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Presidential Column

Bringing Together Diverse Mental Health Professions Under the Banner of Evidence-Based Practice
Dean McKay, Ph.D., Fordham University

On September 24 and 25, the American Psychological Association hosted the Mental Health Summit, a gathering of 25 mental health organizations. This meeting was organized by the executive committee of the Coalition for the Advancement and Application of Psychological Science (CAAPS; Bethany Teachman, Chair; Mitch Prinstein, Member at Large; and myself as Secretary/Treasurer) as well as Tammy Schuler (Director of Outreach & Partnerships, Association for Behavioral and Cognitive Therapies), Doug Mennin, Keith Renshaw, and Jason Washburn. The meeting was generously supported by grants from APA, American Psychiatric Nurses Association, the Annie E. Casey Foundation, and the George Mason University Psychology Department. The following organizations participated and had representatives present:

- American Academy of Child & Adolescent Psychiatry
- American Academy of Family Physicians
- American Association of Marriage and Family Therapy
- American Counseling Association
- American Psychiatric Association
- American Psychiatric Nurses Association
- American Psychological Association
- Annie E. Casey Foundation
- Anxiety & Depression Association of America
- Association for Behavioral & Cognitive Therapies
- Academy for Eating Disorders
- Coalition for the Advancement and Application of Psychological Association
- Council of Graduate Departments of Psychology
- Council of University Directors of Clinical Psychology
- Mental Health America
- National Alliance on Mental Illness
- National Association of School Psychologists
- National Association of Social Workers
- National Institute of Mental Health
- National Latino/a Psychological Association
- Psychological Clinical Science Accreditation System
- RAND Corporation
- Society of Clinical Child & Adolescent Psychology (Division 53 of the American Psychological Association)
- Substance Abuse and Mental Health Services Administration
- US Department of Veterans Affairs

It is worth highlighting that SSCP was very well represented at the summit, even if not officially listed here. Three members of the planning committee were past or current presidents (Mitch, Bethany, and I), and one representative, for the Academy for Eating Disorders (Carolyn Becker) is our current President-elect. As a reminder, SSCP is a member organization of CAAPS. Read on, as I think you will see that the dues SSCP pays as a member organization of CAAPS was very well spent. Across all organizations participating in the summit, there was great enthusiasm, and collectively, we were encouraged by the strong collaborative tone that was adopted and maintained throughout the meeting.

The summit meeting had four broad goals: to build relationships among organizations; determine how different disciplines conceptualize evidence-based practice (EBP); identify common themes around types of evidence emphasized for EBP; and determine how the various organizations can collaborate in the future. At the outset of the meeting, it was recognized that each organization has worked toward increasing the availability of EBP to the public, and accordingly, the broad aim of the summit was to improve the delivery of quality care by bridging the differences in how EBP was defined.

Across the day and a half meeting, there emerged four common themes that the entire group felt required attention. These were as follows:

Barriers to Educating Individuals about EBP

The public continues to have limited information about what constitutes EBP. There are a wide range of explanations, including (but not limited to): under appreciation of the value of EBP; practitioners and researchers relying too heavily on technical jargon to describe EBP to the public; academic turf battles that erode the ability to work collaboratively across disciplines; and of course, insufficient professional training in EBP delivery. To anyone following discussions among members of SSCP or other EBP-focused organizations, you will immediately recognize these challenges as ones worth reckoning with in ensuring the public is better able to access scientifically sound treatment.

Identifying the Needs of Underrepresented and Marginalized Groups

While it was lamented that the public at large remains poorly informed about EBP, the actual availability of EBP to diverse, underrepresented, and marginalized groups is far less than for majority segments of the population. Further, it was noted that EBP are ground in investigations and through treatment model conceptualizations that, in general, are based on clinical presentations derived from majority populations. Accordingly, in order to have true EBP, ongoing and dynamically changing models of empirical support is needed

to ensure that the best treatment is available and tailored to fit the highly diverse needs of the public. The emphasis in the summit was to determine ways to form partnerships with groups representing the full diversity of the public.

Challenges in Shared Understanding of EBP

Each discipline has adopted it's own 'language' of EBP. Further, each group generally has it's own understanding and definitions of EBP. If you are an academic who does not provide services, this has obvious problems in how different disciplines communicate regarding research evidence. If you provide direct-care services it is also obvious that this creates barriers in how services can be integrated, obtaining reimbursement from third-party payers, and the ways diverse groups can be best served. This led the summit meeting to decide to pool our diverse disciplines into crafting a shared definition of EBP. As part of this, it was determined that the representatives at the summit would arrive at consensus of what was outside the scope of EBP (i.e., eliminate reliance on single criterion as a guide to decision making).

