No. 196.

Dyason, K. M., Shanley, D. C., Hawkins, E., Morrissey, S. A., & Lambert, M. J. (2019). A systematic review of research in psychology training clinics: How far have we come? *Training and Education in Professional Psychology, 13*(1), 4–20. https://doi.org/10.1037/tep0000196

Fazel, S., Yoon, I. A., & Hayes, A. J. (2017). Substance use disorders in prisoners: An updated systematic review and meta-regression analysis in recently incarcerated men and women. *Addiction, 112*(10), 1725–1739. https://doi.org/10.1111/add.13877

Fondacaro, K. M., & Harder, V. S. (2014). Connecting Cultures: A training model promoting evidence-based psychological services for refugees. *Training and Education in Professional Psychology, 8*(4), 320. https://doi.org/10.1037/tep0000071

Fondacaro, K., & Mazulla, E. (2018). The chronic traumatic stress framework: A conceptual model to guide empirical investigation and mental health treatment for refugees and survivors of torture. *Torture Journal, 28*(1). https://doi.org/10.7146/torture.v28i1.105477

Gallagher, J. R., & Bremer, T. (2018). A perspective from the field: The disconnect between abstinence-based programs and the use of motivational interviewing in treating substance use disorders. *Alcoholism Treatment Quarterly, 36*(1), 115–126. https://doi.org/10.1080/07347324.2017.1355223

Ghumman, U., McCord, C. E., & Chang, J. E. (2016). Posttraumatic stress disorder in Syrian refugees: A review. *Canadian Psychology/Psychologie Canadienne, 57*(4), 246. https://doi.org/10.1037/cap0000069

Gray, B. L., Dewey, L. M., & Fondacaro, K. M. (2020). Torture, psychological inflexibility, and mental health outcomes among resettled refugees in the United States. *Journal of Refugee Studies*. https://doi.org/10.1093/jrs/feaa044

Hanley, G. P., Iwata, B. A., & McCord, B. E. (2003). Functional analysis of problem behavior: A review. *Journal of Applied Behavior Analysis, 36*(2), 147–185. https://doi.org/10.1901/jaba.2003.36-147

Heatherington, L., Messer, S. B., Angus, L., Strauman, T. J., Friedlander, M. L., & Kolden, G. G. (2012). The narrowing of theoretical orientations in clinical psychology doctoral training. *Clinical Psychology: Science and Practice, 19*(4), 364–374. https://doi.org/10.1111/cpsp.12012

Hunt, E., Peters, R. H., & Kremling, J. (2015). Behavioral health treatment history among persons in the justice system: Findings from the Arrestee Drug Abuse Monitoring II Program. *Psychiatric Rehabilitation Journal, 38*(1), 7–15. https://doi.org/10.1037/prj0000132

Johnson, J. E., & Zlotnick, C. (2012). Pilot study of treatment for major depression among women prisoners with substance use disorder. *Journal of Psychiatric Research, 46*(9), 1174–1183. https://doi.org/10.1016/j.jpsychires.2012.05.007

Lanza, P. V., García, P. F., Lamelas, F. R., & González-Menéndez, A. (2014). Acceptance and commitment therapy versus cognitive behavioral therapy in the treatment of substance use disorder with incarcerated women: Drug abuse treatments to incarcerated women. *Journal of Clinical Psychology, 70*(7), 644–657. https://doi.org/10.1002/jclp.22060

McMurran, M. (2009). Motivational interviewing with offenders: A systematic review. *Legal and Criminological Psychology, 14*(1), 83–100. https://doi.org/10.1348/135532508X278326

Mollica, R. F. (2008). *Healing invisible wounds: Paths to hope and recovery in a violent world*. Vanderbilt University Press.

Nilsson, J. E., Schale, C. L., & Khamphakdy-Brown, S. (2011). Facilitating trainees' multicultural development and social justice advocacy through a refugee/immigrant mental health program. *Journal of Counseling & Development, 89*(4), 413–422. https://doi.org/10.1002/j.1556-6676.2011.tb02838.x

Pettus-Davis, C., Howard, M. O., Dunnigan, A., Scheyett, A. M., & Roberts-Lewis, A. (2016). Using randomized controlled trials to evaluate interventions for releasing prisoners. *Research on Social Work Practice, 26*(1), 35–43. https://doi.org/10.1177/1049731515579203

Prilleltensky, I., & Nelson, G. (1997). *Community psychology: Reclaiming social justice*. https://psycnet.apa.org/record/1997-08663-010

Provine, D. M. (2011). Race and inequality in the war on drugs. *Annual Review of Law and Social Science, 7*(1), 41–60. https://doi.org/10.1146/annurev-lawsocsci-102510-105445

Refugees in America | USA for UNHCR. (n.d.). Retrieved February 12, 2021, from https://www.unrefugees.org/refugee-facts/usa/

Rollnick, S., Butler, C. C., Kinnersley, P., Gregory, J., & Mash, B. (2010). Motivational interviewing. *BMJ, 340*. https://doi.org/10.1136/bmj.c1900

Sacks, S., Chaple, M., Sacks, J. Y., McKendrick, K., & Cleland, C. M. (2012). Randomized trial of a reentry modified therapeutic community for offenders with co-occurring disorders: Crime outcomes. *Journal of Substance Abuse Treatment, 42*(3), 247–259. https://doi.org/10.1016/j.jsat.2011.07.011

Schweitzer, R. D., Brough, M., Vromans, L., & Asic-Kobe, M. (2011). Mental health of newly arrived Burmese refugees in Australia: Contributions of pre-migration and post-migration experience. *Australian & New Zealand Journal of Psychiatry, 45*(4), 299–307. https://doi-org.ezproxy.uvm.edu/10.3109/00048674.2010.543412

Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry, 16*(2), 130–139. https://doi.org/10.1002/wps.20438

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *JAMA, 302*(5), 537–549. http://doi:10.1001/jama.2009.1132

Sullivan, C. J., McKendrick, K., Sacks, S., & Banks, S. (2007). Modified therapeutic community treatment for offenders with mica disorders: Substance use outcomes. *American Journal of Drug & Alcohol Abuse, 33*(6), 823–832. https://doi.org/10.1080/00952990701653800

UNHCR (2021). *Refugees in America*. https://www.unrefugees.org/refugee-facts/usa/

Wagner, P., & Sawyer, W. (2018). *States of Incarceration: The Global Context | Prison Policy Initiative*. Prison Policy. https://www.prisonpolicy.org/global/2018.html

Wildeman, C., & Wang, E. A. (2017). Mass incarceration, public health, and widening inequality in the USA. *The Lancet, 389*(10077), 1464–1474. https://doi.org/10.1016/S0140-6736(17)30259-3

Zlotnick, C., Johnson, J., & Najavits, L. M. (2009). Randomized controlled pilot study of cognitive-behavioral therapy in a sample of incarcerated women with substance use disorder and PTSD. *Behavior Therapy, 40*(4), 325–336. https://doi.org/10.1016/j.beth.2008.09.004

Addressing Diversity, Social Justice, and Equity among Training Clinics:

THE 2020 APTC DIVERSITY SURVEY RESULTS

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The Diversity Statement of APTC highlights our members' dedication to "furthering cultural awareness, competency, and humility through supportive learning opportunities and environments… engaging in training activities which increase an understanding of individual and cultural diversity, and focus(ing) on the inter-play between contextual factors and intersectionality among all people." However, are we, as Clinic Directors, succeeding in accomplishing what our Diversity Statement purports?

In preparation for our 2020 APTC Conference, the Diversity Committee conducted a Survey in January 2020 aimed at gathering information regarding diversity and social justice training among our clinics.[1] We wanted to gain a better understanding of how our Clinic Directors are attending to this important mission. Our clinics serve a vital role in the training of our future Health Service Psychologists and in developing cultural and individual diversity competencies in our graduate students (Fouad et al., 2009). Furthermore, the APA guidelines on multicultural education (APA, 2017a), clinical supervision (APA, 2015), and specific clinical populations (e.g., *Psychological Practice with Lesbian, Gay, and Bisexual Clients*; APA, 2012) emphasize the importance of training students in diversity issues.

Although unable to present at the 2020 conference due to the COVID 19 pandemic, we want to share the survey results now, and describe how our clinics are addressing diversity and social justice. It is our hope that findings from the Survey will help improve an understanding of how approaches to cultural awareness and humility in training clinics are evolving and being advanced. While the Survey was conducted before the increased national attention to social justice and diversity-related concerns (e.g., the Black Lives Matter movement), we recognize this important moment in history and how this may affect training clinics. Impressively, our Survey results provide insights into how we have already been infusing innovative social justice opportunities into our training clinics. The Survey also highlights our challenges and barriers, as well as offers training ideas to advance diversity awareness and social justice initiatives.

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Who Are Our Respondents?

We report that 101 Clinic Directors completed our Survey. Among those who responded, more than half were 50 years of age or above (58%), while approximately one-third were 35-49 years old (34%). Most respondents identified as White (80%), Cisgender females (76%).

Creating a Welcoming Environment

The Survey highlighted ways in which training clinics strive to create a congenial atmosphere that effectively serves diverse clients and patients. Specifically, 37.6% of responding Clinic Directors reported they have a diversity statement, many of which included themes that focus on clients, training, and/or multiculturalism (see Table 2). Some respondents reported that they make the diversity statement visible in the clinic (e.g., framed on the wall in the clinic waiting room) and/or on their website as a way to make clients feel welcomed and respected in their clinic.

