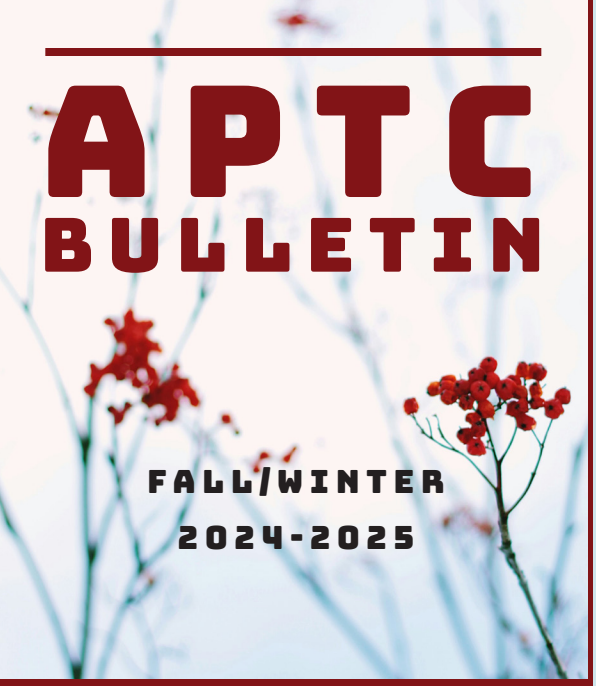

APTC BULLETIN

FALL/WINTER
2024-2025

Practicum Education & Training

A Publication of the
Association of Psychology Training Clinics
https://aptc.org

Co-Editors:
Stephanie McWilliams, Ph.D., CMPC
West Virginia University
Linnea R. Burk, Ph.D.
University of Wisconsin, Madison

Editorial Assistant:
Johnathan Meier
West Virginia University

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APTC Mission: The Association of Psychology Training Clinics (APTC) is a professional organization for directors of doctoral-level psychology training clinics and interested associates and affiliates. The organization is affiliated with the American Psychological Association (APA). APTC has established a multipurpose mission and specifically seeks to:

(a) promote high standards of professional psychology training and practice in psychology training clinics;

(b) facilitate the exchange of information and resources among psychology training clinics that provide doctoral-level practicum training in professional psychology; and

(c) interface with related professional groups and organizations to further the goals of APTC, including influencing the establishment of standards and guidelines on service delivery and training of future psychologists.

CURRENT OFFICERS

President
Jennifer Schwartz
Ph.D., ABPP
University of North Texas
jennifer.schwartz@unt.edu

President-Elect
William Salton
Ph.D.
Yeshiva University
william.salton@yu.edu

Past-President
Scott Gustafson
Ph.D., ABPP
Florida Institute of Technology
gustafson@fit.edu

President Emeritus
Robert Hatcher
Ph.D.
Graduate Center—City University of New York
rhatcher@gc.cuny.edu

Secretary
Jennifer Hames
Ph.D.
University of Notre Dame
jhames@nd.edu

Treasurer
Risa Broudy
Ph.D.
George Washington University
rbroudy@gwu.edu

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Colleen Byrne

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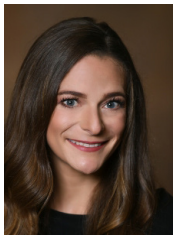
Leticia Flores

Member at Large
Robyn Mehlenbeck
Ph.D., ABPP
George Mason University
RMehlenb@gmu.edu



Early Career Member-at-Large
Kristy McRaney
Ph.D.
The University of Southern Mississippi
kristy.mcraney@usm.edu

Member at Large
Stephanie McWilliams
Ph.D., CMPC
West Virginia University
srmcwilliams@mail.wvu.edu

STANDING COMMITTEES & WORKING GROUPS

Assessment Committee Chair:
Jordan Wright
(ajw11@nyu.edu)

Awards & Recognition Chair:
Sara Boghosian
(sara.boghosian@usu.edu)

Bylaws & Documents Chair:
Rob Heffer
(rob-heffer@tamu.edu)

Collaboration & Liaison Chair:
Stephanie McWilliams
(srmcwilliams@mail.wvu.edu)

Diversity Chair:
Dinelia Rosa
(rosa@tc.columbia.edu)

Finance Working Group Chair:
Risa Broudy
(rbroudy@gwu.edu)

Membership & Resources Chair:
Jen Hames
(jhames@nd.edu)

New Director/Mentoring Chair:
Robyn Mehlenbeck
(rmehlenb@gmu.edu)

Professional Competencies and Practicum Training-Chair:
Stephanie McWilliams
(srmcwilliams@mail.wvu.edu)

Programs & Conferences Co-Chairs:
Bill Salton
(william.salton@yu.edu)
Kristy McRaney
(kristy.mcraney@usm.edu)

Publications Chair:
Stephanie McWilliams
(srmcwilliams@mail.wvu.edu)

Research Committee Co-Chairs:
Jackie Hersh
(hershjr@appstate.edu)
Ryan Farmer
(rlfarmer@memphis.edu)

Technology Group Chair:
Miriam Thompson
(miriameadyt@ucsb.edu)

Council of Past Presidents (COPP) Chair:
Colleen Byrne
(colleenbyrn@gmail.com)

Stephanie McWilliams
APTC Bulletin Co-Editor

While I have been part of the APTC for many years and active on a number of committees, this is my first go at serving as a co-editor of the APTC bulletin. Heidi (Zetzer) handed over some very big shoes to fill and with this first issue, all I can think is, "How did she make it look so easy?". From day one as part of the APTC, I have valued this publication so much because it really does summarize all of the work, visible and invisible, that we do as training clinic directors. No outside group of professionals could possibly understand! Well, this publication helps with that in my opinion. It showcases the depth and breath of impact clinic directors have on the profession, from training to research, and it is nothing short of amazing.

This issue is focused on the topics covered at our last conference in San Diego, CA, "Resources and Resiliency". I don't think there is a more resilient and resourceful group of people. From diversity considerations to caring for students, this issue touches on so many facets of our job as clinic directors. I sincerely hope you enjoy all of the wonderful contributions of your APTC colleagues and can use this publication to improve your professional experience in some way. Thank you to all of the authors! Your work is very much appreciated. Thank you to the production team, our student assistant, Johnathan Meier, and my co-editor, Linnea Burk for your help in making this edition happen. And finally, thank you to Heidi for laying the groundwork for the APTC Bulletin as a respected, peer-reviewed publication and resource for psychology professionals. We all owe you one!

—Stephanie

APTC 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.

Setting the Stage

APTC's New President's First Column

Jennifer Schwartz, Ph.D., ABPP
Drexel University

This is my first President's Column as APTC President, and I'm truly honored to be serving in this role. APTC has been my consistent professional home for over 20 years, across three training clinics, and three different states. No other professional organization has been as big a support to my career as APTC. All y'all (have to get the Texas in!) are my colleagues, friends, kindred spirits, biggest cheerleaders, best advice givers, fastest sources of data, and even shoulders to cry on when necessary. I always say that I "grew up" in APTC, having been Tony Cellucci's TA when he was Treasuer (so I kept the spreadsheet on everyone's dues as a doctoral student). Those were the early days when APTC was new, and membership was much smaller. Just as I've grown as a Director over the decades, APTC is also evolving.

One of my first initiatives as your President has been to work with our executive committee and committee leadership to define the charges of our committees and goals for the coming year. APTC's growth has been incredible, and reflecting your diverse interests, there are many ways to get involved in initiatives that will further the goals of APTC. Clinic Directors, by definition, are hard workers who get tasks done! So, it's no wonder that whenever there have been perceived needs, a committee forms, goals are set, and work products are developed. Examination of the existing committees has shown that given the present size of our organization and the varied professional supports we provide for our members, almost all of our committees are as relevant now as when they were created. Ahead of our annual conference, we will publish our updated committee list, charges, and annual goals. I hope you consider joining!

"...[T]raining clinics set the stage for the direction of the next generation(s) of psychologists.

Their directors are the visionaries for the art that unfolds on that stage."

My second big initiative, which I hope will far outlive my time as your President, is a next bold step for APTC. I would like to create a committee charged with examining the feasibility of, proposed structure for, and path to sustainability of an APTC Clinic Review and "Seal of Approval." Our programs have all been through site visits and program alignment reviews. Sometimes, our clinics are a small piece of those reviews, never the focus, and reviewers are not typically training clinic experts. Although the feedback from these reviews allows departments/programs to receive praise, lobby for resources, and gather suggestions for areas for growth from fresh eyes, the training clinic may not benefit specifically. Thus, I foresee a clinic-specific review and APTC endorsement as a tool for directors to stay current and adequately resourced, as well as a way for applicants to vet training programs. The first step in developing such a tool is ascertaining who might have an interest in being on the APTC Clinic Review committee (please email me).

Finally, training clinics set the stage for the direction of the next generation(s) of psychologists. Their directors are the visionaries for the art that unfolds on that stage. Directors study their craft, gather data about past successes and failures to inform the next steps, and generate systems that impact administration, education, and service delivery that inspire the psychological artists of the future. I hope to see all y'all (got it in there twice!) at our annual conference in Nashville, TN, where we'll hear from all y'all (3x!) about the Art and Science of Clinic Direction!

Honoring APTC Acheivement

2024 Conference Awards

The APTC Spruill Award

The APTC Spruill Award went to A. Jordan Wright this year. The Spruill Award is the highest honor an APTC member can achieve within the organization. The purpose of this award is to honor a member who demonstrates longstanding and active involvement in APTC, commitment to excellence in training, and dedication to innovative and best practices in doctoral training clinics. This award is intended to recognize clinic directors who display excellence and innovation in training practices, administrative procedures, integration of research and practitioner training, and who provide outstanding service and leadership to APTC. Dr. Wright was clearly well-deserving of this high honor due to his ongoing efforts to inform, educate, and advocate for APTC members in the realm of psychological assessment. His willingness to be a liaison between ATPC and Pearson was certainly beneficial to all of us and clearly went above and beyond the call of duty. Jordan has unselfishly made himself available to so many training clinic directors in recent years when they have had issues with assessment processes, especially as we were all trying to figure out how to conduct assessment during the COVID-19 pandemic.

The Clinic Innovations Award

The Clinic Innovations Award was given to two amazing training clinic directors: Natasha Gouge and Robyn Mehlenbeck. This award is intended to honor a member clinic of APTC and it's director who have implemented a meaningful innovation that positively impacted the training, research and/or service provision being done in that clinic.

Dr. Gouge was recognized for data driven innovations in the training clinic's assessment training sequence. At the conference, she presented to our membership about this new approach to training psychology graduate students to competently do psychological assessment and we were quite impressed. In fact, I know that several other directors are hoping to do something similar in their clinics now that the process and positive outcomes of this new rotation were outlined for us.

Dr. Mehlenbeck was recognized for the development of an impactful stepped care model of treatment. She also recently presented to our membership about this innovative model of care that was developed in the GMU training clinic to more efficiently utilize resources and provide intervention to move people. In fact, another one of our member clinics (U of Buffalo) is actually modeling their new program based on this Stepped Care Model as well! These are exactly the type of creative innovations that improve our field broadly both in terms of training and in terms of making the most impact in the communities we serve. Dr. Gouge and Dr. Mehlenbeck are both invaluable members of our organization and it was an honor to be able to celebrate them and their clinics at our recent conference.