Message Communication Needs

The final theme that arose continually during the summit was the need for experts across disciplines to be more effective at communicating with the media. Most professionals lack solid training in how to engage with the media, such as providing memorable statements regarding EBP, as well as how to deliver messages about the value of EBP in easy to digest ways. Across disciplines it was also emphasized that discussing mental health in ways that reduce stigma was also essential.

The summit concluded with specific action steps that would be taking place in the coming months, several of which are already well underway. A draft cross-disciplinary definition of EBP is already in development; one that it is hoped will ultimately be adopted by the boards of the participant groups and will be disseminated to the public. Plans are in the works for ways to promoting EBP. Efforts are in development to further attract organizations representing diverse populations. Plans are in the works for collaborative media consultation to educate providers and researchers in best methods for interacting with journalists and other media professionals. In an effort to further educate the public, efforts are underway to develop a Patient Bill of Rights that emphasizes EBP, either in its entirety or to be amended to existing ones adopted by the disparate organizations. And finally, the summit members agreed that engagement with payers to stress EBP (such as through new billing codes) is essential in increasing the availability of quality care for the public.

The coming months will see a good deal of additional work through planning calls. The participating members of the summit left the meeting with reasonable (and high) expectations for achieving the goals articulated at the outset. Be on the watch for further developments resulting from this summit meeting.

Author Note: This marks my last column as SSCP President. I want to take this opportunity to thank the SSCP community for the chance to serve the organization; it has truly been an honor. I look forward to many more years contributing to the important ideals and mission of SSCP.

Diversity Corner

Diversity Spotlight: Dr. José Soto
Yara Mekawi, M.A. & Joya Hampton, M.A., M.Ed.

This issue's Diversity Spotlight features Dr. José Soto, who is currently an associate professor in clinical psychology at Penn State. Originally hailing from the Bronx, Dr. Soto began his psychological science journey as an undergraduate at Harvard, and then moved across the country to obtain his master's and doctoral degrees at UC Berkeley. He fell in love with psychology early on, and became specifically interested in clinical psychology after reading "Girl Interrupted," and then working as a research assistant at McLean Hospital. At the same time, he worked with Dr. Deborrah Frable to complete an honor's thesis looking at the behavioral and psychological experiences of minorities at Harvard. Dr. Soto recalls, "It was definitely a formative experience for me and, though stressful at the time, began what would be a long line of research work focused on examining the experiences of cultural and ethnic minorities." His current research focuses on the intersections of culture, health and emotion, and he has published in journals spanning multiple subdisciplines within psychology, such as *Cultural Diversity and Ethnic Minority Psychology*, *Personality and Social Psychology Bulletin*, and *Emotion*. Dr. Soto is currently working on deriving a more sensitive measure of racial climate and trying to relate that measure to aspect of physical and mental health. When he isn't busy uncovering subtle but pervasive experiences that may contribute to health disparities in this country, he enjoys spending time with his wife and children watching sci-fi and superhero movies. Despite repeated condolences about his baseball team preference, Dr. Soto supports the New York Mets with fervor and pride. Go Mets!

1. How do you define diversity?

I think of diversity very broadly. For me, it encompasses any number of personal characteristics that are centrally defining (gender, race, ethnicity, sexual orientation, etc.) and shared by a group of people in an identifiable community.

2. What are some barriers to studying minorities?

There are several barriers to studying minority groups in this country and at this particular time in our nation's history. First and foremost, for researchers like myself, access to the populations of interest may be limited depending on your location. Rural or small college towns do not attract as many minorities relative to bigger cities and that means university researchers can struggle to get adequate representation among the student population or even the surrounding communities. This lack of access makes collaborations more important and collaborations take time and effort to develop, though they are often worth it. Second, many members of minority and marginalized groups are skeptical about research and for good reason (see Tuskegee Experiments, etc.). So even if you have access to the populations of interest, they may have little interest in participating for fear of negative consequences (either personally or to their group).

3. From your research, what are some major themes or lessons learned about culture and emotion?

The main lesson I have learned is that the relationship between culture and emotion is complex. From some of the work I've done, it seems like cultural differences in emotion that do exist seem to be more notable in self-reported experience, slightly less notable in emotional behavior and almost non-existent in the physiological domain. However, other factors influence this relationship, too, such as experiences of discrimination, cultural identity and acculturation, and gender. Thus, the answer to the question of how does culture influence emotion always depends on the various contextual factors under consideration. The lesson I take away from all of this work is that what matters is how your culture and these other contextual factors shape your values and worldview, which then are likely to impact emotional processes and the consequences of those processes to individual health and well-being.