The majority of responding Clinic Directors indicated they increase the diversity of clients by creating a welcoming environment (87.3%). For example, they ensure diversity is represented in clinic art, magazines, brochures, toys, and signage, which is consistent with recommendations from the American College Health Association (ACHA; n.d.). ACHA also recommends subscribing to gay, lesbian, bisexual, transgender, and queer (GLBTQ) and ethnocentric magazines (such as Out, Ebony, Latina, etc.). One Clinic Director described displaying a photo collage of clinic staff to demonstrate visible forms of diversity. Respondents also reported receiving "Safe Zone" training and displaying certificates and designation stickers in their clinic. This is consistent with the ACHA recommendation to "display GLBTQ symbols (such as a rainbow flag or pink triangle) and ethnocentric decorations" (ACHA, n.d., section 7).

Survey respondents also indicated that they ensure accessibility for diverse individuals by providing bariatric chairs (26.5%), large font size (24.5%), translators (19.6%), and braille signs (18.6%). Additionally, some respondents stated that they have gender neutral bathrooms. Clinic Directors emphasized that marketing was also part of creating a welcoming clinic atmosphere, including using bilingual advertising materials, flyers for specialized services for diverse clients, and the use of personal pronouns in email signatures. One Clinic Director detailed how their clinic's use of forms translated into another language and self-report measures interpreted with culturally appropriate norms contributes to clients feeling welcomed and respected. As an additional way to create a welcoming environment, ACHA also recommends using client satisfaction surveys to gather feedback about the site (ACHA, n.d.). In addition to asking about satisfaction with clinical services, clinics could also ask about how welcoming, inclusive, and supportive clients found the clinic and staff to be.

Additional Ways to Increase the Diversity of Clinic Clientele and Documentation Considerations

Besides creating a welcoming environment to increase the diversity of clinic clientele, a majority of Clinic Directors also endorsed utilizing sliding scale fees (86.3%). More than half of respondents noted that they engage in outreach and advertisement (62.7%) as well, while almost half endorsed that they keep socioeconomic status/legal status anonymous (46.1%). As noted by the APA Presidential Task Force on Immigration (2012), undocumented immigrants fear deportation and being identified as undocumented, which typically prevents them from seeking mental health help. This fear has been likely heightened recently due to sociopolitical unrest, including increased anti-immigrant sentiment and immigration enforcement (Saadi et al., 2017).

There are risks inherent in documentation of immigration status; undocumented clients could face stigmatization and discrimination in addition to the risk of immigration enforcement involvement if someone were to see the information and contact immigration officials (Kim et al., 2019). Instead, when coordinating referrals, information regarding immigration status could be shared verbally or by using alternative language in a patient health chart, such as "ineligible for insurance" or "immigration stressors." Legal organizations and medical immigration advocates have recommended not documenting immigration status (Kim et al., 2019). Keeping immigration status anonymous, as many of our clinics do, is a way that we can protect our clients and make the clinic more welcoming to individuals who may be hesitant to engage in our services.

Being Sensitive to Collection of Diversity Data

One area that requires thoughtfulness is *when and how* clinics collect diversity data from clients. Just under half of the responding Clinic Directors (42.2%) reported that they collect diversity data prior to intake (e.g., during a phone screening), while a little over half reported waiting to collect data during the intake (51%). A small number (6.8%) indicated they do not collect this information. One potential benefit of obtaining data early is being able to match clients to clinicians based on aspects of diversity, if requested by the client. Another benefit could be for the clinician to be better prepared during the intake to be sensitive, such as using the language the client used (e.g., personal pronouns). Regardless of when the information is collected, respondents reported asking about a variety of demographic variables and identities, including sexual identity (23.7%), race/ethnicity (27.7%), gender (27%), and religion (21%). In addition to asking about other identities, Clinic Directors noted that they sometimes elicited open-ended responses to these questions to allow clients to describe their identities more accurately.

Table 1
Clinic Directors Demographics

Demographic	Percentage
Age	
50 or above	58%
35-49	34%
Under 35	8%
Ethnicity	
White	81%
Black	5%
Middle Eastern	5%
Multiracial	5%
Latinx/Hispanic	4%
Asian	3%
Other	1%
Gender	
Cis-gender Female	76%
Cis-gender Male	23%
Gender non-conforming	1%

Table 2
Themes of Clinic's Mission Statements Regarding Diversity

The Psychology Clinic:

- is a *welcoming* community, and treats all individuals with *dignity, respect* and *sensitivity,*
- embraces diversity in its many forms, *but not limited to age, race, ethnicity…,*
- strives to create a *safe, inclusive,* and *affirming* environment, that *values* the contribution of diverse perspectives,
- has *respect* for the diversity and dignity of all our clients, and a commitment to *being an ally,*
- *values* the differences and similarities among people, and *respects* the multiple identities of clients and communities with whom we work,
- provides services that are *culturally sensitive,*
- *trains* students to work effectively with individuals who embody intersecting demographics, attitudes, beliefs, and values,
- *does not discriminate* based on age, race, ethnicity….

In addition to deciding when to collect diversity-related information, Clinic Directors also need to decide *how* to ask for this information. For example, ACHA recommends that providers "ask separate questions about race and ethnicity… as well as about sexual orientation." (ACHA, n.d., section 5). In relation to gender, Deutsch (2016) notes that many organizations, including the Mayo Clinic and the U.S. Centers for Disease Control and Prevention (CDC), suggest a "two-step" method for collecting data regarding gender identity that asks, "what is your gender identity?" and separately, "what sex were you assigned at birth?" Tate and colleagues (2013) recommend including an option of intersex for the birth-assigned question (in addition to male and female) and phrasing the identity question to ask about *current* gender identity and highlight the importance of including an option of genderqueer given that genderqueer is considered conceptually distinct from other transgender spectrum identities.

Another approach when asking about gender identity and providing options (e.g., female, male, transgender male, transgender female, nonbinary or genderqueer) is to encourage clients to "Choose all that apply" and include additional options, such as "Another gender," "I don't know," and "Choose not to disclose" (Guss et al., 2020). Of note, the question "What is your gender identity?" in addition to "What name should we use for you?", "What pronouns should we use for you?", and "What sex were you assigned at birth on your original birth certificate?" was found to be acceptable to a group of racially diverse young people (aged 15-25 years) with diverse gender identities in a primary care setting (Guss et al., 2020). Interestingly, while most of the respondents denied having any concerns regarding privacy or confidentiality, a handful described being unsure in relation to being observed by parents or others while completing the forms (Guss et al., 2020). Thus, it could be helpful to allow clients to complete the paperwork in private.

Training Students in Multicultural Competencies:

While the Survey provided a wealth of ideas about how to create a welcoming clinic environment, it appears that training students in multicultural competencies may be a bit more challenging. There is an overall lack of attention to trainees' competence and ability to conduct diversity and social advocacy work on all levels, including in our communities and organizations (Burnes & Christensen, 2020). Survey results indicate that approximately 85% of culturally-informed treatments are "taught" in supervision, suggesting the lack of more systematic training. Only about half (53.9%) of supervisors are systematically evaluated by students on their diversity supervision. Furthermore, only approximately 28.4% of faculty/colleagues monitor supervisor diversity competency. The *APA Guidelines for Clinical Supervision in Health Service Psychology* (2015) state that "supervisors aim to be knowledgeable about the effects of bias, prejudice, and stereotyping… and model client/patient advocacy," and "promote the supervisee's competence by modeling advocacy for human rights and intervention with institutions and systems." Whereas few supervisors appear to be evaluated on their own diversity competencies, Survey results indicate that trainees are more closely monitored. Over 75% of trainees are assessed on these competencies through practicum evaluations and review of recorded sessions. Over 50% are also evaluated by multicultural class grades and by annual reviews.

Promoting Student Self-Reflection:

Self-reflection has been noted to be a key component in developing competencies in the area of individual and cultural diversity (Burnes & Manese, 2008). The Survey revealed that clinics are engaged in numerous methods for enhancing student self-awareness. These methods include didactic/experiential training (86.3%), supervision/case presentations (86%), workshops and conferences (61.8%), diversity events (59.8%), and having available library resources (52.9%). Clinics also noted being engaged in innovative efforts to encourage student self-reflection, which include bi-monthly social justice groups, having a Diversity Training Committee, sending out a Diversity Survey every three years, having a "Power and Privilege" series, and having an Underrepresented Graduate Students in Psychology group. Some clinics and their departments also ask students to attend outreach programs as part of class requirements, as well as "fully integrate" culturally-informed assessment and therapy in their coursework and in supervision. One clinic also noted that they have a Minor in Diversity Science.

Supporting Supervisors:

Supportive supervision is critical to the professional development and training of doctoral students, protection of clients, and advancement in the field (Bernard & Goodyear, 2014; Falender & Shafranske, 2012). Thus, increasing attention should be given to supervisor competencies. In particular, supporting supervisors in developing multicultural skills, such as developing diversity self-awareness, teaching culturally responsive treatments, and learning to provide services to culturally and linguistically diverse clients are paramount. As noted above, Survey results indicate that practicum students are primarily "taught" culturally-informed treatments (83.3%) through the supervision they receive in their training clinics. Most supervisors report using unstructured approaches (65.7%) to teach culturally-informed treatments. Of those who use structured approaches in supervision, 29.4% report using the ADDRESSING model (Hays, 2008), 4% use the Cultural Formulation Interview (DSM-5; American Psychiatric Association, 2013), 2.9% use the MECA model (Falicov, 2017) and 1% use the Dadlani et al. (2012) model.