Mentorship Awards

This year two amazing APTC members were awarded the Mentorship Award: Naomi Tabak and Lisa Smith. The purpose of this award is to recognize an APTC Training Clinic Director who demonstrates extraordinary mentorship of another training clinic directors. Both were nominated by colleagues who felt that the mentorship provided by them was invaluable to their careers. I think that we can agree that the mentorship provided within this organization is difficult to find anywhere else and these two members are stellar examples of this!

The APTC Research Award

The APTC research award went to Matthew Calamia this year. This award was created to honor clinic directors who are conducting important research in and/or through their training clinic. At the time of our conference in March, Dr. Calamia and his team at the LSU psychology training clinic had published three important articles related to better understanding noncredible responding in ADHD assessment. This is an important topic in both the training and provision of ADHD assessment. The APTC awards committee felt strongly that Dr. Calamia and the LSU Clinic deserved this award and we were honored to present this award to him at the conference.

The Friend of APTC Award

Dr. Michael Nadorff was the recipient of the Friend of APTC award this year. This award is intended to honor a person who is not a member of APTC but who demonstrates longstanding support of our organization and of training clinics in general. He was nominated by Dr. Emily Stafford for being of tremendous support to her and his nomination was seconded by another training clinic director to whom he provided valuable advice and support during a very difficult time for that clinic. We are grateful to have both of them involved in training future psychologists. He was delighted to receive this award and was disappointed to not be able to attend the conference in person in March.

— The 2024 Awards Committee
Sara Boghosian (chair), Lettie Flores, Scott Gustafson, Lee Cooper, and Miriam Thompson

Navigating Stormy Seas:

What To Know And How To Proceed When A Student Files A Grievance

Sara Boghosian, Ph.D.
Utah State University

Robyn Mehlenbeck, Ph.D. ABPP, Mason University

Leticia Flores, Ph.D.
University of Tennessee, Knoxville

Caitlin Williams, Ph.D.
University of Tennessee, Knoxville

Scope of the Problem

Although official numbers cannot be known due to the privacy rights granted to students by the Family Educational Rights and Privacy Act (FERPA; 2021), as well as due process rights inherent to the academic setting, anecdotal evidence from personal communications and other channels indicates that complaints about clinical supervisors, clinic directors, and faculty are increasingly common at academic institutions. Of 77 respondents to a recent survey of the APTC membership, 19% reported experiencing a student-initiated grievance against them at either the department or university level. Over a third (35%) of training clinic director respondents had experienced a training relationship or interaction that led them to fear a student would file a grievance. In addition, an overwhelming majority (82%) of respondents reported knowing about a student-initiated grievance being filed against a faculty-member colleague, and 71% reported believing that such grievances have become more common in recent years. Regardless of the veracity of this fear, it is likely that this perception leads to increased distress on the part of most training clinic directors.

These complaints and the processes universities use to investigate them can be time-consuming and distressing for both the students and faculty involved. Although the goal of these processes is to ensure that mistakes are caught and corrected, the emotional stress can be overwhelming. In fact, once a complaint is filed at the university level, the process often overtly prevents restorative justice or alliance repair methods which are much more in line with our training and values as psychologists. It is often the case that the individual against which the complaint has been filed is prevented from interacting with the student at all while the investigation is underway.

Training clinic directors are in an increasingly challenging position for addressing these situations due, in part, to the multiple roles they occupy (e.g., a clinic director, direct supervisor, departmental faculty member, and mentor, while also a gatekeeper, cheerleader, and protector of students and the public). Given the rising levels of burnout and higher turnover amongst faculty nationwide, it is important to enhance faculty effectiveness and resilience during and following these grievance processes when they emerge. This article will outline some of the common procedures and timelines involved in a student-instigated faculty grievance process. The authors will also summarize and normalize some of the common reactions to student complaints and investigation processes, based on their own experiences and based upon the recent survey of APTC membership. Finally, recommendations will be made for effective coping and self-care during the long investigation process, as a lack of preparedness for addressing such charges has been noted as a major source of distress. Suggestions will also be made for moving forward professionally after a student grievance investigation with a goal of enhancing resilience.

The Processes In Student-Initiated Grievance Investigation

Those directors who find themselves accused of charges such as harassment, discrimination, and retaliation can find the experience deeply wounding, both professionally and personally. Most, if not all, clinic directors enter this line of work because they have a strong investment in students and their clinical success and see themselves as clinical "champions" for their students. They are just as often members of marginalized communities and so have a particular focus on helping students from similarly marginalized backgrounds become professionals in the field.

There are different levels of complaints that may be filed. A director may be accused at the program level, the department level, or the university level. In the recent survey of psychology training clinic directors, one-third of respondents who had experienced a student-initiated grievance reported that this occurred at the program level, with another third each reporting grievances being filed at the department and university levels. Responses at each of these levels may differ, but it is critical to understand the resources at your disposal and the units that may become involved.

First, it is crucial to consult with your university attorney if an accusation of "causing harm" or an official grievance is made, regardless of whether the grievance is at the program, department, or university level. The attorney can advise as to what steps you may need to take. They can also advise if it is a legal versus another kind of issue (e.g., personnel), which can be very helpful in knowing how to address the issue.

In addition, there are different university units that may become involved in investigating and deciding the outcomes of these kinds of adversarial events. Depending on the type of complaint lodged, the University may have an overarching investigative unit that oversees all complaints related to FERPA, Title VI, Title IX and similar laws. It is important to know that the units may also be dispersed across the institution. This dispersal may make the process feel more or less splintered and disjointed, and the director may spend more time and energy than they would prefer trying to deliver information to and obtain updates from the various constituents.

There are several major factors that can contribute to a director's difficulty navigating these situations. The personal shame and embarrassment that can accompany such a charge may reduce the willingness of a director to share this information with professional colleagues, including other clinic directors. Paradoxically, it is these very colleagues who can provide vital psychological support and guidance during such situations. Another factor that might inhibit a director from discussing their situation is the fear of violating privacy laws related to the student complainant. Although FERPA law protects students from unlawful release of their educational records, these kinds of complaints appear to be exempt from FERPA protections (U.S. Department of Education; Office of Civil Rights, 2021; U.S. Department of Education, 2024).

Title IX and other federal protections may play a role in protecting the student complainant's privacy. In some instances, the student complainant may be recognized as a "student" (in a graduate program), a "university employee" (teaching/research assistant), or both. This lack of clarity can often serve to muddy the waters about what the director can legally and ethically share with others. This scenario can also leave the director with a feeling of increased exposure and vulnerability. Though the student has the ability and power to accuse the director of misbehavior, there does not appear to be a formal vehicle for the director to make a similar complaint against what they may experience as an offending student. The only role a director is able to occupy is as someone who must argue for and defend their innocence. The result is akin to being a character in Kafka's story, "The Trial", where the charges seem nonsensical and where guilt appears to have been decided before anything else.

When the university's relevant review committees accept these complaints as valid charges to be investigated, the director's professional communications are often consequently sequestered. This means that the director is ordered to avoid deleting all emails, texts, voicemails, and other recorded communications, as they may hold evidence of the charges being filed against them by the student complainant. This sequestration extends not only to university-owned equipment but also to the director's personal laptops/phones, as they interact with university email and remote servers. Directors may understandably experience this as a major violation of their own privacy, as well as an intrusive force exerted by the university on their everyday functioning.

Common Reactions to Student Complaints

Being accused of discrimination is often extremely distressing, given clinic directors' commitment to the training and ethical treatment of graduate students. In the recent survey of training clinic directors, in which 15/77 reported personally experiencing an official student complaint, reactions included: "Surprise;

frustration; fear of retaliation for talking about it," "anger, disappointment, worry, helplessness, desire to give up/quit/find a different job," and "surprise, frustration with the way it was handled." Other reactions that were shared were "confusion, anger; defeat," "anxiety, frustration," and "fear, anger, guilt." Finally, these responses were shared by respondents, "Grief, anger, anxiety, chronic stress," "shock, fear, embarrassment, anger, sadness," "hurt, sadness," and "worry, confusion, mistrust, frustration, reduced 'enjoyment' in my job." Given that this question was formatted as an open-response query, it is striking to see how similar responses were by the vast majority of training clinic directors who had personally experienced a student-initiated grievance.

These reactions are understandable, given that one's sense of professional identity is threatened when a complaint is made or a grievance is filed. As training clinic directors, we often see ourselves not only as ethical professionals but also as student allies and role models. A student-initiated complaint takes aim at all of these identities and produces significant damage to one's sense of closeness or alliance to a student with whom the director may need to continue a training relationship. Given that doctoral students are often in training with clinics (and directors) for four to five years, this truly unique relationship can feel tainted and, consequently, hard to address while the complaint is going through a university process. The actual type and intensity of the distress likely differ by generation and other cultural factors, including the director being part of a marginalized group themself. Older directors may experience this as a potentially fatal blow to the end of their long careers. Or they may feel somewhat more "battle-hardened" by past professional experiences and thus able to weather the storm that such circumstances bring. Newer and/or younger directors may experience such complaints as an existential threat to their fledgling career and a most unwelcome addition to the already steep learning curve they may be facing in their position. Finally, our roles as training clinic directors are often unique within our departments, and grievances can engender fear of reputational damage.

What APTC Membership Has Done

In an open response question on the recent survey of training clinic directors, eight respondents who had received a student-initiated grievance filed against them reported responding by approaching the student and attempting to work through the issue directly. 15 out of 15 respondents who experienced a student-initiated grievance reported that they sought support and consultation from colleagues, specifically other faculty, their department chair, or other members of APTC. Six respondents reported that they responded by focusing upon good documentation, whereas three respondents looked to their department's policies and procedures to determine how to proceed. Five respondents reported spending time in reflection following the complaint, with a goal of determining how to learn from the experience or alter future behavior. Three directors discussed responding with increased caution, establishing boundaries, or by "silencing" themself. One respondent each talked about praying, lowering expectations, and discussing the issue in therapy.

Recommendations If You Have a Student-Filed Grievance

Our first recommendation upon receiving a grievance is to take at least 24 hours to respond directly in any way to the student if that is an appropriate response. Alternatively, limit an email to the acknowledgement of the letter/email and indicate you need time to respond. The initial emotional reaction is likely to be intense, particularly if it comes from a student with whom you felt you had a good, and often longer-term, relationship. During this time, consult a trusted colleague (in or outside the program—including one of us!) and also set up a time to consult with your University legal department. It can be helpful to have a colleague join you for that consultation to provide support for you as well as to help retain the information discussed.

In one example, one of the authors received an email indicating that she had caused "personal and professional harm" to two students by sharing a webinar resource with the clinic therapists. The webinar was not required but was one of many shared as a "possible resource for you and/or your clients." The emotional response was particularly painful as both students had previous excellent relationships with this supervisor and director, including frequent respectful discussions about diversity and identity issues – and though it seemed to be a program-level grievance initially, it was unclear if any university-level grievance had been filed. The director of clinical training at the time joined the author in the initial meeting with the University attorney, who asked to involve a representative from the Diversity, Equity, and Inclusion (DEI) office. This meeting was reassuring on a basic level—the office representative confirmed that the director had not done anything legally concerning and made excellent suggestions for appropriate follow-up.