4. How does this type of research benefit the field of psychology?

It is critical to consider the multiple contextual factors that are influencing the individual at any moment in time. That is

true for when they are healthy, but also for when they are not healthy. Culture and context is always there, it is just a matter of whether we are aware of these forces.

5. What has been your experience in publishing race/culture-specific articles in clinical psychology journals?

Although I haven't had many challenges in publishing race-specific articles, I did encounter one review from a paper submitted to a prominent clinical journal that demonstrated a lack of comprehension about the issues being discussed (discrimination among African Americans). I ultimately decided not to contest the reviews, partially because it did not occur to me that I could, but I feel that this is one example of how undercurrents that minimize cultural issues can keep work that is focused on culture issues relegated to more specialty journals.

6. How has your clinical work with racial/ethnic minority individuals influenced your research questions?

I think clinical work with individuals from various minority groups has helped to highlight the need for a more nuanced understanding of their experience, with an explicit focus on how their status in society has shaped their worldview and the subsequent consequences of that worldview. These issues are rarely discussed in clinical contexts, but they can often be important aspects of a person's life. If I can produce research that helps to demonstrate the role that being a minority in this society can have on mental and physical health, then that gives us license to open up the discussion about the importance of these issues with our clients and with the field.

Awards & Recognition

SSCP Student Poster Award Winners

SSCP holds a student poster competition at each annual meeting of the Association for Psychological Science. This year, we had 70 posters presented by student members, with 6 Award Winners (presented below) and 5 Distinguished Contributions. This is also the first year SSCP has offered awards specifically for posters related to global mental health.

2017 Poster Award Winners:

Ema Mumper, Stony Brook University, The State University of New York, *Diathesis-Stress Model of Anxiety: Influence of Early Temperament & Life Stress*
Roman Palitsky, University of Arizona, *Interpreting Depression: Humanism and Normativism Influence the Construal of Suffering*
Shabnam Hossein, Emory University, *Inferring Temporal Symptom Networks from Cross-Sectional Data: An Assessment of Conceptual Limitations*

The Inaugural Global Mental Health Student Poster Competition:

Jessica Fitts, University of Illinois Urbana-Champaign, *Perspectives on Mental Health from Healthcare Providers and Advocates in Sierra Leone* (FIRST PLACE)
Raksha Kandlur, Teachers College, Columbia University, *Coping Strategies Among Farmers at Risk for Suicide in Southern India* (TIED SECOND PLACE)
Anushka Patel, The University of Tulsa, *Does Intimate Partner Violence Influence Treatment Effects on Depression? Findings from a Randomized Controlled Trial for a Culturally-Adapted Behavioral Activation Treatment in Goa, India* (TIED SECOND PLACE)

Lawrence H. Cohen Outstanding Mentor Award

Bethany Teachman is a Professor, Director of Clinical Training, and Director of Diversity and Inclusion at the University of Virginia psychology department. She received her Ph.D. from Yale University, and her B.A. from the University of British Columbia. Her lab, the Program for Anxiety, Cognition, and Treatment, investigates cognitive processes that contribute to the development and maintenance of anxiety and emotion dysregulation. The lab is especially interested in how thoughts that occur outside of our conscious control contribute to anxiety and avoidance, and how we can change thinking styles. Dr. Teachman has had continuous funding from the National Institutes of Health and private foundations for more than a decade and is author on numerous publications, including books on treatment planning and eating disorders. Dr. Teachman is winner of an American Psychological Association Distinguished Scientific Award for Early Career Contribution to Psychology, national mentorship awards, and is an Association for Psychological Science Fellow, and a former Fellow at Stanford's Center for Advanced Study in the Behavioral Sciences. Currently, Dr. Teachman is director of Project Implicit Mental Health, a public website that allows visitors to complete tasks assessing automatic associations tied to mental health, and director of MindTrails, a public website that provides free online cognitive bias modification training. Teachman serves as current chair of the Coalition for the Advancement and Application of Psychological Science, current chair of the advisory steering committee for the American Psychological Association's clinical practice guidelines initiative, and is past president of the Society for a Science of Clinical Psychology.