Evaluation of multicultural competencies appears to be critical, as nearly 80% of respondents consult informally with other faculty and 74.3% consult informally with Clinic Directors regarding diversity issues. Most consultation occurs around sexual orientation (56.9%) and race/ethnicity (52%). Only a small number of respondents (5.9%) indicated that there were formal mechanisms for consultation (e.g., full departmental trainings, specialty clinics with office hours for consultation or weekly clinic committee meetings) to address and support supervisors' questions about individual and cultural diversity competencies. Interestingly, clinics that endorsed providing free clinical services (22% of respondents) versus those who *do not provide free services* were more likely to monitor and train their supervisors on diversity competencies ($\chi 2$, $p < .05$).

Recognizing Diverse Students' Identities:

Understanding the supervisory relationship, particularly as it relates to the identity interaction between supervisors and supervisees, is critical and may affect the supervisory working alliance and the supervisee's development of multicultural competence (Ladany et al. (Ladany et al., 1997). The APA *Guidelines for Clinical Supervision in Health Service Psychology* (2015) highlight the importance of diversity competencies in the supervisory relationship. These supervisor competencies not only include recognizing and addressing similarities and differences between the supervisor, supervisee, and client, but also the inherent complexities associated with intersectional identities of each member of the triad.

Results from the Survey highlight how supervision of students with diverse identities was addressed. Most supervisors acknowledged creating a safe space for open discussion around culture (83%) and discussing cultural bias (74.5%). Over half of supervisors (59.8%) also encouraged their supervisees to share conceptualizations shaped by their own experience of diversity. Furthermore, close to half (46.1%) initiated a discussion about their shared and unshared identities. In order for there to be a good supervisory working alliance, both cultural humility and metacompetence (knowing what you don't know) are needed among supervisor and supervisee. Thus, a self-assessment of each member of the "supervision triad" (supervisor, supervisee, and client) regarding "the cultural niche" is encouraged (Falender et al., 2014).

Social Justice Promotion Within Our Clinics

The events of the past year have created heightened awareness of the inequities of rights, opportunities, and resources among persons with less privilege and power, as well as the urgent need for psychologists to step up and develop new, inspired ways to promote social justice in practice, science, education, and the training of students. The *APA Ethics Code* (2017b) identifies "justice" as one of the five core principles underlying the delineation of the ethical standards. Furthermore, the *APA Multicultural Guidelines* (APA, 2017a) establish psychologists' responsibilities to advance justice. Specifically, Guideline 5 states that "psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression… and seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services" (APA, 2017a).

The APTC Survey revealed many ways in which clinics contribute to social justice learning in the clinical practicum. Several clinics highlighted in their mission statements their aspirations to advance justice (see Table 3). These statements underscore the contributions of oppression, marginalization, and discrimination to human suffering.

Many of the previously described efforts by clinics to create a welcoming environment and to recruit diverse clients help advance social justice by creating more accessible services for the underserved. Although almost all training clinics offer lower fees for services, often based on sliding scales, some respondents reported offering a "free clinic" (22%), thereby creating more access for persons and families with limited resources. Consistent with recommendations from the social justice and liberation psychology literature, about half (49.4%) of Clinic Directors report that they routinely self-disclose aspects of their own background or personal identities to facilitate cultural discussions during supervision and to possibly promote more understanding of those with less privilege.

A large number of respondents (63%) indicated that their programs encourage students to provide community outreach, while 34.7% reported that their clinics offer outreach services in the community for underserved populations. Examples included providing therapy to persons in low-income neighborhoods, homeless shelters, and afterschool programs. Many clinics reported being able to reach a number of underserved populations, including racial (Black, Latinx), gender and sexual orientation (LBGTQI, non-binary), geographical (Appalachian, rural, urban), immigration status (undocumented, mixed status families, refugees), learning differences (developmental and intellectual challenges), cultural/linguistic (Spanish speaking, international and exchange students), and age (children, elders) groups.

Many clinics reported that they are engaging in new and creative ways of promoting social justice activities in their communities and collaborating with other agencies. Examples included partnerships with a local refugee resettlement organization, a local free medical clinic, agencies working with Latinx and Black youth, schools serving low- income communities, and a free/low- cost prenatal clinic primarily serving the Latinx community. One program is working with a homeless shelter in collaboration with their law school to provide evaluations for persons with persistent mental illness to aid in their applications for Social Security Disability (SSD). Other clinics reported providing services for other underserved populations, including pro bono evaluations for immigrants who have been victims of violent crime, assessments for persons seeking gender affirmation and transition, and treatment for domestic abuse offenders.

Clinics described efforts to create specialized services for underserved groups and to demonstrate their solidarity with social justice causes. Clinics are increasingly offering bilingual services (66.7%) and providing supervision in a non-English language (60.7%). Providing bilingual and Spanish-only assessment and intervention services to clients often involves more effort on the Clinic Director's part, such as recruiting bilingual supervisors, translation services, ordering materials in other languages, and/or engaging in expanded outreach. Clinics also reported participating in local MLK and Gay Pride parades, representing their clinics in local cultural fairs, and organizing a volunteer day of service during a holiday.

Although almost all clinics reported that their departments have some type of diversity committee (81.2%), fewer than 10% indicate that their *clinic* has a diversity committee or club. Clinics with diversity committees state that they develop outreach and social justice-oriented activities, conduct diversity-oriented research in the clinic, and develop ideas to promote cultural sensitivity and diversity awareness among their clinicians and supervisors.

Significant challenges in advancing social justice training and initiatives were also highlighted in the Survey. Some Directors reported that "social justice" is a complex concept and thus, hard to translate into actionable ideas within a training clinic. This concern might be accentuated when some faculty and supervisors may not support social justice initiatives and would rather focus on clients' presenting issues. There was also some concern that it is sometimes difficult to discern the difference between personal and professional responsibilities regarding social justice advocacy. Further, many noted that limited funding and resources, pressure to earn money in the clinic, the busy schedules of students and faculty, and lack of supervisors' knowledge in social justice frameworks provided additional barriers. Perhaps the most significant obstacles for adopting more social justice instructional opportunities may reflect systemic issues. Several respondents noted issues such as the possible lack of university support for activities that might be deemed too "political," general inertia and tendency to maintain the status quo, and the competing priorities of other missions in a clinic, program, or department.

Table 3
Representative Statements from Clinics' Mission Statements Explicitly Promoting Social Justice

The Psychology Clinic....

- seeks "to be sensitive to the effects of diversity-related issues such as oppression, marginalization, discrimination, and other forms of intolerance on our clients' stress, coping, and adjustment,"
- is based in a program that "strives to develop in our students a professional identity grounded in an active sense of social responsibility combined with an appreciation and respect of cultural and individual differences,"
- is "aware of the impact of privilege, prejudice, marginalization, and discrimination in the lives of individuals. We strive to create an atmosphere where we foster dialogue and promote actions that respect and honor all persons,"
- believes "it is important to view an individual in their contexts, which is often shaped by systems of oppression, while also recognizing and celebrating strengths that arise from our differences."

Conclusion

Despite the barriers reported, Clinic Directors seem to have found intentional ways to increase their clinic's training of competencies in such an important area as diversity and social justice. It is clear that a commitment to training individual and cultural diversity competencies is needed not only from Clinic Directors, but from their department and university as a whole. In light of the recent events regarding inequities of rights and social unrest, we encourage each Clinic Director to take a self-assessment of their own individual and cultural diversity knowledge, attitudes, and skills, as well as their clinics' approaches to supporting multicultural competencies (see Table 4).

References

American College Health Association; ACHA. (n.d.). *10 ways to make your health center more welcoming for diverse students*. https://www.acha.org/documents/resources/10Ways_WelcomeDiversity.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association Presidential Task Force on Immigration. (2012, January 1). *Psychology of immigration 101*. American Psychological Association. http://www.apa.org/topics/immigration/immigration-psychology

American Psychological Association. (2012). Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients. *American Psychologist, 67*(1), 10-42. *https://doi.org/10.1037/a0024659*

American Psychological Association. (2015). Guidelines for clinical supervision in health service psychology. *American Psychologist, 70*(1), 33–46. https://doi.org/10.1037/a0038112

American Psychological Association. (2017a). *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*. Retrieved from http://www.apa.org/about/policy/multicultural-guidelines.aspx

American Psychological Association. (2017b). *Ethical principles of psychologists and code of conduct with 2010 and 2016 amendments*. Retrieved from http://www.apa.org/ethics/code/index.aspx

Bernard, J. & Goodyear, R.K. (2014). *Fundamentals of clinical supervision* (5th Edition). Upper Saddle River, NJ: Merrill.

Burnes, T.R., & Christensen, N.P. (2020). Still wanting change, still working for justice: An introduction to the special issue on social justice training in Health Service Psychology. *Training and Education in Professional Psychology, 14(2)*, 87-91. http://dx.doi.org/10.1037/tep0000323

Table 4
Ideas for Advancing Diversity and Multicultural Training in Your Clinic

A review of the quantitative and qualitative data from the APTC Diversity Survey reveals a number of common areas in which clinics are promoting impressive training in multicultural education, diversity awareness, and social justice. These themes, along with some exemplars, may form a useful rubric in which training clinics can self-evaluate their progress, identify new areas of focus, and develop innovative ways of advancing students' foundational competencies in cultural humility and social justice.