Second, document everything. Though time-consuming, documenting all the steps you have taken, as well as your perspective on everything that occurred, will help you in the long run. If a formal investigation is initiated, this documentation will help you to recall details, dates, intentions, and steps taken. In the same vein, be careful of what you write to colleagues within the program and especially outside the program (think FERPA). In the example above, the author was able to share every written communication with the attorney and, ultimately, with the DEI office. These steps were acceptable within the scope of the complaint, even with FERPA protections in place for the students.

Third, see if there is any opportunity for face-to-face discussion and resolution with a mediator, working with the offices that may be involved (i.e., ombudsman). In the above example, the DEI office provided a mediator to have a face-to-face meeting, with the student being able to bring their advisors for support as well.

If there is not an option for face-to-face discussion with an objective mediator, such as during a formal investigation, it is critical that you obtain your own support from colleagues in or outside the program. Some support may even include covering a portion of your work so you have adequate time to address the grievance.

Be proactive in talking to the office(s) involved to understand the steps and what information is shared with whom. For example, a Title IX complaint may have a different process than a DEI or conduct complaint, and the timelines may vary. Policies are also often unclear as to what information is shared with both parties. Finally, these formal processes often are drawn out and can span a year or more. This nebulousness contributes to the anxiety of working with students in small cohorts, even if you are no longer working with the student who filed the grievance. As one director has been reminded by legal counsel, "it's a marathon, not a sprint".

Moving Forward With Resilience

Whether it is a formal or informal grievance, this is a difficult time to be a clinic director and to be working with students. Know that you are ***NOT ALONE*** and that you should not go through this process alone! Tell the shame response to "get lost" as it is not helpful. Though you have to respect and follow privacy laws, you can still receive support from others who have gone through it. You do not have to give prohibited details to receive support.

It is OK to take some time off to take care of yourself, including engaging in some rewarding activities. In some cases, there may be supportive measures or policies in place through the office investigating the complaint that can help you to create the space for increasing self-care. Taking a step back and focusing on self-care helps put things in perspective.

As we tell our students, each experience is one we can learn from. Is it painful to stop sharing resources like one director once did, in a clinic-wide email? Absolutely. However, encouraging students to go to your office hours to discuss what resources might be right for them allows for more individualization. Are we also looking at how we can grow? Was a part of the concern valid, but just delivered in a way that feels terrible? Try not to ruminate, but think through the things you would do the same or differently in a future situation. Trusted colleagues can guide you in finding your own part in the situation and growing from it while also supporting you through the process.

Remind yourself that your training clinic director colleagues ***DO NOT THINK LESS*** of you, and more likely than not, they have had to deal with something similar in their departments—or will be dealing with something similar in the near future. APTC is here for you, today and tomorrow.

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REFRAMING

the Imposter Phenomenon and Fostering Resilience in Psychology Training Clinics

Heidi A. Zetzer, Ph.D.
University of California, Santa Barbara

Heidi A. Zetzer, Ph.D.

Graduate students frequently report feeling like imposters (Collier & Blanchard, 2023; Hashtpari et al., 2023). The "imposter phenomenon" (IP; Clance & Imes, 1978), often called "imposter syndrome," describes "high achieving individuals who, despite their objective successes, fail to internalize their accomplishments and have persistent self-doubt and fear of being exposed as a fraud or imposter" (Bravata et al., 2020, p. 1252). The concept of IP originated with a paper by Clance and Imes (1978, p. 241), who observed that the high-achieving white women with whom they worked as instructors and therapists attributed their successes to external factors like someone else's mistaken positive appraisal or just good luck. Clance and Imes (1978, p. 241) concluded, "Women who experience the imposter phenomenon maintain a strong belief that they are not intelligent; in fact, they are convinced that they have fooled anyone who thinks otherwise."

Prevalence

More recently, researchers have studied the imposter phenomenon among undergraduate students from communities of color and found that feeling like an imposter and minority status stress are common among African American, Latinx American, and Asian American students (Bernard & Volpe, 2020; Cokley et al., 2013). Bravata et al. (2020) found that *both* imposter feelings and minority status stress were predictive of psychological distress, but feeling like an imposter was *more predictive*. The researchers also found no gender differences. Bravata et al. reviewed 62 studies with a total of 14,161 participants from a wide range of populations and found IP prevalence rates of 9 to 82%, with the highest rates reported by GenZ college students.

Between 30% (Henning et al., 1998) and 80% of psychology graduate students have reported feeling like an imposter (Castro et al., 2004). Doctoral students are particularly vulnerable to IP thoughts and feelings because they develop their competencies in environments infused with high expectations and varying degrees of interpersonal insularity that increase self-doubt (Sverdlik et al., 2020). Such environments exacerbate a fear of being exposed (Bothello & Roulet, 2018) and invite ruminations about whether one belongs (Cope-Watson & Betts, 2010; Jöstl et al., 2012). Students with minoritized identities (e.g., BIPOC and LGBTQ+) find themselves exhausted by IP along with the added layers of stereotype threat, microaggressions, isolation, internalized stigma (Mangan, 2021; Matsuno et al., 2023), and a general lack of affirmation and support from faculty or their department.

IP is remarkably common, not just for students but among working people in general. Using just one item from the Clance and Imes measure of IP, "I'm disappointed at times in my present accomplishments and think I should have accomplished much more," Shanafelt et al. (2022) found that 27.4% of the physicians and 18.4% of the general professional working population reported this statement to be often true or very true. Using the full IP scale, they found that nearly 1 in 4 physicians reported feeling like an imposter. IP was more intense for women, younger, and VA-employed physicians. Frequent and intense imposter thoughts and feelings were associated with higher levels of emotional exhaustion, burnout, and suicidality and inversely related to professional fulfillment. The researchers concluded that physician training puts developing professionals in a perpetual state of inadequacy because of the

perfectionistic norms of the profession, which leads to avoidant coping behaviors and interpersonal isolation (feeling like you are the only one dealing with IP).

Academic faculty are not free from the IP trap of perfectionistic standards, high levels of scrutiny, and interpersonal isolation (Hutchins & Rainbolt, 2017). Academic environments are fraught with the pressure of "publish or perish" (Kets de Vries, 2005) and/or perform or perish. Psychology Training Clinics (PTCs) are infused with their own set of unique demands on directors (Graham et al., 2023), including pressure to build and sustain funding (Mehlenbeck et al., 2024; Panzarella et al., 2017), remediate underperforming students (Wise et al., 2012), purchase and run sophisticated technology (Flores et al., 2014; Schueller, 2024), and prepare your own promotion packet without any guidance (Stafford, 2023)! Add the stress of concerns about students (Byrne, 2023) and client welfare, and training clinic directors may find themselves in a "perfect storm." Given the wide range of demands and lack of graduate education for this extraordinary skill set, it is no wonder that PTC directors (especially new ones) can feel like imposters themselves.

Impact

Nearly everywhere we look, there is evidence that elevations in the intensity of IP thoughts and feelings are associated with increased depression, anxiety, and psychological distress (Chrisman et al., 1995; Henning et al., 1998; McGregor et al., 2008; Pákozdy et al., 2023). Experiencing IP also impacts job performance, job satisfaction, and burnout (Bravata et al., 2020). What is the cause of all of this suffering?

Unfortunately, IP is commonly viewed from an individualistic lens (Feenstra et al., 2020). This is no surprise because its conceptual origins stem from affluent white women whose experiences of "benevolent sexism" in a patriarchal world led them to self-doubt. The use of the term "imposter syndrome" does not help either. The APA Dictionary (2018) defines a syndrome as " n. a set of symptoms and signs that are usually due to a single cause (or set of related causes) and together indicate a particular physical or mental disease or disorder. Also called **symptom complex**." So, feeling like an imposter is practically a disorder? How could something so common affect so very many capable people?

The Re-Frame

Numerous studies have linked IP to the stress of growing, living, and working in oppressive minoritizing systems (Cokely et al., 2013; Nadal et al., 2021). Numerous authors have identified the impact of systemic oppression, including tokenism, microaggressions, and bullying, as the sources of this kind of self-doubt (Bravata et al., 2020; Thompson & Brown, 2022; Tulshyan & Burey, 2021). Such systems position minoritized people, primarily women and BIPOC/LGBTQ+ folx, as second class, unqualified, and not really belonging in predominantly white, male, or prestigious positions. These "isms," along with overt discrimination, negative stereotyping, microaggressions, and other forms of diminishment, translate into self-doubt about one's capabilities, even when there is evidence to the contrary. A main effect of this barrage is IP (Nadal et al., 2021; Tulshyan & Burey, 2021), and yes, white cis hetero men experience it too. Family upbringing and social class also play a part in IP (Mangan, 2021). IP is a cross-cultural phenomenon evident in any place where the "appearance of intelligence is vital to success" (Kets de Vries, 2005, p. 2).

What Can We Do?

The literature on empowerment, resilience, and radical healing (French et al., 2020; Tran, 2023) is a rich resource for discovering principles and developing organizational interventions and individual or group practices that are likely to dilute and reduce the insidious thoughts and feelings associated with the imposter phenomenon. Here are some recommendations:

- Normalize imposter thoughts and feelings. PTC directors and faculty members can reduce imposter thoughts and feelings by sharing their own experiences. For example, I still get anxious and feel like a fake when I present to groups. I imagine someone standing up in the audience, pointing directly at me, and shouting, "Wait a minute! You're not an expert! You don't know what you're talking about!" Has this ever happened? Nope, but I *still* fear it.
- Externalize the problem (e.g., deShazer, 1982; Tran, 2023). Attributing the cause of these thoughts and feelings to internalized isms or pressures that come from the environment rather than oneself is a good start to overcoming feelings of inadequacy (Prakash et al., 2023).
- Build group cohesion among trainees to reduce competition and promote a sense of belonging.
- Foster resilience by identifying and reinforcing trainees' unique strengths.
- Demystify the graduate education process by making expectations and benchmarks clear.
- Draw on ancestral and cultural resources. There

are many heroes and stories of resilience in our collective narratives, and inviting, sharing, and centering those stories can shift individual and group narratives. Shifts in these narratives can initiate and support systemic change as well as individual resilience.

- Finally, consider Tran's (2023) persuasive reframe: from imposter to *infiltrator*. Tran asserts that success in biased systems requires W.E.B. DuBois' concept of "double consciousness," in which entrants to such systems must adapt their presence to the demand characteristics of the environment. This requires constant attention to what the authorities are thinking.
    - PTC directors may be required to think, "How do I achieve success in an environment that marginalizes clinical training? How will my actions/decisions be viewed by my DCT, Chair, or Dean? How do I earn the respect of my colleagues?"
    - BIPOC/LGBTQ+ students need to navigate relationships with faculty mentors who may not share or truly understand their lives or their values. Students may ask, "What does my advisor want from me? How do they perceive me? Can I be myself?"
    - Tran (2023, p. 187) proposes that those who live with a "double consciousness" identify themselves not as an imposter but as an *infiltrator*. "The infiltrator holds onto their 'true' self and respects their dual consciousness." They "infiltrate the oppressive system and disrupt it." They "use silence strategically" and choose when to disrupt.

While this might seem individualistic, a collective reframe that names the systemic demands of the academy can be empowering. Tran's reframing of IP as an infiltrator promotes a sense of agency, not inauthenticity or assimilation. It is empowering, invigorating, and a far more positive self-construal than oneself as an imposter. PTC directors and faculty mentors who acknowledge the requirements of the academy and share their own strategies for navigating the conditions of worth will help students recognize and respond in a manner that builds a sense of agency and honors their whole selves.