Awards & Recognition

Outstanding Student Clinician Award

Kimberly Pentel, M.A., University of North Carolina, Chapel Hill
Kimberly Pentel, M.A. is a doctoral student in the Clinical Psychology Ph.D. program at the University of North Carolina at Chapel Hill in Dr. Donald Baucom's Couples Lab. In her research and clinical work, she develops and evaluates couple-based talk therapies to treat relationship distress and individual psychopathology. She has worked on a range of research projects studying how to recognize and treat issues such as depression, anxiety, post-traumatic stress disorder, and eating disorders. Kim is passionate about developing culturally sensitive and responsive, affirming, and accessible care for those that have been historically underrepresented in couples research. For her dissertation, Kim is serving as Primary Investigator for the ACCESS Program (Affirming Couples Counseling to Engage Same-Sex partners), overseeing a pilot study involving the development, delivery, and evaluation of a couple therapy specifically for same-sex female couples. As the Psychology Clinic Assistant, Kim screens potential clients and helps assign trainees cases across the various specialty clinics of the UNC Department of Psychology Community Clinic.

What are your clinical interests?
My research and clinical work focuses on developing and evaluating empirically supported psychotherapies for relationship distress and individual psychopathology. I am interested in critically examining and tailoring evidence-based therapies to maximize treatment outcome and developing culturally sensitive interventions for groups that have been historically under-represented in the couples field. I also enjoy providing clinical training and supervision to young therapists and increasing LGBTQ literacy and visibility among graduate student trainees and faculty.

Why is this area of clinical work exciting to you?
Psychopathology does not occur in a vacuum. Loved ones are often deeply affected. Building off of my training in cognitive-behavioral couple therapy in Dr. Donald Baucom's UNC Couples Lab, I conceptualize cases and design treatment from an interpersonal perspective. Moreover, individual mental health, romantic relationship distress, stressors based on the society we live in (such as sexual minority stress) are all linked. It can be a powerful experience to lay out a road map for therapy for clients that identifies the individual-, couple- and environmental-level factors impacting their well-being and helps them visualize the steps to reach a better place in their lives. Many couples seen in our UNC Couples Clinic and treatment research studies have been searching for a long time to find an affordable, well-trained, local therapist they feel will be sensitive and affirming to their needs. Being able to address that gap in local mental health care is important and rewarding.

Who are/have been your mentor(s) or clinical influences?
The mentorship, clinical supervision, and support I have received from my advisor Dr. Donald Baucom has imbued in me a deep appreciation for couple research and theory and laid the foundation of my clinical thinking that I will carry with me for my career. He has helped me learn to make sense of complex clinical cases, design a course of therapy that is deeply tied to case conceptualization and informed by evidence-based practice, and ensure all decisions in the therapy room are made with purpose and delivered with warmth. Dr. Erica Wise, director of the UNC Psychology Training Clinic, has graciously served as a faculty ally as I arrange clinical trainings and workshops within our program. She has shaped my thinking around professional ethics, self-care, merging social justice work with psychotherapy, and attending to personal identity and politics in the therapy room. Conversations with my post-baccalaureate mentor Dr. Steffany Fredman spurred my initial interest in the interpersonal context of psychopathology and the couples field. Lastly, my undergraduate mentor Dr. Nalini Ambady provided a wonderful example of how to conduct applied, "real-world" research and always remember cultural context.

What advice would you give to other students pursuing their graduate degree?
To whatever degree your schedule allows, pursue clinical work that energizes you. Seek out supervisors, mentors, and peers whom you trust to talk about your own well-being as a therapist (e.g., how your personal identity influences your therapy work; the impact of societal/political events on you and your clients). Seek out a wide range of supervisors, and if you can, gain the experience of being a supervisor for other trainees. Identify faculty allies who will amplify your voice as a graduate student. Seek out trainings/workshops to address gaps in your training. Though a psychotherapy treatment outcome dissertation may take longer than archival data analyses, it can be deeply rewarding. Do not lose yourself in your graduate work. Be kind to yourself.

Awards & Recognition

Outstanding Student Clinician Award

Amy Sewart, M.A., University of California, Los Angeles
Ms. Sewart is a 5th year clinical psychology PhD student at the University of California, Los Angeles. Working with Dr. Michelle Craske, Amy's research interests lie in advancing human models of fear learning and translating this knowledge to improve evidence-based treatment of anxiety disorders. She is also interested in cognitive, affective, and behavioral mechanisms that generate and maintain anxiety disorders, such as anxiety sensitivity.

What are your clinical interests?
My primary clinical interest is exposure-based therapy for anxiety-related disorders. Specifically, I'm interested in enhancing associative learning during exposure with my clients in an effort to improve treatment response and mitigate relapse.