- **Create a welcoming atmosphere for diverse clients** (e.g., crafting or revising a diversity statement for your clinic to include your commitment to antiracism and social justice, reviewing client forms and clinic procedures to ensure they promote inclusivity of diverse identities, using preferred names and personal pronouns, attending to the clinic's physical space by reviewing magazines, artwork, and signage, having multiracial dolls/toys, training staff to be culturally sensitive).
- **Improve clinic accessibility by making accommodations for clients' needs** (e.g., acquiring wheelchair access, braille signs, large font on forms, translators, gender-neutral bathrooms, forms and testing materials translated into another language).
- **Develop new ideas about how to increase diversity of clients** (e.g., engaging in outreach to diverse communities, advertising, revisiting fees and clinic procedures, collaborating with other agencies, having visible representations of diverse staff, student clinicians, and supervisors, promoting diversity and social justice missions on clinic website).
- **Expand approaches to promote multicultural sensitivity and self-awareness among students and supervisors** (e.g., didactics, workshops, case presentations, DVDs, books, diversity events, "movie night," Safe Zone training).
- **Organize a Clinic Diversity Committee or Club** (e.g., a student-led organization, distinct from a department committee, can bring much energy, knowledge, and creativity to promote diversity initiatives within the clinic).
- **Enlarge your library of diversity training materials by adopting more digital resources.**
- **Consider expanding clinic services or developing outreach programs to include more underserved populations** (e.g., bilingual clients and families, clients who need free services, minority race clients, immigrants, refugees, religious communities, sexual and gender minorities, rural communities).
- **Create a training plan to educate students and supervisors on best practices for working with a specific underserved population.**
- **Be intentional about how to train students in diversity competencies and how to evaluate and monitor their progress** (e.g., case conceptualization, treatment plans, case presentations, preliminary exams, practicum evaluation forms).
- **Ensure multiple methods of teaching culturally responsive treatments and assessment services** (e.g., courses, assigned articles, case presentations, workshops, grand rounds, specialty clinics, use of specific cultural models – ADDRESSING, MECA, DSM-5).
- **Support supervisors in using more effective approaches to address diversity in supervision** (e.g., discussions in supervision of the shared and unshared identities of supervisor, supervisee, and client, use of the "broaching" technique (Jones et al., 2019), peer consultation for supervisors, creating a safe space for open discussions of cultural issues, encouraging a cultural humility approach, inviting feedback for supervisors from supervisees).
- **Monitor supervisor multicultural training and competence** (e.g., annual reviews, supervisor evaluations by supervisees)
- **Implement a plan for promoting students' development of awareness, knowledge, and skills in advancing social justice** (e.g., partnering with community organizations working with underserved communities, establishing a new specialty clinic within the training clinic serving an underserved population, developing bilingual services, recruiting students and supervisors from less privileged backgrounds, continuing to use telepsychology and other methods that improve accessibility of services, adding pro bono services, organizing a group of students and supervisors to represent your clinic at social justice events such as marches, parades, and cultural celebrations, collaborating with other campus organizations to promote justice).
- **Identify obstacles to advancing diversity training and social justice initiatives in your clinic, and consult with students, supervisors, faculty and other training clinics on how to overcome such obstacles.** Send your ideas, photos, and success stories to the APTC Diversity Committee so we can help celebrate your progress and be inspired by your actions.

Burnes, T.R., & Manese, J.E. (2018). *Multicultural Supervision: New models, lenses and applications*. San Diego, CA: Cognella Publishing.

Dadlani, M. B., Overtree, C., & Perry-Jenkins, M. (2012). Culture at the center: A reformulation of diagnostic assessment. *Professional Psychology: Research and Practice, 43*(3), 175–182. https://doi.org/10.1037/a0028152

Deutsch, M.B. (2016, June 17). *Creating a safe and welcoming clinic environment*. UCSF Transgender Care. https://transcare.ucsf.edu/guidelines/clinic-environment

Falender, C. A., & Shafranske, E. P. (2012). The importance of competency-based clinical supervision and training in the twenty-first century: Why bother? *Journal of Contemporary Psychotherapy: On the Cutting Edge of Modern Developments in Psychotherapy, 42*(3), 129–137. https://doi.org/10.1007/s10879-011-9198-9

Falender, C.F., Shafranske, E.P. & Falicov, C.J. (2014), *Multiculturalism and diversity in clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Falicov C.J. (2017). Multidimensional Ecosystemic Comparative Approach (MECA). In Lebow J., Chambers A., Breunlin D. (Eds.) *Encyclopedia of Couple and Family Therapy*. Springer, Cham. https://doi.org/10.1007/978-3-319-15877-8_848-1

Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B., Collins, F. L., Jr., & Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology, 3*(4, Suppl), S5–S26. https://doi.org/10.1037/a0015832

Guss, C. E., Eiduson, R., Khan, A., Dumont, O., Forman, S. F., & Gordon, A. R. (2020). "It'd be great to have the options there": A mixed-methods study of gender identity questions on clinic forms in a primary care setting. *Journal of Adolescent Health, 67*(4), 590–596. https://doi-org.proxy006.nclive.org/10.1016/j.jadohealth.2020.03.030

Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd edition). Washington, D.C.: American Psychological Association.

Jones, C.T., Welfare, L.E., Shekila Melchior, S. & Cash. R.M. (2019) Broaching as a strategy for intercultural understanding in clinical supervision, *The Clinical Supervisor, 38*, 1-16, https://doi.org/10.1080/07325223.2018.1560384

Kim, G., Molina, U. S., & Saadi, A. (2019). Should immigration status information be included in a patient's health record?. *AMA Journal of Ethics, 21*(1), E8–E16. https://doi.org/10.1001/amajethics.2019.8

Ladany, N., Brittan-Powell, C. S., & Pannu, R. K. (1997). The influence of supervisory racial identity interaction and racial matching on the supervisory working alliance and supervisee multicultural competence. *Counselor Education and Supervision, 36*(4), 284-304. https://doi.org/10.1002/j.1556-6978.1997.tb00396.x

Saadi, A., Ahmed, & S., Katz, M.H. (2017). Making a case for sanctuary hospitals. *Journal the American Medical Association, 318*(21), 2079–2080. doi:10.1001/jama.2017.15714

Tate, C.C., Ledbetter, J.N., & Youssef, C.P. (2013). A two-question method for assessing gender categories in the social and medical sciences. *Journal of Sex Research, 50*(8), 767–776. doi:10.1080/00224499.2012.690110

TEACHING PSYCHOLOGY GRADUATE STUDENTS HOW TO FORMULATE CLINICAL IMPRESSIONS THROUGH A SOCIAL JUSTICE LENS:

Using the Recognition and Affirmation; Empowerment; and Statement of Assessment Limitations (R.E.S.) Model to Guide This Process

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In psychology graduate training programs, students learn the general building blocks of psychological report writing. For instance, in many cognitive assessment courses, students learn to report the following: reason for referral, background information, behavioral observations, assessment results, summary, and recommendations (see Weiner & Costaris, 2012). These aforementioned sections form the crux of many psychological reports in graduate training programs, but the conclusions and clinical impressions may lack a sense of social awareness, especially with respect to social justice. In that regard, psychology graduate students would benefit from learning how to formulate clinical impressions through a process wherein they are explicitly taught the multiple variables that contribute to a client's overall functioning. When formulating clinical impressions, it is critical to examine the client's presenting problems through a lens of social justice. This requires active analysis of how the client's adverse life experiences and marginalized aspects of their identity (e.g., race, sex, gender, social class, education, ability status) have played a role in their present level of functioning. This can be accomplished by using the Recognition and affirmation; Empowerment; and Statement of assessment limitations (R.E.S.) model. The R.E.S. model provides a structure by which to highlight key environmental and experiential factors critical to understanding a client's unique situation which then directly informs clinical impressions and recommendations through the lens of social justice and advocacy.

What are clinical impressions?

Clinical impressions are opinion-based and evidence-based declarations of an individual's present level of functioning. The clinical impressions section of an evaluation report represents a combination of the clinician's conceptualization and analysis of multiple sources of information: interview data from the examinee and other informants (e.g., therapist, teacher, physician); results from assessment of various abilities, skills and traits (e.g., cognitive, motor, personality, attention); observations; and clinical judgment (e.g., one's expertise, training, and opinion). Clinical impressions should address the "Five Ps" (Macneil, et al. 2012), which could be implemented in a psychological report as follows:

1. A statement of the *presenting* problem or referral reason.
2. A description of which *predisposing* factors have been contributing to the presenting problem. For example, Macneil et al. (2012) note the importance of discussing any mental health vulnerabilities (e.g., family history of depression) or core beliefs (e.g., "I am a horrible person.").
3. An explanation of the *precipitating* factors leading to the onset of the current problem. For example, did a major event occur in the individual's life?
4. An explanation of *perpetuating* factors that have been preventing the individual from making progress.
5. Finally, highlighting the *protective* factors that would enable the individual to overcome this problem. For example, perhaps the individual has a strong network of friends and family, all of whom are willing to assist the individual.

Why are clinical impressions difficult to formulate and difficult to teach?