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Rebuilding a Clinic with APTC Guidance

From Surviving to Thriving

Laura Burch, Ph.D. and Madison Streb, M.S.
St. Louis University

Laura Burch, Ph.D.

Madison Streb, M.S.

I began the position of Clinic Director in the fall of 2023; my predecessor retired right as the COVID-19 pandemic began, so the role had been vacant for over three years. The clinic needed rebuilding, restabilizing, and a means to grow. Our account balance was in the negative, and when a faculty member asked me to purchase a $60 manual for the clinic, I had to say no. Thanks to guidance from the APTC website and mentorship, we were able to begin rebuilding and come in line with legal and ethical standards. As our clinic stabilized, I attended the APTC conference and was inspired to move beyond surviving to thriving by locating grants to fund services and creating on-campus contracts (Bullet et al., 2024; Mehlenbeck et al., 2024). As a result, we created a proposal for grant funding and received $115,000 to provide no-cost psychological assessments to underserved individuals in our community. We also created an on-campus contract with the university to be reimbursed for the services we provide to students pro bono. Now, our clinic is thriving again and is a core training site for psychological assessments. We have generated revenue to meet the demands of our program and provide stipends for student clinicians, coverage for core faculty breaks, and an allowance to purchase that $60 book! I am grateful for the inspiration and support APTC has provided me and our clinic as we move beyond surviving to thriving, and we are indeed arguably as resilient as ever.

Introduction

I became a clinic director in the fall of 2023, two weeks after I finished my internship (albeit I went to graduate school as a second career, so I had a few life lessons under my belt). My predecessor retired at the beginning of the COVID-19 pandemic, so the role had been vacant for over three years. None of the current students knew a pre-pandemic program that was alive and well. In-person appointments—and indeed, appointments in general—had significantly declined. We had zero therapy clients on our waitlist, and several student clinicians had been waiting months for a new client. Accountability was inconsistent at best. Attention to legal and ethical concerns—well, let us not go there. By the time I started as Director, the clinic account was in the negative, and when a faculty member asked me to purchase a $60 manual for the clinic, I had to say no. I had my work cut out for me.

Creating Stability

I was encouraged by my predecessor and everyone from whom I sought guidance to start with the APTC website. In my first week, I joined the organization, and shortly after, I was assigned an APTC mentor. Thanks to these resources, I gained my footing and identified a roadmap for addressing clinic challenges, including meeting with students and faculty to better understand their needs, challenges, and strengths from their perspectives; assessing clinic needs and barriers to change; meeting with our HIPAA office and university general counsel to ensure we were in legal and ethical compliance; and creating a clinic manual that outlined our new policies and procedures. We began rebuilding the clinic's productivity and commitment to compliance, and I met with students and faculty monthly to review progress. Slowly, we generated a small therapy waitlist, and our account balance began skewing positive. We were headed in the right direction.

Building Resources

As our clinic stabilized, I reflected on the amazing mental health resources our student clinicians provide and the vast need for these services in our city (City of St. Louis Department of Health, 2020). Surely, we could increase quality training for our students while providing services to the community; who would not want to fund that? So, I did what any self-respecting clinic director would do: I cold-called potential funding sources and begged. After many phone calls and multiple rejections, one site indicated interest, and we had several discussions about how our clinic could meet the needs of under-resourced individuals in our community. After several promising conversations, however, the site stopped returning my calls and emails, and it seemed that all was lost.

Then I attended my first APTC conference on Resources and Resiliency, and wow, did the inspiration flow! I learned about the creative ways other clinics were increasing productivity and resources by creating a reputation, fundraising, and finding community donors (Mehlenbeck et al., 2024), as well as partnering with special interest groups, creating on-campus contracts, and locating grants to fund services (Bullet et al., 2024). I also learned that my models for operation can and will change frequently, and that is okay (Mehlenbeck et al., 2024). Furthermore, and perhaps most importantly, I was rejuvenated and ready to press on (funny how this line of work can lead to burnout so quickly). I returned from the conference and was inspired to reach out to the site *just one more time*. Lo and behold, we were back on. I created a proposal of the services we offer, which included how our services could address the needs of our community in a way that aligned with the funder's mission. After the review and approval from university stakeholders, we agreed that the grant agency would pay for St. Louis City residents of all ages to receive psychological evaluations through our clinic at no cost to the client. We received funding to provide up to $115,000 worth of assessments for this first year (a number I had to talk *down* because of our scope!). I then identified clinical psychologists who would be willing to supervise these assessments and created six assessment practicum positions within the clinic for our students. The project is now underway! Students are increasing their total number of integrated evaluations while receiving quality training in assessment—all while providing much-needed services for free to our community.

But Wait, That's Not All!

Another area of concern was identified in our clinic review. As part of our mission, we offered free therapy and assessments to all university students, yet as the need for mental health services continued to rise (Abrams, 2022; Kim et al., 2022), so did our number of pro bono cases. I knew this state of affairs was unsustainable, but I did not want to reduce free services to students. Equipped with information from the APTC conference about on-campus contracts (Bullet et al., 2024), I reached out to leadership in student development and shared our conundrum regarding the lack of sustainability of the current arrangement as well as a proposed solution (aka, they give us money). A key point was that our clinic had modeled our free services after our university counseling center; however, the counseling center receives funding from undergraduate tuition as part of student health fees, while our clinic does not. The university was willing to hear this and ultimately found a private donor to pay for student therapy and assessment services. This is a semester-by-semester agreement, and I do not know for certain that it will continue in the long term.However, what I do know is that I will keep asking questions and advocating for our clinic, clients, and community.

Results

Our clinic is thriving again, and its energy is reminiscent of a pre-COVID time. We are now a core training site for psychological assessments, and our assessment productivity is projected to nearly triple this year compared to last year. The clinic has generated revenue to meet the demands of our program: we have reinstated student stipends and we can now purchase needed materials (such as that $60 book!). We also have enough funds to pay adjunct professors to cover student supervision between semesters, which gives our core clinical faculty a much-needed break.

Student Perspective

For the students who did not know this program prior to the COVID-19 pandemic, it was challenging to comprehend what a fully and effectively functioning clinic looked like. Not only did this compound the stress of completing a clinical doctoral degree, but the inconsistent policies and procedures and lack of funding also fostered frustration, discontent, and poor accountability. When the state of the clinic finances was reviewed during a program meeting, students felt little agency to make meaningful changes. However, students had high hopes for the new clinic director and were willing to trust her lead, even if just a little bit. As the director's enthusiasm grew, so did that of the students, and many have demonstrated an openness to trying new ways of boosting productivity and efficiency. These changes have sometimes been challenging for some students, particularly those who have been in the program the longest and have thus had the least structure. Still, students acknowledge the necessity for change and continue participating actively in this process by offering suggestions and solutions to the long-standing problems they know so intimately. As the clinic has stabilized, the students' trust in and excitement for the process has followed suit. They are expressing growing interest in funded practicum placements through the clinic, increasing the breadth and depth of their assessment training, and committing to fidelity to clinic policy. Not only has this response allowed the vision of the clinic director to unfold effectively, but it has also boosted morale and responsibility among the students.

Lessons Learned & Future Directions

I have made some mistakes along the way, including too many changes too quickly. I am used to working in a silo. Working in academia, where changes occur slowly and decisions are almost always a collective endeavor, was a new *opportunity* for me. Managing my expectations regarding my timeline versus reality is also a constant growth area, as is being open to being wrong. I suppose growth takes time, but I know I have colleagues across the country for support and that I am not alone in this very niche (and misunderstood) role. Perhaps most importantly, I have learned to be flexible, not to give up when things do not look promising, to be creative, and to ask for help. I am grateful for the inspiration and support APTC has provided me and our clinic; we have built up resources to move beyond surviving to thriving, and we are indeed arguably as resilient as ever.

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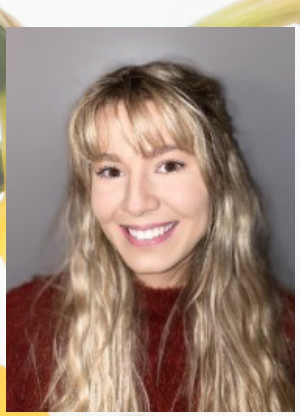
Building Resilience to Clinical Work:

Practical Tips for First-Time Practicum Students

Deanna Barthlow-Potkanowicz, Ph.D, HSPP
and Taylor Fox, M.S.
Indiana University-Indianapolis

Deanna Barthlow-Potkanowicz, Ph.D, HSPP



Taylor Fox, M.S.

When a graduate student begins clinical work, it is both an exciting and a daunting time. Trainees experience several types of stressors as they begin to conduct therapy sessions and manage a client caseload. Some of those stressors relate to self-efficacy and confidence in their abilities as a clinician (Flasch et al., 2016). Others relate to having the required knowledge to conduct intake interviews, create treatment plans, or choose interventions. Additional stressors are more interpersonal in nature, such as maintaining boundaries with clients, conducting oneself in a professional manner, and being present in one's clinical work while navigating stressors in other areas of life. Galvin and Smith (2017) identified themes in the stressors reported by clinical psychology doctoral students, such as feeling unprepared when they first start seeing clients, putting more work on themselves to prepare for client sessions to compensate for their perceived lack of experience, and comparing their competence level to that of other trainees. Skovholt and Rønnestad (2003) noted that trainees might overestimate their ability to generate change in clients or struggle with the contradiction that their academic success in a classroom might not directly translate into being an effective clinician.

There is some recent research available on self-care and even burn-out in psychology trainees (e.g., Seabrook, 2022; Beks & Doucet, 2020), and there has been some effort to identify interventions such as ACT to help reduce stress in therapist trainees (Stafford-Brown & Pakenham, 2012). However, there remains a lack of literature providing trainees with direct, practical strategies for coping with the stress of acclimating to clinical work. The purpose of this article is to provide clinical supervisors with tips they can offer to first-time practicum students for building up resilience to the pressures of clinical work. The goal is to provide ideas that are often learned through time, practice, and experience.

Getting Acclimated

1. Ask questions and seek support from your clinical supervisor and from advanced students who have already been through your current stage of training. Check in with fellow students to see what challenges they have encountered and to brainstorm solutions or coping strategies.
2. Trust the process: Advanced practicum students often say that feeling comfortable engaging in clinical work is something that "just happens" over time. The direct contact hours will gradually accumulate, you will learn the needed skills, and tasks will come to you more easily through repeated practice.
3. Keep in mind that everything takes longer in the beginning. You are learning how to write documents such as intake reports and progress notes, and it is normal to dedicate more time at first. For example, writing a progress note might take thirty minutes at first as you decide what is important to include, but later can take as few as five to ten minutes.

Managing Feelings of Being Overwhelmed

1. Practice compartmentalization. When you are at practicum, focus on your clinical work and responsibilities, and when you are not at your practicum site, focus on the other equally important requirements of your graduate program.
2. If possible, do not schedule multiple clients back-to-back in your first practicum experience. Give yourself time to adjust to the fatigue of seeing several clients in a row.
3. Consider speaking with your thesis/dissertation advisor if you find that adding clinical work is leading to you falling behind in other program responsibilities.
4. Do not feel pressured to immediately know everything or be perfect at every task at the start of practicum work. Do not apologize for being in this training stage of your career.
5. Allow yourself flexibility in your therapy approach. There is not just one version of a "good" or "right" therapist. Although evidence-based care is obviously important, a clinician can also incorporate their own unique experiences, personality, and perspective. Therapy is still both an art and a science.