Clinical impressions are challenging to formulate because there is no clear report writing guide to follow. A helpful and practical approximation to the development of clinical impressions guide is illustrated by the "case formulation graphic organizer" (p. 127), developed by Wiener and Costaris (2012). It can be difficult to reflect upon the constellation of factors that are contributing to the client's present level of functioning that is sensitive and respectful. It is also difficult to balance being succinct yet thorough. Pondering the various efforts involved in writing clinical impressions, may give one pause when considering what would be required to teach graduate students this essential skill. However, this is possible and steps to accomplishing this feat are discussed in the next sections with emphasis on teaching graduate students how to write clinical impressions that are socially conscious.

How are socially conscious clinical impressions formulated?

The formulation of strong clinical impressions in and of itself is insufficient if it is not accomplished through the lens of social justice. Social justice is concerned with the unequal distribution of opportunities (e.g., wealth, education) and its impact on people in society. Social justice is specifically concerned with elevating the voices of those whose worth and standing in society has been diminished because of their identity. There is a responsibility to ensure that the formulation of clinical impressions accounts for inequities or adverse

life experiences endured by an individual because of race, sex, gender, social class, religion, ability status, or other immutable identity characteristics.

For instance, imagine a comprehensive psychological assessment on an individual from a low-income and economically marginalized (LIEM) background who was not afforded the same access to quality healthcare, education, and community resources. After reviewing an individual's poor performance on standardized measures of reading comprehension and math achievement, the clinician also notes that the examinee performed well on measures of attention and other cognitive processing assessments. In this specific example, it is important to note that the individual's lack of access to well-resourced schools is a likely reason for their underperformance. In fact, one may say that their math and reading performance is an underestimate of their true academic performance. It would be important to state these considerations rather than suggesting this individual is impaired in reading and math.

The R.E.S. model of clinical impression development

Recognition and affirmation. At the outset of formulating clinical impressions, it is essential for the clinician to recognize and affirm adverse life experiences and/or aspects of identity that have played a role in the individual's present level of functioning. This recognition and affirmation should be clearly stated and easily understood by the client. Below is a fictional example, "Mr. Wise," a 44-year-old Black male:

> Since he was child, Mr. Wise has repeatedly experienced racial microaggressions, which have been aimed at his performance in school. Over the course of this assessment, Mr. Wise shared the painful experiences of being one of the few Black students in a predominately White school. He shared how his peers ridiculed him for his difficulty learning in school and that they attributed his learning problems to being Black. Mr. Wise explained that ever since his formative school years, he has always internalized a negative self-concept of being intellectually inferior to his White counterparts. It is the opinion of the examiner that this negative self-concept may have impacted Mr. Wise's performance on assessment domains that are historical strengths of his.

Empowerment. Drawing from the example above, it is important to include a statement that is empowering of the individual. This is important because examinees are placed in a vulnerable situation whereby clinicians are pointing out their areas of "deficit" or "weakness," which may feel disempowering. Below is an example based upon Mr. Wise:

> Mr. Wise has overcome significant racial and academic adversity. At a young age, Mr. Wise was made aware that learning problems were intrinsically related to the fact that he was Black. Although this hurt Mr. Wise and at times, he even believed himself to be "stupid," he decided that he was going to ignore these constant threats to his intellect by focusing on his learning needs. Mr. Wise recognizes that he still requires support in reading comprehension and reading fluency, but this only fueled his desire to pursue a Master's degree in physics.

Statement of assessment limitations. Following identification and explanation of assessment scores, it is crucial to include a statement that underscores the limitation of assessments. Below is an example:

> Standardized assessments of intellectual functioning, measure a construct known as "intelligence." Traditional views of intelligence place value on higher-order processing skills such as working memory, reasoning, verbal knowledge, and decision making. Historically, these higher order processing skills have been considered to be predictors of future learning and success, however the assessments used to judge these skills are culturally biased in favor of a Eurocentric form of intelligence. In that regard, intellectual assessments may not be thoroughly valid on individuals who represent ethnically and racially minoritized backgrounds. Furthermore, there are several factors that assessments cannot measure such as motivation, curiosity, creativity, work habits, and school achievement. This should be considered when interpreting the scores in this report.

In considering how to engage graduate students in conceptualizing a case from a social justice perspective, we might consider how to invite them to consider the value of cultural humility; that is, acknowledging what we do *not* know about another person's life. When we consider the meaning of humility, we encourage others' perspectives and experiences and do not assume full knowledge (even when considered an "expert" with an advanced degree). The R.E.S. model provides us with a guide in conceptualizing clinical assessment cases. We "Recognize and affirm" the contextual variables that may function as obstacles to a client's development (e.g., poorly resourced schools) and/or aspects of a person's upbringing that served as reservoirs of support (e.g., active church involvement, dedicated coaches or teachers). We look for messages of "Empowerment" and signs of self-empowerment such as continued focus on goals, maintenance of relationships (e.g., with friends, teammates, band mates, community organizations) that point to a person's resilience. If we take the time to learn about our assessment clients as people, our feedback meetings can incorporate a "Statement of the limitations", an admission that our psychological tests rarely measure valuable characteristics such musical or athletic talent, empathy, and self-confidence in the face of adversity. Conversations with clients from a stance of cultural humility can inform our ability to provide useful recommendations rooted in an understanding of our clients' life experiences.

References

Macneil, C. A., Hasty, M. K., Conus, P., & Berk, M. (2012). Is diagnosis enough to guide interventions in mental health? Using case formulation in clinical practice. *BMC Medicine, 10*, 111. doi:10.1186/1741-701

Wiener, J. & Costaris, L. (2012). Teaching psychological report writing: Content and process. *Canadian Journal of School Psychology, 27*, 119-135. doi: 10.1177/0829573511418484

DECOLONIZING
THE CURRICULUM IN HEALTH SERVICE PSYCHOLOGY

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I am approaching the topic of Decolonizing the Curriculum in Health Service Psychology (HSP) from the standpoint of a white cisgender 50-something woman raised in the 1960's and 70's (Vietnam Era) by an unconventional hippie artist father and a second wave feminist artist mother in religiously and racially integrated Cleveland suburbs. After higher education in Ohio, I moved to SoCal, graduated from the University of California, Santa Barbara (UCSB) with a PhD in Counseling Psychology, and worked for Antioch University, Santa Barbara for ten years. Antioch University was founded in 1852 in Ohio and has been committed to social justice since its beginning. The founder of Antioch, Horace Mann said, "Be ashamed to die until you have won some victory for humanity." This history, including 14 years as a director of a psychology training clinic that serves a culturally diverse community of students and clients, has informed my reading, analysis, and summary of what it means to decolonize the curriculum in Health Service Psychology.

In concert with Black Lives Matter, university students across the country issued calls for action following police violence and the civil unrest precipitated by the deaths of George Floyd, Ahmaud Arbery, Jacob Blake, Walter Wallace Jr., Sandra Bland, Breonna Taylor, and many others. Graduate students in HSP organized and demanded accountability from program faculty and administrators. Many of these university leaders issued public statements supporting Black Lives Matter and the principles of diversity, equity, and social justice in the academy, but our students have insisted on more than words. There is a long history of institutions coping with student demands through performative actions, which *resemble* change, but do not lead to *real* change. But this time, there was a critical mass of truth tellers and calls for accountability that created an imperative for deep structural change in the academy, starting with decolonizing the curriculum. But once on board with this mission, how do faculty members proceed? How do we, as educators, deconstruct the canon while teaching it? Is this even possible? How do we make progress without repeating earlier mistakes?

The purpose of this article is to: a) provide an example of the precipitants for socially responsive deep structural change in an HSP program, b) define decolonization as the foundation for those changes, c) describe the outcome of a tremendous undertaking led by the Council of Chairs of Training Councils (CCTC) to build strategic change modules that can be used to decolonize HSP programs and promote social responsiveness, and d) to draw attention to the CCTC tools available for decolonizing the curriculum.[1]

Precipitants of Change at UCSB

Doctoral students in the Counseling, Clinical, & School Psychology (CCSP) program at UCSB identified the need for deep structural change in 2018 through a student-generated department climate survey. After the death of George Floyd and during a Cost of Living Adjustment (COLA) campaign, students returned to the survey results and produced a list of recommendations for faculty and department leadership, which included a call for greater transparency and a structure for accountability regarding the department's commitment to Diversity, Equity, and Inclusion (DEI). CCSP faculty are now working actively

[1] The Decolonizing the Curriculum Working Group was led by Amy Reynolds, a counseling psychologist at the University of Buffalo. A. Jordan Wright and I were the APTC members on this committee. Wright represented APA's Board of Educational Affairs. The APTC members mentioned in this article served on other working groups.

to deepen our knowledge of and insight into Anti-Black racism, racial injustice, and racial healing, and we are steadily "decolonizing the curriculum." The department, which had previously relied on other DEI structures, formed its own DEI committee that includes students and faculty. The students constructed a *GoogleDoc* that is accessible to everyone in the department and in which all faculty report their DEI activities. Monthly committee reports are sent over email. In my opinion, it is the built-in accountability that is making a difference in our efforts at UCSB.

Student recommendations included a pointed call-to-action for faculty to decolonize the curriculum. Once this happened the question became, "How do we do that?" Decolonizing the curriculum first requires an understanding of what decolonization actually means.

What Does Decolonizing the Curriculum Mean?

Decolonizing the curriculum is a complex process that cannot be accomplished through a simple redesign. Decolonization requires self-interrogation by educators and the institutions in which we work. It requires more than intention and performative effort. It requires *real action*. Decolonization is more than a change in attitude or an infusion of awareness. While it might start with reading *How to Be Anti-Racist* by Ibram X. Kendi (2020) or *Caste* by Isabel Wilkerson (2020; both highly recommended), the deep structural change that is needed by educators in our field requires what French et al. (2020) call "radical hope."