Note-Writing

1. Write four to five key ideas as bullet points during a therapy session that can be used later as a framework to write the progress note more quickly. Writing down several key ideas will "jog your memory" later and also serve as a way to "offload working memory" during the session.
2. When you have several individual therapy appointments scheduled on the same day, try to start writing a progress note in the time between appointments. Even if you do not finish the note, it is less overwhelming later to finish notes that are already partially completed.
3. Talk with your supervisor about how long various notes typically take to write, and if you seem to be taking significantly longer than that, use a timer to see how long you are needing to complete each type of note.
4. When setting aside a long block of time to write multiple notes, use a timer to limit yourself to a certain amount of time spent on writing each note.
5. Consider scheduling an appointment with yourself on your daily calendar to spend one hour writing notes. Keep that appointment.
6. Alternatively, depending on the number of clients on your caseload, commit to writing a minimum number of progress notes per day (e.g., two notes per day) to divide the work into manageable chunks and to avoid procrastination and falling behind.

Time Management

1. For those trainees who video-record sessions for supervisors to watch later: choose clips to show in supervision meetings, preferably by the end of the day in which the therapy session occurred so that you do not spend extra time days later trying to remember with what session you need the most help.
2. Log your clinical hours (e.g., Time2Track software) at the end of every practicum day so that you do not fall behind.
3. When possible, give yourself time between client appointments to prepare. When you first start seeing clients, arrive at the appointment 10-15 minutes in advance to allow time to center yourself and gather materials.

4. For practicum sites at department training clinics, when possible, schedule buffer time between other meetings and client appointments. For example, try not to schedule an 11 a.m. client if you are coming from a 10 a.m. research lab meeting.
5. Prepare for a testing appointment the day before. Check to make sure all needed testing materials are available. On the day of the testing, arrive 20-30 minutes early to allow time to get all the materials set up at a calm and relaxed pace.

Self-Care

1. If you tend to be more introverted, plan on feeling exhausted at the end of a day when you first start seeing clients. Assume you might be too tired to work on writing/research projects or even for socializing with friends until you start to build up a resilience to engaging in direct clinical work for several hours a day.
2. If you are at a practicum site for a full work-day, take a quick walk within or outside the building between client appointments to reset.
3. Take a meal for lunch/dinner, or if you are on-the-go most of the practicum day, take foods that do not need to be reheated and that can be easily eaten across several sittings!
4. When balancing clinical work with other responsibilities, be mindful of your schedule and bandwidth, and account for the unexpected. For example, when out of town for a conference or personal travel, avoid scheduling a client appointment early on your first day back to the clinic to give yourself sufficient time to adjust from travel and in the event of unexpected travel delays.

Conclusion

Starting clinical work is an exciting time for a graduate student. But, there are also challenges that are not always directly addressed in a practical way. Students usually add clinical work as another element to their training without taking away other responsibilities already in place, like classes, research, and graduate assistantship tasks. Clinical work is a challenge to a trainee's actual available time as well as to their emotional resources and ability to manage stress. While the focus of preparation for clinical work is often on ethics, treatment interventions, and theoretical orientations, it is also important to help trainees adapt to the everyday challenges of a new type of work. The authors hope the ideas presented in this article can be a helpful starting point for a conversation between supervisor and supervisee.

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Darlene Ngo, M.S.

Hannah Hwang, M.Ed., M.S.

Jennifer Schwartz, Ph.D.

Opting In

Client-Clinician Matching in Doctoral Psychology Training Clinics

Darlene Ngo, M.S., Hannah Hwang, M.Ed., M.S., and Jennifer Schwartz, Ph.D.
University of North Texas

Consideration of client preferences has been known to be part of evidence-based practice (APA, 2006), as doing so tends to be associated with reduced attrition and increased positive outcomes (Swift et al., 2018). However, training clinics have the difficult task of meeting client needs without sacrificing the quality of clinical training. The literature provides support for matched dyads in therapy in terms of increased therapeutic alliance (Chao et al., 2012), but whether client-clinician matching improves treatment (e.g., Cabral & Smith, 2011; Erdur et al., 2003; Smith & Trimble, 2016) or even training outcomes is a topic of debate. At the University of North Texas Psychology Clinic (UNTPC), the discussion surrounding if and how to best implement therapeutic matching while prioritizing the training needs of our student clinicians has been ongoing. In our clinic, Clinical and Counseling Psychology doctoral students provide outpatient therapy and assessment services to a diverse adult population. The current article will weigh the benefits and costs of therapeutic client-clinician matching based on identities (e.g., racial/ethnic, religious, sexual orientation) in the context of training clinics.

One argument for implementing client-clinician matching is that an increase in therapeutic alliance improves therapy attendance, thereby bolstering both training and treatment. As ethnoracial match has been associated with improved attendance by Black, Hispanic, and American Indian/Alaska Native clients (Joiner et al., 2022), increasing therapeutic alliance and therapy attendance, especially in racial/ethnic minority (REM) clients, is a promising approach to addressing disparities in mental healthcare. Furthermore, this approach may motivate training programs and clinics to increase the diversity of trainees.

Another reason for client-clinician matching is a sense of increased empathy and decreased judgment because of the client and clinician's shared background or experiences. Matching can lead to an opportunity for advocacy:

> "I think that client-clinician matching not only offers the option for clients to choose a clinician who matches a specific identity of the client and offers a unique connection, but it also provides an opportunity for clinicians to serve their own community while in training."
>
> —Second-year Counseling Psychology student

> "I think clinician-client matching can be helpful in building rapport by having someone with similar lived experiences, but I also think being matched with a clinician of a different background can also lead to good insights on both parties."
>
> —Second-year Counseling Psychology student

Still, despite literature on racial/ethnic, religious/spiritual (R/S), and gender matching providing inconsistent or null findings on treatment outcomes (Blow et al., 2007; Cummings et al., 2014; Dimmick, 2022; Schmalbach et al., 2022), trainees may find that working with R/S and gender-matched clients is rewarding outside of measurable treatment or training outcomes.

> "To be honest, I don't really have that many thoughts about it. I feel like when I notice it the most is when I get a new client, and I see on their intake if they had some sort of preference for a clinician. For most of mine, I'll notice it states, 'I want to work with an Asian therapist,' or 'I want to work with someone who also identifies as a woman.' Then, I'll usually bring that up in my intake to understand why and how that match was important to them. But usually, I am pretty satisfied with any of the matches I get with any of my clients."
>
> —Third-year Clinical Psychology student

Lastly, therapeutic matching reflects and prepares trainees for "real world" circumstances (e.g., in private practice), where clients often seek out therapists to suit their needs and preferences. Trainees may also utilize matching to diversify their practicum experience where needed.

> "As clinicians-in-training, it is important for us to work with people that we will work with when we are professionals. However, as trainees, we currently have the additional support to work with identities that we don't have a lot of experience with and learn from these moments. Matching is beneficial for both clients and clinicians, but clinicians need to be able to work with a diverse clientele as well. My only concern about matching is oversaturation. For instance, if a clinician hold[s] an identity that other clinicians may not share or want to disclose, that clinician will lose the opportunity to work with a more diverse clientele just because of the ratio of matches with clients."
>
> —Third-year Counseling Psychology student

Those against client-clinician matching may argue that the practice is detrimental to training by decreasing the diversity (both in client background and presenting concern) of trainees' caseloads, which is especially pertinent for those who plan to enter institutions (e.g., VAs, hospitals, correctional settings) without this practice.

> "[I am] not a huge proponent for this because I feel like it's difficult to get/keep clients, and I don't want my client pool to dwindle if I don't match their criteria... even though I try or am trained to be open and capable of helping anyone who walks through our doors...many of us do not get to choose [our clients] so this is good exposure. I also think it takes an opportunity away from the client because although we don't match, we can still offer insight they may have never thought about."
>
> —Second-year Clinical Psychology student

The feasibility of client-clinician matching has also been debated (Ertl et al., 2019) as the demographic makeup of clinicians in training settings may not be conducive to therapeutic matching (Callahan et al., 2018). For example, survey responses from substance use disorder (SUD) treatment centers across the country suggest that even when there is potential for a client and clinician to be racially/ethnically matched, it is not done as often. Instead, most supervisors from these centers prioritized culturally sensitive treatment practices over matching (Steinfeldt et al., 2020). Matching may even be counterproductive, as microaggressions from a racially/ethnically matched clinician can have a stronger negative impact (Hook et al., 2016), and clients of racial/ethnic minority identities tend to prefer therapists with culturally responsive training/treatment approaches over just racial/ethnic matching (Swift et al., 2015). A proposed solution is to increase multicultural competence among all clinicians (Hook et al., 2016), which would benefit trainees preparing for a career in any institution and is a central component of competent psychological training/practice (APA, 2017).

Lastly, several ethical issues are related to therapeutic matching, especially in a training clinic context. Trainees may feel pressured or concerned about disclosing more marginalized identities in a context where there are clear power differentials (e.g., supervisors, clinic directors). Similarly, trainees may struggle with the boundaries of self-disclosure to their superiors and/or clients, especially when already matched with a client. Other ethical consid-

erations when working with demographically similar clients (Raja, 2016) include potential for transference or countertransference, increased presumptiveness (e.g., assumed similarity; Cabral & Smith, 2011), or even over-emphasizing the role of this identity in the client's life and the treatment environment.

We proposed the use of an "opt-in" model to address client-clinician matching practices in a diverse training clinic. This method allows trainees to customize their training and practicum therapy caseloads to their career goals. Two graduate student representatives (GSRs, one from each program) collaborated to create a Qualtrics demographics survey. This survey required students to opt-out or opt-in and self-disclose for each identity they would like to be used for client-matching. The identities included were race, ethnicity, sexual orientation, gender, languages spoken (fluently), religion, and military service/background. For example, a student may choose to self-disclose their gender and race/ethnicity but not their sexual orientation. Students are also given a short answer text box for each item to elaborate if necessary. Information from the Qualtrics survey is only accessible by the training clinic director and clinic office staff and will be used only in case assignments. This survey is always open throughout the year: in the case that the trainee changes their mind about their self-disclosure (or lack thereof), they may update their responses. Trainees may also feel hesitant about the impact of therapeutic matching on therapeutic or training outcomes. As a result, the GSRs conducted a brief literature review on these topics and included several articles for further reading at the end of the survey's instructions.

> "As long as clinician identities are collected in a confidential manner and not in an unnecessary way, I think matching can be helpful. Special consideration does need to be made when inquiring about non-salient and hidden identities for the protection of the clinician."
>
> —Third-year Counseling Psychology student

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ENHANCING CLINICAL PRACTICE THROUGH INTEGRATION OF DIGITAL ASSESSMENT

Kacey Gilbert, Ph.D. and Braden Calvin, M.S.
Oklahoma State University

Kacey Gilbert, Ph.D.

Braden Calvin, M.S.

Technology has become an integral part of our daily lives. Psychologists are encouraged to integrate technology into their training and practice to connect and engage with clients more efficiently and more effectively. Innovations such as mood trackers and teletherapy have emerged to facilitate this and have been readily embraced. However, the development and integration of digital platforms for administering assessments has progressed slowly, primarily due to cost and the lack of independent research on new platforms (Benson et al., 2019; Boake, 2002; Clark et al., 2017). Digital assessment formats have been a part of psychology for several years, yet their integration into daily practice has remained limited. A study by Benson et al. (2019) revealed that an increasing number of psychologists are using software to enhance assessment and service delivery for clients. Psychologists rarely use technology to administer assessments; instead, they largely reserve it for scoring assessments, administration, and rating scales (Benson et al., 2019). By embracing technological advancements in assessment, we can improve the efficiency of our practices, reach remote clients, and ensure that our trainees are receiving education in the most up-to-date practices. Before this can be done, psychologists must consider the benefits, disadvantages, and costs of implementing such practices.

Benefits of digital test administration

There are numerous benefits to the digital administration of many assessments. Wahlstrom et al. (2016) highlight several advantages of the digital platform, including enhanced examinee engagement, automated administration rules (such as reversal and discontinue rules), score calculations, a built-in timer, a microphone for recording responses, and the ability to write answers directly on the tablet. Additional benefits include a reduction in administration errors, immediate scoring, portability, and improved visual presentation (Corcoran, 2022; Kaufman et al., 2016). Digital administration enhances the testing process's reliability, standardization, and objectivity (Butcher, 1987). Moreover, Hays and McCallum (2005) point out that the popularity of digital test administration has increased in mental health settings due to its speed, lower costs, and greater accuracy. Overall, these advantages enhance the efficiency and accuracy of test administration.

Disadvantages of test administration

While digital administration offers several advantages, there are also important factors to consider. Limitations of digital administration include a lack of individualized context and reduced communication and

rapport between the examiner and examinee (Pade, 2016). Utilization of a digital platform requires specific technological skills and access to the necessary tools. Unfortunately, few training programs currently prepare future school psychologists for these practices (Clark et al., 2017). Additionally, there are ethical responsibilities to consider when conducting digital assessments, as data misuse can occur in any setting and may be more prevalent with digital formats. An independent study conducted by Gilbert et al. (2021) found that there was a lack of equivalency between traditional and digital test formats. Lastly, careful interpretation of the results is crucial. Butcher (2013) notes that computer-generated scores can lead to erroneous results; therefore, it is advisable to combine clinical judgment with computer-generated reports when making clinical decisions rather than relying solely on the latter (Weiner & Greene, 2007).

Funding opportunities for digital assessment integration

As noted, one disadvantage of digital administration is the additional training and costs associated with new practices. Many psychologists have successfully found financial assistance as they move toward adopting digital assessments. First, many universities offer internal grants to support students' training and education, specific to integrating new technology. Our clinic successfully obtained an internal technology grant that funded the purchase of several iPads and test administrations. It was imperative to make a case for the innovation of such practices in our field, the importance of preparing our students to use such measures, and the improved quality of assessment services provided to the community as a whole. Universities often have other competitive funding opportunities that directors can explore specific to certain populations, such as underserved clients, women, and rural communities. An additional resource can be testing companies themselves. Pearson Inc. and the Woodcock Institute have annual calls for research proposals that include funding for technology and test administrations. These research calls can be an ideal way to integrate research and funding into a training clinic. Finally, if graduate students work in the training clinic and are affiliated with a course, there may be purchase discounts available through testing companies.

Conclusion

The integration of technology into psychological assessments is undoubtedly the future of the field. We encourage clinics and psychologists to adopt these advancements. Beyond simplifying administration and scoring as well as reducing errors, digital assessments offer additional benefits like enhanced examinee engagement and motivation. Additionally, it is essential to critically evaluate the available research before incorporating new technologies to ensure the delivery of well-supported, evidence-based services to clients. Finally, because implementing new practices can be time-consuming and costly, it is important to seek opportunities both within and outside your institution for financial and training support.

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HABLO ESPAÑOL PERO...

More ethical considerations for providing Spanish-language services in a monolingual clinic

Jessica M. Garcia, M.A., Emily Badillo-Winard, M.A., Ilana S. Berman, Ph.D.
University of North Carolina-Greensboro

Jessica M. Garcia, M.A.

Emily Badillo-Winard, M.A.

Ilana S. Berman, Ph.D.

Spanish-speaking trainees are often eager to gain experience conducting therapy in Spanish with clients from Hispanic/Latinx populations. Given population-level vulnerabilities resulting from marginalization, Latinx individuals experience significant disparities in seeking mental health care (Gearing et al., 2022). They may seek care support from community-based clinics offering reduced fees, such as a university-based training clinic. Per psychologists' ethical mandate to serve the public and do no harm (i.e., beneficence and non-maleficence) and the training responsibility of a graduate school program, it is important to carefully consider the welfare of the individuals we serve and graduate students. Specifically, training clinics with Spanish-speaking students but no Spanish-speaking supervisors have unique considerations in assessing students' language competency, both student and supervisors' cultural competence and humility, and students' budding clinical expertise.

Inspired by a recent APTC article (Ramos, 2023), we describe how our community-based psychology training clinic, which offers evidenced-based therapies to diverse community members, including monolingual Spanish speakers, has responded to the challenge of having primarily monolingual English-speaking supervisors in various ways over time. To amplify the voices of graduate student clinicians and contextualize our recommendations, two advanced Spanish-speaking graduate students share diverse perspectives on their unique experiences in this domain.

As an immigrant with monolingual-Spanish speaking parents (Jess, fifth-year graduate student) and a second-generation individual raised in a bilingual, Spanish-speaking household (Emily, fourth-year graduate student), we are both familiar with the barriers Spanish speakers face navigating unfamiliar and complex healthcare settings. Therefore, we are passionate about reducing barriers to care and providing Spanish speakers with quality mental health services. Jess, while recalling her experiences, wrote:

> For me, graduate school has been a series of exposures, and my experience conducting therapy in Spanish has been no exception. My first Spanish-speaking therapy experience occurred during my first practicum year in the clinic (second year in the program) after receiving an email from a faculty member who thought I could be a good fit for working with this family. My supervisor at the time only spoke English and engaged me in a thoughtful conversation regarding the nuances of taking on this case, assuring me I would not have to if I didn't feel comfortable.

I made the values-aligned decision to accept the request, which was actually for two young brothers (ages 4 and 7) experiencing immigration-related PTSD symptoms. As a new clinician, I consulted with a trauma expert, who provided guidance on structuring therapy sessions based on the family's needs, including logistical and cultural considerations. It was challenging to be learning both skill sets simultaneously: how to work with young children and their family following trauma, and how to facilitate sessions in Spanish.

When changing supervisors at the end of the term, I was fortunate to be paired with the only Latina supervisor in the program (at the time). Working with a Spanish-speaking Latina supervisor meant that we conducted supervision in Spanish, which further aided my acquisition of psychology-specific vocabulary and allowed me to engage in role plays, thereby strengthening my skills and confidence. This allowed me to progress up the exposure ladder to work with several monolingual Spanish-speaking clients under the supervision of a monolingual English-speaking supervisor.

I'm grateful that my program facilitated these experiences, as working with these clients has been a highlight in my training experience. It is also important to note that I simultaneously navigated the well-documented challenges of other Spanish-speaking trainees (e.g., Lopez & Torres-Fernandez, 2019; Mezquita, 2020; Ramos, 2023; Verdinelli, 2009), such as increased labor demands and concerns about the quality of supervision (given some supervisors' inability to view/understand session recordings), considerations related to culture and diversity that could have been better addressed with a supervisor with a shared Latinx/Hispanic identity (e.g., how much of X behavior may be explained by my client's cultural upbringing and context?). Nonetheless, I consider my training experience worth the challenges.

The Latina supervisor mentioned above has since transitioned to another institution. For some time, the faculty supervisor team was only English speaking. Though some students have external placements working with multilingual populations and supervisors, clinic supervisors wrestled with providing similarly meaningful experiences in-house without the ability to review video recordings or facilitate Spanish role plays. Emily recalled:

My Spanish is more conversational than formal. Sometimes, I don't know how to say psychological terms in Spanish (¿cómo se dice "cognitions"?). As I started in our clinic, I heard advanced students discussing the extra time they spent preparing for Spanish-speaking clients. Without Spanish-speaking supervisors, they independently studied new therapeutic concepts to ensure they understood them well enough in English and had the vocabulary to deliver them in Spanish.

When asked if I wanted to see Spanish-speaking clients in the clinic, it felt like a choice between spending extra time working to take on Spanish-speaking clients with an English-speaking supervisor (forgoing research and homework time) or spending time getting more comfortable conducting therapy in English and delay this important goal (and my ability to serve these populations) until I have "more time" (after completing program milestones) to devote to this endeavor. I chose to wait; however, that choice soon felt artificial.

When assigned my first monolingual Spanish-speaking client, I introduced myself in English using an interpreter. Maybe it was the way I'd nod or react to their words before the interpreter spoke that gave away that I understood them. The client directly asked me if I spoke Spanish. I hesitated and said (in Spanish), "Yes, I understand," and immediately, I sensed a shift in their demeanor. They expressed feeling relieved to have a provider who could understand them! With the interpreter in the room, I also felt a sense of relief. When I felt like a 'no sabo kid' I had someone in the room I could ask for interpreting help; it felt like learning to ride a bike with training wheels. But suddenly I was in uncharted territory; was this allowed? (Spoiler: yes) This wasn't covered in our interpreter training.

I still haven't had a Spanish-speaking supervisor, but the experiences I've gained working with interpreters have helped me feel more confident in my abilities to independently see Spanish-speaking clients in the future.
Perhaps other students in my situation could walk this "middle path" to working with Spanish-speaking clients as new trainees without having to learn it all at once. It feels selfish at times to use resources to hire an interpreter when I can generally understand my clients, but I'm learning

to reframe: to acknowledge and embrace that this provides a role for those of us who are ni de aquí, ni de allá (from neither here nor there) to scaffold our experiences as budding clinicians.

These examples illustrate two unique challenges multilingual students face: attempting to learn clinical skills in multiple languages when formal instruction is only provided in English and increasing confidence in professional Spanish language skills. While we highly recommend that graduate student clinicians pursuing Spanish therapy provision be paired with a Spanish-speaking supervisor, this option may not be available in all training programs, as there are approximately twice as many Hispanic trainees (11-12%; Assefa et al., 2023) as there are psychology faculty (5%; Bischel et al., 2019).

In response to these and other student experiences in our program, clinic supervisors have since decided that unless paired with a Spanish-speaking supervisor, junior students should focus on learning their fundamental clinical skills and must wait until their "Advanced Practicum" rotation (generally 3rd year of clinic experience, 4th year in the program) to conduct therapy directly in Spanish. Further, we have increased access to Spanish-language materials (e.g., manuals, handouts, articles) for clinician and client use. When conducting therapy in Spanish with a supervisor who does not speak the language, we echo recommendations to seek consultation with Spanish-speaking mental health providers, as this reduces the demand that the student clinician act as a "cultural broker" for the supervisor.

Beyond the need for consent forms professionally translated into Spanish, our clinic also navigated logistical complications when our bilingual Billing Coordinator resigned, as the candidates most qualified for this position did not speak Spanish. Until we could recruit and onboard the next cohort of bilingual undergraduate students for support, our clinic occasionally relied on Spanish-speaking graduate students (an admittedly unfair burden) to assist with administrative tasks, including initial client phone calls and emails. We have also attempted to make the clinic space more welcoming for Spanish-speaking clients by recruiting Spanish-speaking undergraduate support staff for our front desk and updating building signage and waiting room materials to be bilingual.