Radical hope is one of five components in the French et al. (2020) psychological framework for radical healing for People of Color and Indigenous Individuals (POCI). The framework is grounded in the Psychology of Liberation, Black Psychology, Ethnopolitical Psychology, and Intersectionality. The other four components are: collectivism, critical consciousness, strength and resistance, and cultural authenticity and self-knowledge. Radical hope is centered in faith that "one can fight for justice and that the fight will not be futile." Such hope "is radical because it transcends one's ability to envision and understand what the future holds" (p. 26). Decolonizing our curriculum and courses also requires radical hope; a trust that the principles of diversity, equity, and inclusion will sustain the efforts of educators as we *deconstruct* the curriculum and *build it anew* with the goal of bringing the margins of the psychological canon to the center (hooks, 1984). This effort requires disassembling, deconstructing, and naming and/or discarding the hidden presumptions that have been baked into the colonial mentality of Western Psychology. But, what is coloniality?

In a 2019 call for submissions, the editor of the *Journal of Social Issues* defined coloniality as "habits of mind and ways of being (e.g., colonial mentality and racial privilege; see David & Okazaki, 2006; Phillips & Lowery, 2018) that have roots in the colonial period and persist long after colonial rule" (G. Adams, personal communication, June 15, 2019). Such habits and ways of being are at the foundation of Euroamerican-centric ontologies, epistemologies, and interpretive frameworks. Such models reinforce the marginalization of minoritized populations by subordinating intellectual traditions that are outside of Western, educated, industrial, rich, and democratic (WEIRD) centers of authority; "the global order." This is how we got scientific racism, eugenics, and the *Tuskegee Study of Untreated Syphilis in the African American Male* (Alsan et al., 2020). Racist violence is embedded in psychological science and manifests itself in our models (e.g., constructions of the family life cycle, and "good" mental health). It will take more than an infusion of multicultural psychology and Black Indigenous and People of Color (BIPOC) narratives to deconstruct this history in the academy.

One solution that has prompted enthusiasm in the academy is "decolonizing" its main components including the curriculum. However, "decolonization is not a metaphor" (Tuck & Yang, 2012, p. 3).

> Decolonize (a verb) and decolonization (a noun) cannot easily be grafted onto pre-existing discourses/frameworks, even if they are critical, even if they are anti-racist, even if they are social justice frameworks. The easy absorption, adoption, and transposing of decolonization is yet another form of settler appropriation. When we write about decolonization, we are not offering it as a metaphor, it is not an approximation of other experiences of oppression. Decolonization is not swappable for other things we want to do to improve our societies and schools. Decolonization doesn't have a synonym.

Tuck and Yang (2012) refer to decolonization as unsettling and say that it should be unsettling. Decolonizing is a method of inclusion, but it is not about simply adding on, or adapting in, indigenous perspectives or methods. There are numerous approaches to decolonization and it is wise for faculty members to educate ourselves about them. Decolonization is not easy. There is more than one path and the journey is perilous because of the tendency to lapse into colonial constructions of reality. The default programming is strong. I am reminded of the quote from Audre Lorde, "*The master's tools will never dismantle the master's house*" (1983, p. 98), which means that it is impossible to use colonial thought to decolonize a class or syllabus. Educators need another kind of approach and each of us should not pursue that approach alone. For example, by "alone" I mean that I should not decolonize my syllabus all by myself. I am too embedded in the academy to see the Eurocentrism or androcentrism or heterosexism or cisgenderism that is baked right into my choices. Multiple perspectives and critical consciousness are required (Comas-Díaz, 2020; Singh et al., 2020; Torres Rivera, 2020).

It is incumbent on well-meaning white cisgender faculty members, like me, not to burden our BIPOC LGBTQ+ colleagues or students with the responsibility of pointing out the colonizing components of the curriculum or syllabi. This is an especially important consideration when the resulting workload is inequitable and physically and emotionally draining. Outside consultants can be paid to foster exploration, insight, and action among all faculty members in order to meet the varying needs of faculty, which are related to our wide range of social locations and identity development statuses (e.g., Helms, 1995). Looking outside one's program or department is a great way to infuse diverse perspectives without overburdening BIPOC and LGBTQ+ faculty and students. Social responsiveness resources like those created by CCTC have been built by broad coalitions of professionals dedicated to DEI and social justice who have willingly and generously shared their expertise. Deep structural change takes time. It is hard work. Radical hope (French et al., 2020) is required because we may not know where we are going until we get there.

CCTC

CCTC launched its mission to build and disseminate tools for promoting social responsiveness in HSP programs in 2018. The original plan was to hold a national conference that aimed to increase the capacity of North American health service psychology programs to restructure themselves for DEI and Social Justice. When the pandemic made it clear that the conference could not be held safely, the CCTC planning committee pivoted and built an online structure and organizational process that produced nine modules and more than nine tool kits for social responsiveness in health service psychology. APTC leaders, Karen Fondacaro and Lettie Flores, served on the planning committee and Saneya Tawfik, A. Jordan Wright, Dani Keenan-Miller, Debora Bell, Lynn Gilman, and I were among the 159 people across 14 training councils and 9

liaison associations that participated in working groups.[2]

The three-year effort culminated during Debora Bell's leadership of CCTC[3] and a draft of the modules is available to APTC members on our website[4]. This draft is only a summary. The entire set of modules and toolkits are being finalized and will be disseminated broadly and for free. The modules are: 1) Diversifying the HSP Pipeline, 2) Increasing Shared Governance in Program Structures, 3) Decolonizing and Transforming the Curriculum Across All Levels of Training, 4) Moving Toward Socially Responsive HSP Research Training, 5) Socially Responsive Ethics and Professionalism, 6) Social Justice and Advocacy, 7) Community Engagement, 8) Socially Responsive Evaluation of Students, Faculty, & Supervisors, and 9) Lifelong Learning.[5]

Decolonizing the Curriculum

The introduction to *CCTC Module 3: Decolonizing the Curriculum Across All Levels of Training*[6] (e.g., including internship and postdocs), is grounded in a persuasive argument for the need "to promote critical consciousness, foster critical thinking, center marginalized voices, engage students in co-constructing knowledge, center BIPOC ways of being, knowing, and doing, critique the academy," teach and demonstrate advocacy and action as essential HSP skills, and "incorporate curriculum transformation so deeply into our training programs that syllabi audits become part of everyday efforts in training" (p. 3). The 41-page module includes: a) an academic course and internship/postdoctoral seminar inclusiveness audit tool, b) an example of a traditional individual psychotherapy syllabus and a contrasting "liberated" syllabus, to demonstrate the difference between the two, and c) readiness guide, references, and resources.

Hopefully, professionals engaged in education and training of HSP students, will seek to blend the resources available in *Module 3* to take the following steps towards decolonization of the curriculum (remember we don't know exactly where we are going): 1) use audit tools to self-assess, 2) self-interrogate; watch out for white supremacy, cisgender privilege, heteronormative assumptions and other pitfalls, 3) consult with seasoned experts, advocates, and activists, 4) get good examples of liberated syllabi, 5) build in program structures that examine the curriculum as a whole and syllabi on a routine basis, 6) invite, appreciate, and compensate BIPOC/LGBTQ+ professional and student viewpoints that differ from your own, 7) let go of control/power and trust the process, 8) get feedback, 9) practice mindfulness, 10) engage in collective action, and 11) embrace change.

[2] Please let me know if I left someone out. It's a long list of contributors and I may have missed you!
[3] Debora Bell is the Chair of CCTC from 2019-2021.
[4] https://aptc.org/
[5] Lettie Flores was a member of this Working Group in addition to serving on the planning committee.
[6] Also available at https://aptc.org/

References

Alsan, M., Wanamaker, M. & Hardeman, R.R. (2020). The Tuskegee Study of Untreated Syphilis: A Case Study in Peripheral Trauma with Implications for Health Professionals. *J GEN INTERN MED* 35, 322–325. https://doi.org/10.1007/s11606-019-05309-8

Comas-Díaz, L. (2020). Liberation psychotherapy. In L. Comas-Díaz & E. Torres Rivera (Eds.). *Liberation psychology: Theory, method, practice, and social justice* (pp. 169-185). American Psychological Association.

David, E. J. R., & Okasaki, S. (2006). Colonial mentality: A review and recommendation for Filipino American Psychology. *Cultural Diversity and Ethnic Minority Psychology, 12*, p. 1. https://doi.org/10.1037/1099-9809.12.1.1

French, B.H., Lewis, J.A., Mosley, D. V., Adames, H.Y., Chavez-Dueñas, Chen, G., & Neville, H. (2020). Toward a psychological framework of radical healing in communities of color. *The Counseling Psychologist, 48*, 14-46. Doi: 10.1177/0011000019843506

Helms, J. (1995). *An update of Helm's White and people of color racial identity models*. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (p. 181–198). Sage Publications, Inc.

hooks, b. (1984). *Feminist theory: From margin to center*. South End Press.

Kendi, I.X. (2020). *How to be an antiracist*. One World. An imprint of Random House.

Lorde, A. (1983). The master's tools will never dismantle the master's house. In C. Moraga & G. Anzaldúa (Eds.). *The bridge called my back: Writings by radical women of color*, pp. 98-101. Kitchen Table: Women of Color Press.