We strongly advocate for identifying Spanish-speaking supervisors to support trainees as they learn to provide therapy in Spanish. When this is not possible, training clinics have the responsibility to balance the referral of clients to Spanish-speaking community providers (services that may come with a higher cost, longer waitlist, or less emphasis on high-quality, evidence-based practices) with the opportunity to provide trainees with valuable experiences, in exchange for the additional burden of independent study to fill the gaps.

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How Are You, Really?

Addressing Psychology Graduate Student Wellness in a Practicum Course

Adrienne J. Means-Christensen, Ph.D.
Virginia Tech University

Research consistently indicates that psychology graduate students suffer from stress, burnout, and imposter syndrome at relatively high rates (e.g., El-Ghoroury et al., 2012; Rico & Bunge, 2021). The American Psychological Association's (APA) *Guidelines for the Equitable and Respectful Treatment of Students in Graduate Psychology Programs* emphasize the need for graduate programs to attend to graduate student wellness in all its forms: psychological, physical, and financial (APA, 2023). Beyond graduate student wellness, the APA ethics code (APA, 2017) highlights the importance of being aware of and addressing the impact of "personal problems" (p.5) on psychologists' work. As such, APA-accredited programs have a mandate to support the health and wellness of graduate students and assist them in mitigating the impact of wellness issues on their work-related activities (APA, 2017; APA, 2023).

As a rigorous clinical science program at an R1 university, Virginia Tech confronts graduate student stress and the accompanying low morale on a regular basis. Although our program has not collected data about students' psychological well-being in the past, we anecdotally notice periodic decreases in morale and increases in students' reports of dissatisfaction. APA's guidelines suggest that faculty can make a difference in students' wellness by cultivating a "graduate education experience that is positive and enriching" (APA, 2023). Our program and others (e.g., Rosenbaum 2024) have recognized that this must be done while ethically preparing our students for their profession, which precludes the relaxation of training standards.

To address these issues, our practicum training team enacted several strategies to acknowledge student stressors and support coping. Two relatively simple methods that our program enacted were (1) "the check-in" and (2) self-care accountability. Neither of these strategies addresses the issues underlying student distress (e.g., workload, research expectations, anxiety associated with early clinical work). Still, both presented opportunities to understand students' experiences and encourage balance in the students' lives.

Our first method of acknowledging student stressors, "the check-in," involves asking our graduate students to describe and rate (using a 1-10 scale) their current emotional functioning during weekly group supervision meetings. We simply asked, "How are you?" and expected and encouraged an honest response that was met with support and interest. In answering the question, students decide their own level of comfort with self-disclosure and share as little or as much as they choose. The goal of the check-in is threefold. First, the question is meant to encourage self-reflection. Knowing whether one is psychologically doing well or poorly is essential to making determinations about whether and how to engage in work-related, particularly clinical, activities. Second, the goal of asking students to discuss their well-being in a group format is intended to enhance social support. Norms are powerful forces (e.g., Gross & Vostroknutov, 2022), and if a student believes that they are the only one who is struggling or experiencing stress, it follows that they would be more likely to experience imposter syndrome or another form of negative self-judgment. Relatedly, the third goal of the check-in is to normalize the experience of stress in a demanding graduate program so that the experience of stress does not feel "wrong" and is framed as something to work with and not avoid.

The weekly check-in ratings were tracked, and data were presented to students during the spring semester so that they were aware of the trends. The check-in data were also presented to the clinical faculty so they were aware of the program climate and trends. Practicum supervisors decided not to intervene when students' ratings were quite low but to watch the trends and intervene only if a particular student reported extremely low ratings week after week, which did not occur.

Table 1

Graduate Student and Supervisor Check-In Ratings

	Fall 2023 Semester			Spring Semester 2024			Academic Year 23-24		
Participants	*n*	Mean (*SD*)	Range	*n*	Mean(*SD*)	Range	*n*	Mean(*SD*)	Range
2nd Year Students	5	5.63 (1.96)	1-9	5	6.36 (1.64)	2-9	5	6.09 (1.80)	2-9
4th Year Students	4	6.01 (1.69)	1-8.5	4	6.81 (1.29)	3.5-9	4	6.43 (1.53)	1-9
Supervisors	2	6.71 (1.36)	4-8	2	7.08 (1.00)	5-8.5	2	6.91 (1.76)	4-8.5
Total	11	6.11 (1.77)	1-9	11	6.75 (1.43)	2-9	11	6.48 (1.62)	1-9

Note: Check-ins are answers to the question "How are you?" rated on a 1-10 scale, with 10 being best.

The second method of acknowledging student stressors emphasized the benefits of engaging in wellness strategies (e.g., Myers et al., 2012). This method offered students an opportunity to attend to and be held accountable for self-care. Self-care accountability involved graduate students and faculty making public commitments to weekly self-care goals. Using a shared spreadsheet, students voluntarily identified one or two weekly self-care goals. Typical examples were engaging in exercise, leisure activities (watching a movie or sporting event or doing a craft), or food preparation on the weekend. The goal achievement was tracked on the spreadsheet, and students earned a weekly token if they met their goal. Twice each semester, the tokens were placed into a drawing for gift cards that could be used for treats or further self-care.

Check-ins were implemented in the fall semester, and self-care accountability started in the spring. As can be seen in Table 1, students' ratings were relatively higher during the spring semester than during the fall semester, although no statistical analyses were completed due to sample size. Students' ratings were more variable than supervisor ratings, particularly on the lower end. Supervisors pointed to the trends and range as encouragement, particularly for the second-year students (i.e., it does get better). Reports from graduate students indicated that they liked both strategies.

As a result of these experiences, our faculty concluded that attending to student wellness can be done using relatively simple strategies. When students feel understood and supported, and their efforts toward self-care are encouraged, they may feel better overall. There were several limitations in this program, most notably the anecdotal and correlational nature of the endeavor. In the future, our program plans to replicate and systematize some of these strategies in order to be able to make stronger conclusions about the impacts of these programs.

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Breaking Barriers:
Women of Color as Student Directors

Xiaoying Guo, M.A, M.S. and Scott Gustafson, Ph.D.
Florida Institute of Technology

Introduction

Leadership involves using power and authority to influence others (Yukl, 2009). Women earn 58% of Master's degrees and hold more than 50% of the managerial and professional positions in the United States workforce. However, they occupy 16.4% of corporate officer roles and 2.0% of CEO positions in major companies (Prime, Carter & Welbourne, 2009; Catalyst, 2007). Although slight progress has been made over the past decade, with women now occupying 32% of global leadership roles, their representation remains low, particularly in STEM fields where women hold only 12% of senior positions. These persistent disparities highlight ongoing structural barriers, such as gender biases and stereotypes, that continue to impede women's advancement in leadership roles (World Economic Forum, 2023; Meza-Mejia et al., 2023).

However, for women of color, these numbers are more limited due to intersectional barriers involving gender and race. They face compounded challenges from underrepresentation, stereotyping, and a lack of access to key networks, which makes their journey to leadership more difficult (Sanchez-Hucles & Davis, 2010). These challenges demand targeted strategies to support their advancement and success in leadership roles.

Xiaoying Guo, M.A, M.S.

Scott Gustafson, Ph.D., ABPP

Challenges

The mechanism behind women being underrepresented in leadership can be partially explained by examining the challenges to entry. Eagly and Carli (2007) highlight the gender bias that favors men as natural leaders due to assertive masculine traits, while women are often perceived as less suitable for leadership because of their association with traits like compassion and a more relational approach (Prime, Carter, and cWelbourne, 2009). In their study, Prime et al. (2009) found that senior managers perceived women as excelling in "caretaking" leadership behaviors, such as supporting and mentoring others. However, they rated men higher in "take-charge" behaviors, like delegating and problem-solving.

For women of color, these challenges are even more complex. Sanchez-Hucles and Davis (2010) highlight the underrepresentation of women of color in leadership roles due to multiple factors, including ethnosexual stereotypes that portray them in narrow and often negative roles., Erving et al. (2024) discuss how Black women are socialized under the 'Superwoman Schema,' which pressures them to be strong, suppress emotions, resist vulnerability, succeed against the odds, and prioritize others over themselves. Additionally, women of color in leadership often face exclusion from informal networks, limiting their access to crucial mentoring and sponsorship opportunities necessary for career progression (Sanchez-Hucles & Davis, 2010). Communication style differences can lead to misinterpretation or devaluation, making it harder for women of color to be recognized as effective leaders. Nirmul, Cabrejo, and Smith (2023) identify four key patterns in the leadership experiences of women of color: the necessity of early access to leadership opportunities, the critical role of mentorship and sponsorship, the importance of

visibility, and the struggle to persevere. Despite these barriers, even when opportunities do arise, women of color often face exclusion, marginalization, and a lack of recognition for their achievements, all of which harm both individuals and the broader profession.

Personal Journey

As a woman of color serving as a student director in a clinical psychology program in the United States, I have encountered unique challenges that have significantly shaped my leadership journey. The lack of diversity within the program often leaves me feeling isolated and pressured to represent an entire demographic, which can be an overwhelming burden. This experience is consistent with the finding by Locke (2021), who noted that Latinx doctoral students in counseling programs often feel like they are representatives of their entire culture, leading to feelings of misunderstanding, invisibility, and marginalization. Similarly, Asian women often experience cultural pressures that emphasize humility and deferential communication styles, which can conflict with the assertive behaviors typically valued in leadership roles (Cho et al., 2017). This cultural dissonance often leaves Asian women feeling marginalized, misunderstood, and pressured to represent their entire demographic in predominantly Western environments. Access to leadership opportunities for women of color is not just about being given a chance—it is about being seen and valued in environments that often overlook them. As a result, I have had to create my own opportunities in an environment that was not originally designed to support me.

Balancing the assertiveness required for leadership with the humility valued in my culture presents an ongoing internal conflict for me. In traditional Chinese culture, humility is often seen as a key virtue, where maintaining harmony and deference to others is highly valued (Hwang, 1987). Assertiveness, on the other hand, can sometimes be viewed as disruptive, and for a Chinese woman in a leadership position, navigating these cultural expectations is particularly challenging. The pressure to assert oneself in a predominantly Western context, where assertiveness is often equated with competence and leadership, contrasts sharply with the cultural ideal of modesty and cooperation in Chinese culture (Li & Fisher, 2004).

The struggle is not merely theoretical; it is an emotional burden. I find myself walking a fine line between being authoritative enough to earn respect and collaborative enough to remain approachable, a balance complicated by my race and gender. Assertiveness, in my case, risks being misinterpreted as aggressiveness, while collaboration may be seen as a weakness, aligning with research showing that women of color often face harsher judgments in leadership roles due to societal stereotypes (Hooks, 1981). This ongoing challenge not only affects my professional identity but also constantly demands my emotional resilience as I navigate leadership spaces that were not designed with me in mind.