Phillips, L.T., & Lowery, B.S. (2018). Herd invisibility: The psychology of racial privilege. *Current Directions in Psychological Science, 27*, 156-162. https://doi.org/10.1177%2F0963721417753600

Singh, A.A., Parker, B., Aqil, A.R., & Thacker, F. (2020). Liberation psychology and LGBTQ+ communities. In L. Comas-Díaz & E. Torres Rivera (Eds.). *Liberation psychology: Theory, method, practice, and social justice* (pp. 207-224). American Psychological Association.

Torres Rivera, E. (2020). Concepts of liberation psychology. In L. Comas-Díaz & E. Torres Rivera (Eds.). *Liberation psychology: Theory, method, practice, and social justice* (pp. 41-52). American Psychological Association.

Tuck, E., & Yang, K.W. (2012). Decolonization is not a metaphor. *Decolonization: Indigeneity, Education & Society, 1*, 1-40. https://uwaterloo.ca/faculty-association/sites/ca.faculty-association/files/uploads/files/decolonization_is_not_a_metaphor_a.pdf

Wilkerson, I. (2020). *Caste: The origin of our discontents*. Random House.

Watch and Lyssn: Trial Use of a Clinical Supervision Platform

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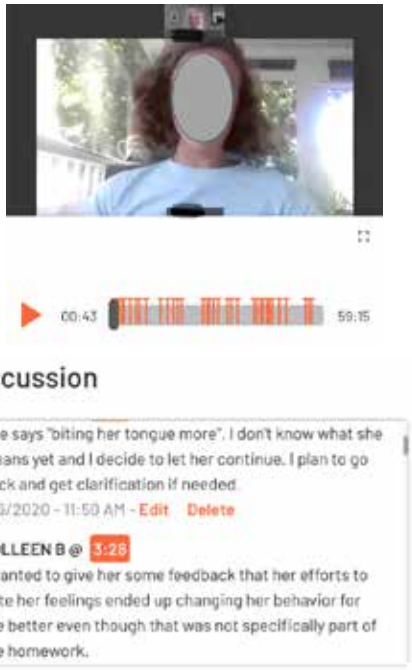
Digital recording was supposed to make things so much simpler. In contrast, many clinical supervisors find ourselves faced with a virtual "pile" of digital recordings to review without much direction beyond what a supervisee says is important. I don't know about you, but I get multiple emails a day from supervisees resembling coded messages straight out of the 1990's TV show *Alias*—"Please see LG 10102020@5:30-15min. Address not doing CBT HW?" Then I'm faced with deciphering the question/request, logging into a VPN, logging onto our secure university server, opening the file, finding & watching the video segment, making notes somewhere, and hoping I remember to email the student back. Our Clinic has dabbled with several systems for managing digital session recordings for clinical supervision, and yet, I find myself wanting a more efficient, reliable system for evaluating skill level and following progress over time. For example, we might be interested in how well a student is learning to develop strong therapeutic alliances or we might want to see if trainees are faithfully adhering to manualized treatments. Without an organized system, these can be difficult tasks.

Lyssn offered a free trial, and I was curious about its features, namely the ability to timestamp supervisors' comments and students' replies. Five trainees and I piloted the Lyssn program for 2 semesters with 13 individual clients receiving weekly therapy via Webex videoconference. This article will outline some Lyssn services, describe our experiences, and list pros and cons compared to our business-as-usual approach.

Dr. David Atkins, founder of the Lyssn clinical supervision platform and Clinical Psychologist in the University of Washington Department of Psychiatry, described Lyssn as a "tech startup by mission-oriented do-gooders" (personal communication, January 6, 2020). Want to know if your trainee is getting better at using open-ended questions? Curious about a trainees' level of empathy? Concerned that your trainees may be forgetting to set an agenda for therapy? All of these can be answered by viewing the session metrics generated by Lyssn, allowing one to "easily review [the] actual practice of psychotherapy." More specifically, the "Lyssn platform provides affordable, HIPAA and FERPA compliant recording and sharing of psychotherapy conversations" with "Artificial Intelligence (AI) technologies" to "support training and quality assurance." The Lyssn AI "translates recordings of conversations into *data* [emphasis mine]," generating metrics of therapists' behaviors. This data provides feedback to trainees and supports skill development of and adherence to evidence-based therapies such as Cognitive Behavior Therapy (CBT) and Motivational Interviewing (MI).

So, how does it all work? The Clinic Director assigns trainees to clinical supervisors and assigns clients to trainees. Trainees upload videos into the client files. Upon opening, a synchronized, searchable session transcript appears to the right of the video, so when supervisors log in they can view recordings, check session metrics, make timestamped comments, and reply to comments. Later, trainees review comments and replies made by their supervisor, thereby starting a real discussion of the session in sync with the video recording. Locating specific moments is streamlined by video markers that correspond in time to the transcript and the ability to do a word search for critical terms like "suicide" or "hopeless." Below is a screen grab of a video image with selected comments. (Note: client gave permission for use of this de-identified image).



Feedback from trainees was overwhelmingly positive. They really liked the ability to write timestamped comments and get replies from their supervisors. Plus, with feedback from Lyssn users, the company is constantly adjusting the AI to improve accuracy of the transcripts. As a supervisor, I found this platform to be a far more engaging experience than simply taking notes while watching session recordings. In short, using Lyssn reduced confusion about what to watch for whom. Other pros & cons are listed below.

Pros:

- Clinic Directors can create custom practicum groups with multiple supervisors
- Icons indicate which videos are new/unwatched
- Video can be input directly from an in-person session or remotely via secure university servers, Google Drive, Box etc.
- Lyssn has rapid, responsive customer support services via email and chat through the website
- Interactive data visualization tools that summarize performance and session content (e.g. subjects raised, symptoms presented) along with support for note-writing are in development

Cons:

- At $9/user/month, the cost could be too high for smaller clinics
- File optimization of uploaded videos takes 10 to 30 minutes depending on network speed
- Accuracy of the transcript is dependent on the strength of the WIFI connection and the quality of users' microphones. Currently, they are not accurate enough for qualitative research
- Metrics of therapists' actions were developed with data from primarily white, college-educated participants and are still being studied, so they should be interpreted with caution

Thanks for reading and don't stress about the tech. Let the APTC listserv do that for you!

References

Lyssn (n.d.) Intelligent Counseling Recording Platform. *Retrieved 16 February 2021, from https://www.lyssn.io/*

Resources

Imel, Z. E., Pace, B. T., Soma, C. S., Tanana, M., Hirsch, T., Gibson, J., Georgiou, P., Narayanan, S., & Atkins, D. C. (2019, April 8). Design feasibility of an automated, machine-learning based feedback system for Motivational Interviewing. *Psychotherapy*. Advance online publication. http://dx.doi.org/10.1037/pst0000221

Pace, B.T., Xiao, B., Dembe, A., Steyvers, M., Narayanan, S., Atkins, D.C., & Imel, Z.E. (2016). What about the words? Natural language processing in psychotherapy. *Psychotherapy Bulletin*, 51 (1), 14-18. https://societyforpsychotherapy.org/wp-content/uploads/2014/11/Bulletin51-1_Online.pdf

Tanana, M., Hallgren, K.A., Imel, Z.E., Atkins, D.C., & Srikumar, V. (2016). A comparison of natural language processing methods for automated coding of motivational interviewing. *Journal of Substance Abuse Treatment, 65*, 43-50. http://dx.doi.org/10.1016/j.jsat.2016.01.006

This technology review is for informational purposes only. It is not an endorsement of the product on behalf of APTC or the author.

Resolution

By Kim Lampson, Ph.D.

1
Resolution... just like that,
I'll decide to not be fat,
Or to no more be too thin,
Or to stop the thoughts within,
Or to never think of food,
Or to end my depressed mood.
It's so easy, so they say,
But of course! It's a brand-new day!
Resolution... just like that.

2
If I were only ten pounds lighter,
Then my days would be much brighter,
So I'll lose that extra weight,
In preparation for the date
When pain will fade and all my fear
Will be replaced by joy and cheer.

3
Resolution... just like that,
I'll decide to not be fat,
Or to no more be too thin,
Or to stop the thoughts within,
Or to never think of food,
Or to end my depressed mood.
It's so easy, so they say,
But of course! It's a brand-new day!
Resolution... just like that.

4
Everyone tells me that being thin
Brings happiness and love within
But no one told me of the danger
That soon I would become a stranger
To the people who know me well
But misunderstand my private hell.

5
Resolution... just like that,
I'll decide to not be fat,
Or to no more be too thin,
Or to stop the thoughts within,
Or to never think of food,
Or to end my depressed mood.
It's so easy, so they say,
But of course! It's a brand-new day!
Resolution... just like that.

6
Friends and family turned away
Thinking I wanted to be this way
All I wanted was to end the pain
But instead the fear of fat now reigns
And rules my life, my thoughts, my days
What once was clear is now a maze.

7
Resolution... just like that,
I'll decide to not be fat,
Or to no more be too thin,
Or to stop the thoughts within,
Or to never think of food,
Or to end my depressed mood.
It's so easy, so they say,
But of course! It's a brand-new day!
Resolution... just like that.

8
Anger is always what I feel.
It boils as I prepare each meal.
"Nice" people stuff it all inside.
Pleasing and perfection is implied.
To express the intensity of my rage
Would be remiss at any age.

9
Resolution... just like that,
I'll decide to not be fat,
Or to no more be too thin,
Or to stop the thoughts within,
Or to never think of food,
Or to end my depressed mood.
It's so easy, so they say,
But of course! It's a brand-new day!
Resolution... just like that.