Strategies for Success

To address institutionalized discrimination, Okoro, Umaru, and Ray (2024) emphasize several key strategies for improving the representation and career advancement of women of color in healthcare professions. They highlight the importance of mentorship, particularly early in one's career, advocating for mentors who can provide support and recognize the specific challenges faced by women of color without suggesting that only mentors from the same background can be effective. The emphasis is on creating inclusive mentoring environments that understand and address the unique barriers women of color face while promoting diverse, supportive networks to foster their growth and advancement in the field. To create a supportive mentorship pipeline, clinic directors can facilitate this by establishing formal mentorship programs that pair early-career women with more senior professionals, especially those from diverse backgrounds. Additionally, early career education plays a crucial role in empowering women of color. Okoro, Umaru, and Ray (2024) recommend that healthcare institutions actively invest in leadership development programs designed specifically for underrepresented groups. For example, clinic directors can host workshops on leadership skills and provide career coaching opportunities to help women of color build the competencies and networks needed to advance their careers (Okoro et al., 2024).

Nirmul, Cabrejo, and Smith (2023) recommend creating an inclusive curriculum and developing models that support marginalized groups by incorporating case studies, role-playing scenarios, and workshops that address real-world examples of

biases in leadership. Clinic directors can take concrete steps by integrating training modules focused on mentorship skills, negotiation tactics, and conflict resolution tailored to diverse leadership dynamics. Additionally, implementing affinity groups or peer support networks within the clinic can provide a dedicated space for women of color to share experiences and access mutual support (Nirmul et al., 2023). These measures not only promote inclusivity but also actively target the systemic barriers that hinder the advancement of women of color in leadership roles.

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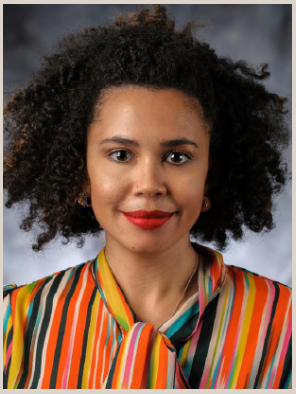
Cultivating Resilience and Inspiring Mental Fortitude:

Training Student Clinicians to Embrace Challenges and Recognize Their Assets



Miriam E. Thompson, Ph.D.
University of California, Santa Barbara

Introduction and History

Over the last ten years, there have been changes in the socio-academic landscape across U.S. colleges and universities (Lukianoff & Haidt, 2018). Historically, college students have vocalized their outrage about injustices and have exercised their right to protest (e.g., American college students protesting U.S. involvement in the Vietnam War). Recently though (and at greater frequency), students have insisted that colleges and universities make known their position regarding certain social, humanitarian, and geo-political issues (e.g., McKenzie, 2020; Institute for Humane Studies, 2020) in the form of public or discretionary statements. These statements are disseminated to acknowledge or decry major events such as mass shootings, public health emergencies, or the passing of controversial legislation. Additionally, students experiencing difficulty with viewpoint diversity have pressured university administration to disinvite controversial speakers (see Foundation for Individual Rights in Education, 2024) and have protested faculty who cover contentious topics in their classes (e.g., Blake, 2023). These few examples demonstrate some challenges students face, such as tolerating discomfort, engaging in binary thinking, difficulty with perspective taking, and reasoning with emotions.

The Issue

Most undergraduate and graduate students begin their educational journeys during a developmental stage that is often considered an extension of their adolescence (Sawyer et al., 2018). Although they are adults, many students look to colleges and universities as infallible surrogate parents and stewards of goodwill. This is certainly an esteemed position to be in, yet the expectation for colleges and universities is to provide students with a suitable learning environment where they can educate, train, and guide students as they complete their programs of study. Similarly, among psychology training clinic directors, our responsibility to our student clinicians is to create an environment that is conducive to their training, learning, and skill development.

As with colleges and universities, psychology training clinic directors can be vulnerable to scrutiny and criticism, particularly when they make mistakes (e.g., accidentally referring to a trainee by the wrong pronoun) or make decisions that students do not agree with (e.g., enforcing a late arrival policy). The issue of importance here is that we are faced with training an increasing number of students who have difficulty adapting to challenges and tolerating distress or discomfort. Moreover, considering

that psychology is one of the most popular fields of study among undergraduates (National Center for Education Statistics, 2023), understanding these recent trends in students' thinking is important for psychology training clinic directors because of the implications it may have on training future cohorts of student clinicians.

Lukianoff and Haidt (2018) frame these recent events through the lens of cognitive behavioral therapy. For reference, cognitive behavioral therapy is a well-researched, evidence-based treatment that helps clients transform ingrained, problematic, and irrational thought patterns into helpful, productive, and rational ways of thinking. Lukianoff and Haidt (2018) explain that some of these students unknowingly engage in a number of cognitive distortions (e.g., "labeling" or "blaming"), which prevent them from noticing nuances and important details. These cognitive distortions impact students' objectivity, meaning they draw conclusions without all of the facts.

The purpose of this article is to equip clinic directors with the tools needed to direct students toward a more pragmatic way of thinking. In the section to follow, there are four brief, realistic training clinic scenarios that cover the challenges some students face. Each scenario is accompanied by a reflection that navigates the issue delicately and thoughtfully.

Psychology Training Clinic Scenarios

Scenario 1. You are supervising Jordan, a graduate student clinician who has been providing psychotherapy to Chris, an adult client. Chris abruptly stops seeing Jordan for therapy after four sessions. Chris does not provide a reason for discontinuing and simply states that they no longer wish to continue therapy. As a result, Jordan gets upset and engages in *mind reading* by assuming that Chris ended therapy because of their ethnicity when, in fact, the reason for the client's termination is unknown.

Scenario 1 Reflection. This situation provides a great opportunity for training clinic directors to acknowledge Jordan's concerns (and convey their support for Jordan) while providing other common reasons for the client's abrupt termination. The clinic director could invite Jordan to consider common reasons clients abruptly terminate sessions, such as lack of progress, high effort required, cost, or time. These objective considerations would help Jordan to refrain from personalizing the experience.

Scenario 2. Haley, one of your graduate student clinicians, is about to conduct her very first therapy session. Following the completion of the therapy session, Haley realizes that she does not want to work with White clients, particularly White male clients, citing her own discomfort and animus as a person of color. Haley frequently makes *what-if* statements such as, "What if one of my White male clients makes an offensive remark?" or "What if I do not know how to engage the client in therapy?"

Scenario 2 Reflection. In this situation, the clinic director is encouraged to acknowledge Haley's discomfort and follow up about their animus toward White people. It would be helpful to remind Haley that our foremost objective as psychologists is to provide quality psychotherapeutic services to everyone, regardless of their background. All psychologists have beliefs, attitudes, and life experiences that shape us. However, to the best of our ability, we are to remain as objective as possible so that our biases (specifically, racial biases) do not hinder our ability to deliver services effectively (see Principle E. in the American Psychological Association Code of Ethics, 2017). Additionally, it would be helpful to share that through the training process, trainees will be exposed to individuals from different backgrounds, which provides us an opportunity to learn from individuals, particularly those we have preconceived notions. Hopefully, this explanation would garner more openness from the student clinician. If not, Haley should continue to be closely supervised to ensure that their position does not interfere with their ability to deliver quality therapeutic services to this client.

Scenario 3. Different political views. After five individual counseling sessions, Ethan's therapy client, Shannon, shares her political beliefs (and who she intends to vote for), which came up during the natural flow of therapy. Not only was Ethan (your student clinician) shocked by Shannon's political beliefs and support of a particular candidate, but he now finds it difficult to empathize with Shannon's presenting concerns (i.e., anxiety, intrusive thoughts, feelings of hopelessness). Ethan *overgeneralizes* by stating that all people with this particular political belief are problematic. Although only eight more sessions remain before therapeutic services end for the academic year, Ethan states that it will be difficult to deliver therapy in light of Shannon's political beliefs.

Scenario 3 Reflection. It will be helpful to explain to Ethan that over the course of his career, he is expected to come across clients with different political beliefs. These differences not only extend to politics, but to religion, values, and moral standards. It is important

to explain that we ought not to make any characterological assessment of our clients based on their political beliefs, and we support our clients' right to self-determination (see Principle E. in the American Psychological Association Code of Ethics, 2017).

Scenario 4. Feeling "Unsafe." During supervision, Jessica, one of your female student clinicians, informs you that Peter, her therapy client, recently shared his views of society, which struck her as overly traditional and antiquated. Although Peter believes women are entitled to the same rights as men, some of Peter's beliefs seem a bit patriarchal. Each week, Peter shares his dissatisfaction with his wife's increasing desire to pursue part-time work instead of remaining a stay-at-home mom to three kids under the age of 10. Reportedly, Peter is annoyed that his wife is trying to deviate from the standards they had agreed upon when they first married. Jessica explains that she feels "unsafe" whenever Peter shares these outdated beliefs. In addition to feeling "unsafe," Jessica is engaging in *emotional reasoning* by stating that she is now feeling anxious every time she conducts sessions with Peter.

Scenario 4 Reflection. It would be helpful to explain to the student clinician that safety refers to physical safety and that she is not in any danger (i.e., no one is intimidating or threatening her). In this case, one's espousal of different values is not dangerous, yet it may make her feel uncomfortable or "anxious." It may be worth having Jessica explore why Peter's views make her feel so anxious. Additionally, it will be important to remind Jessica that our therapy clients are entitled to their opinions, values, and beliefs, even when they are discrepant from our own.

Summary and Conclusion

In summary, recent changes in the socio-academic landscape of colleges and universities have influenced how psychology training clinic directors train graduate student clinicians. These changes have impacted how we respond to unexpected student clinician challenges, such as the challenges stated in this article. Unfortunately, these changes are not straightforward as they frequently involve aspects of one's identity, which has made it increasingly difficult to provide feedback to student clinicians in a manner that is not interpreted as marginalizing, microaggressive, or oppressive. With that said training clinic directors are rapidly learning how to adapt to this new landscape of academia. As we adapt, we all remain united in our commitment to training students to become successful, independent, and ethical psychologists. As a final note, changes and challenges will always exist, but it is our openness to adapting, our desire for creative problem-solving, and the tenacity to face these issues that will lead our profession forward.

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2025 APTC CONFERENCE

March 20-23

NASHVILLE

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We are excited about our upcoming APTC Conference (Thursday, March 20th through Sunday, March 23rd, 2025) at the Lowes Vanderbilt hotel in Nashville, TN (2100 West End Avenue, Nashville, Tennessee, 37203).

Our conference title this year is **The Art & Science of Clinic Direction**. Together, we will tackle such topics as the effective use of outcome measures, dealing with problem students (and faculty), using technology effectively, and designing innovative specialty clinics; coupled with the challenge of creating an excellent and unique training experience for our students while still preserving our own work-life balance!

CONFERENCE SCHEDULE

A preliminary sketch of what to expect is below!

THURSDAY, 3/20

- **Morning:** Executive Committee Meeting*
- **Afternoon:** New Directors & Mid-career Directors Programming
- **Early Evening:** Welcome Reception & New Director Mentor/Mentee Dinner

FRIDAY, 3/21 & SATURDAY, 3/22

- **All Day:** Keynotes, general sessions, and posters
- **Early Evening, Friday:** Happy Hour

SUNDAY, 3/23

- **Morning:** Executive Committee Meeting*

*Details about Executive Committee time and place of meetings and who should attend from the EC will be shared via EC email correspondence.

EARLY REGISTRATION & HOTEL GROUP RATES VALID UNTIL WEDNESDAY, FEBRUARY 26, 2025 @ 11:59PM CENTRAL TIME.