10
It seems like I found out too late
That the answer is not in losing weight,
The patterns now are so ingrained
That changing them brings too much pain,
Depression races through my veins.
Diet Fiend is my new name.

Resolution... just like that.
I'll decide to not be fat,
Or to no more be too thin,
Or to stop the thoughts within,
Or to never think of food,
Or to end my depressed mood,
It's so easy, so they say,
But of course! It's not!
Resolution... just like that.

The Spirits of Psychotherapy (Integration) Yet to Come: A Transtheoretical Carol

Douglas Barnett, Ph.D.
Wayne State University

Long before I learned about psychology and thought about it for a career, I loved *A Christmas Carol* by Charles Dickens, first published in December 1843. I intuitively recognized it as story of redemption, whereby someone old, grumpy, and cruel could be transformed to be kind and young in spirit – "as light as a feather." Sometime during the 1990s, I came to recognize it as a story of psychotherapy and lifespan development. Moreover, I think it is not only an early metaphorical tale of "psychotherapy yet to come," because psychotherapy had not been invented yet, but also foresighted psychotherapy integration and the transtheoretical model. In the 1970s, Prochaska and colleagues (Prochaska & DiClemente, 1982; Prochaska & Norcross, 2018) began to develop the transtheoretical model of behavior change including the stages of change (e.g., precontemplative, action) and the processes of change (e.g., dramatic relief, environmental reevaluation). I do not know whether Scrooge's story of transformation is the first such therapy-like story; however, it appears modern in its recognition that desire for change is an essential ingredient as is empathy and the nonjudgmental support that are provided by Dickens' Christmas spirits. In this essay, I align details of Dickens' story with modern day concepts by psychotherapists, highlighting Dickens' prescience.

Dickens sets the stage of the story by demonstrating the repugnant personality of Ebenezer Scrooge. When the story begins, Scrooge is bereft of any sense of affiliation or joy in communing with others. He scowls at children, dogs, and the disabled who all know to avoid him. He lacks empathy as demonstrated by his miserly treatment of his clerk, Bob Cratchit, who has to warm his hands on a candle because his boss is too cheap to spare a single coal; and his harsh dismissal of charity collectors driving them away by Scrooge's plea to let the poor "die to reduce the surplus population." A portrait of an elderly man utterly and preferably alone and without feeling for his fellow humans; he appears to have always been so bitter that anyone who knows Scrooge is unsurprised by his contempt for humankind. Scrooge is unrepentant for his cruelty toward others, and seems to prefer being avoided by others, "But what did Scrooge care! It was the very thing he liked. To edge his way along the crowded paths of life warning all human sympathy to keep its distance…."

Scrooge is moved through fear of perceived encounters with the supernatural in the form of the ghost of his longtime business partner, Jacob Marley, who had been "dead these seven years this very night." Marley returns to chastise his friend and warn him of a miserable afterlife involving carrying the weight of his uncaring ways in the form of chains as he himself now struggles with a "prodigious chain and cashbox" he must carry for eternity. Dickens' use of afterlife consequences to confront Scrooge with his bad behavior is perhaps his most specific invocation of religious ideology in the form of eternal punishment aside from the novella itself having the name 'Christmas' in its title. In other regards, the story could be secular in terms of encouraging personal growth in the form of greater empathy and compassion for fellow humans. Any supernatural influences readily can be dismissed as "figments of the imagination," or with the hindsight of Freud, Scrooge's own unconscious bursting through in the forms of dreams mistaken for nocturnal spectral visits. Later in the story, it is the seemingly existential fear of a lonely death, unmourned by anyone that appears to concern Scrooge more than afterlife consequences per se.

Marley brings a plan to persist in his campaign to redeem Scrooge. Although the still reluctant, precontemplative Scrooge wonders, whether a night's sleep might be more conducive to his "welfare" than the haunting. Three ghosts are to guide Scrooge through his transformation by guiding him through "shadows" of his past, present, and future—"Christmases yet to come." The first spirit is object relational in focus. Scrooge is brought to witness his younger self experiencing key aspects of his developmental history that appear to help explain how he has hardened as a result of his early relationships. The Ghost of Christmas Past starts Scrooge's journey of change at his childhood boarding school, where Ebenezer was left alone over the Christmas holiday since he is not welcome home to remind his father of his nefarious role in somehow killing his mother (i.e., father's wife) during his birth. In a likely case of identification with the aggressor, we learn that Ebenezer's beloved sister also died in childbirth and Scrooge appears to participate in intergenerational continuity by resenting his nephew for killing his own mother (Scrooge's sister) during childbirth. As the story of his life unfolds, we learn that Scrooge

has experienced several significant losses along the way to his misanthropy. These other losses include his first romantic love and a beloved and fun employer from Scrooge's youth "Old Fezziwig" who is in stark contrast to Scrooge's oppressive management style.

This reminiscence of loved "objects" appears to affect Scrooge deeply as the Ghost of Christmas Past notices tears upon Scrooge's cheeks. Visiting with this and the other spirits produces catharsis as Scrooge "sobs," shedding tears multiple times and he also experiences great joy and caring in response to the visions. The Ghost of Christmas Present arrives second to help Ebenezer focus on the here and now. That is, how his behavior has an impact on those around him. The Ghost of Christmas Present also brings Scrooge to visit people with great hardship who nonetheless give of themselves to others. One visit is to Scrooge's clerk, Bob Cratchit's home, where Bob defends Scrooge's cruelty and frugality as Mrs. Cratchit and their six children complain of his long hours and meager compensation. Tiny Tim Cratchit is introduced as a young, sickly boy who uses a crutch, as his leg is lame. Scrooge witnesses and realizes how his miserliness has made the Cratchit family plight more burdensome and Tiny Tim's life more perilous. Scrooge moved by the visions of the spirit, asked, "…tell me if Tiny Tim will live." To which Christmas Present replied, "…if these shadows remain unaltered by the Future, the child will die." Scrooge begins to realize that he affects others and that his changing can make a difference in others' lives, which is similar to the concept of environmental reevaluation in the Transtheoretical model.

By the time the Ghost of Christmas Yet To Come appears, Scrooge appears to have moved from contemplative to ready for change. This final spirit "fills" Scrooge with a "solemn dread" as he comes to see his death ungrieved. Faced with the emptiness and loneliness of his life by the side of his grave Scrooge vowed, "I will live in the past, the present, and the future. The Spirits of all Three shall strive within me. I will not shut out the lessons that they teach."

The final "stave," as Dicken's calls his story's chapters, to evoke the musical metaphor of a carol; he provides wonderfully satisfying scenes of a transformed Ebenezer. He is eager to make amends and anonymously sends abundant food to the Cratchit family. He surprises his nephew and his wife by attending their convivial Christmas gathering. The opportunities that show Scrooge's inhumanity at the outset were realized with kindness in the end.

With the novella complete, Scrooge becomes "a second father" to Tiny Tim, signaling that the change is lasting and meaningful. The contrast with the Scrooge we first meet is stark and it is clear to the reader that nothing short of a miracle has taken place – both in the rapidity and scope of the change. At the same time, how the change took place is not kept secret from the reader. The process itself and the many ingredients of change are not in fact supernatural. Rather, they are the types of factors that 100 years of psychotherapy innovation and research would discover to be key human change processes —the processes that we as psychotherapists seek to generate and inspire within our clients. As therapists, we hope to help our clients make the connections between their childhood losses and mistreatments; and how these adverse events may have hardened them to others' pain and limited their ability to care. Dickens perhaps more than any other thinker has helped to show through his novels how childhood experiences and relationships matter and shape our characters. Dickens led the way showing through narrative that you can teach old dogs new tricks and that we as humans can continue to grow and change even late in life. Now when my clients seem stuck and change seems far away, I try to imagine what the three spirits might show them of their past, present, and future to move along their transformation.

References

Dickens, C. (1843). *A Christmas Carol*. In Prose. Illustrated by John Leech. London: Chapman and Hall.

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: theory, research and practice, 19*, 276-288.

Prochaska, J. O., & Norcross, J. C. (2018). *Systems of psychotherapy: A transtheoretical analysis*. Oxford University Press. (First edition published 1979)

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Nancy Liu, Ph.D.

Portraits of IPV

Artist's Statement

During COVID-19, our clinic (like many others) has seen a rise in intimate partner violence (IPV) among our clients, particularly female victims of IPV. This is reflective of wider, global trends during COVID-19 (Valera, 2020). After a particularly harrowing week providing supervision for clients who had been assaulted, bruised, blamed, and psychologically squashed, I dusted off my paintbrushes and decided just to paint. I am always struck by the subtleties in facial expressions and also the defiance, strength, and compassion that many women exhibit, even in the face of IPV.

Reference

Valera, E.M. (2020). When pandemics clash: gendered violence related TBI in women since COVID-19. *Lancet, 24*, https://doi.org/10.1016/j.eclinm.2020.100423.

Call for Contributions to the Summer/Fall 2021 Issue of the APTC Bulletin: Practicum Education & Training

The topic for the Summer/Fall, 2021 issue of the APTC Bulletin: Practicum Education & Training is in development. APTC members are invited to submit ideas for a topic by sending an email to hzetzer@ucsb.edu. The Bulletin editors, in consultation with the APTC Executive Committee, will select a topic and a call for proposals will be issued with a due date of early October. Please submit topic ideas by July 1, 2021.