Why is this area of clinical work exciting to you?
Watching clients extinguish debilitating, life-altering fears while knowing that I facilitated this process is incredibly rewarding. My clients are the most courageous individuals I've ever met. Given that my research also involves enhancing exposure-based therapies, it's also exciting to observe associative learning in action.

Who are/have been your mentor(s) or clinical influences?
My biggest clinical influence has been my graduate advisor, Dr. Michelle Craske. I've been fortunate to work with her over the past four years as a therapy supervisee, and more recently as a co-supervisor for junior graduate students learning exposure-based approaches at the Anxiety & Depression Research Center. Dr. Craske has taught me how to flexibly integrate scientific principles – such as threat and reward learning – into clinical practice.

I've also been fortunate to be supervised by Dr. Kate Wolitzky-Taylor. She continues to play an integral role in my development as a cognitive-behavioral therapist. Drs. Craske and Wolitzky-Taylor are highly skilled as both therapists and researchers. To me, they represent the epitome of what all clinical scientists should strive to be.

What advice would you give to other students pursuing their graduate degree?
All students have professional fears and cognitive distortions that arise during graduate school. What if I'm not good enough? I'm a failure if I don't have ten publications before I graduate. I'll look like an idiot if I present my research at that conference. It's easy to become paralyzed by these thoughts, leading to finding graduate school unsatisfying, even aversive. It's also easy to forget that through our clinical training we are equipped with the best skills to fight imposter syndrome. I urge all students to 'practice what they practice' and use evidence-based strategies to challenge these beliefs and extinguish their fears.

Clinician Perspective

The Risks of Risk Assessment
Meredith Sears, Ph.D., Psychologist, Suicide Prevention Program, San Francisco VA

Suicide is a stressful topic for the most seasoned clinician. Anxiety and discomfort can sometimes lead healthcare providers to miss important indicators that a patient's risk of suicide is elevated. Risk assessment tools draw providers' attention to factors that they might not otherwise assess on a routine basis. Well-written measures can also help improve providers' assessment technique (e.g., by offering prompts worded to resonate with patient experiences). These tools have also been shown to identify changes in risk relative to a patient's own baseline (e.g., by separating out acute vs. chronic risk factors; Bryan & Rudd, 2006). Attentive assessment and a more organized approach to stratifying risk ideally lead to improved provider-patient communication and treatment recommendations. Even the best suicide screening and risk assessment tools, however, offer little to no predictive ability (Bryan & Rudd, 2006; Franklin et al., 2017; Large et al., 2016). Even so, these measures have become the current standard of care. At the risk of putting too fine a point on it, they are all we have.

The increasing awareness of suicide as a major public health problem has caused many healthcare systems to implement suicide risk screening and assessment measures more broadly. There are risks associated with these policy changes that require careful consideration.

First, not all assessment tools are created equal. Many are written in clinical jargon, requiring a stressed provider to do the extra work of translating questions into wording that resonates with a stressed patient. Clinicians have a tendency to shift their focus from rapport- and trust-building to checklists of warning signs and risk factors when assessing suicide risk. There are many possible reasons for this shift: liability concerns, anxiety or discomfort, time limitations, ethical responsibilities, lack of experience and even overexposure to acute risk may be some (Petrik et al., 2015). Shifting attention to a risk assessment measure has been shown to increase speech complexity and decrease warmth, to the detriment of the human connection that might improve disclosure accuracy, reinforce help-seeking and build protective relationships (Ganzini et al., 2013; Petrik et al., 2015; Nasir et al., 2017). Thoughtfully-written measures may be able to improve connection and validate patients' experiences rather than create distance between the provider and the patient.

Second, suicide risk screening measures are being introduced into a wide range of clinical settings that have no major mental health presence (e.g., primary care, emergency medicine, obstetrics). This means that many patients first encounter questions about this incredibly sensitive topic from an untrained medical provider, and there isn't always a mental health provider available to step in if an interaction requires more skill (Petrik et al., 2015). Lack of mental health training has ramifications for the effectiveness of both risk assessment and clinical intervention.

There is good evidence to suggest that rapport and therapeutic alliance with providers are critical to positive outcomes for individuals experiencing suicidal crises, such that they reduce the risk of self-harm and increase treatment engagement. Provider empathy and trust-building support accurate disclosure of suicidal thoughts and behaviors (Ganzini et al., 2013; Petrik et al., 2015). Mental health providers are more likely to be trained in the evidence-based practices that emphasize collaboration with the patient, validation, accurate reflection, and thoughtful handling of ambivalence (e.g., Motivational Interviewing [MI; Britton, Williams & Conner, 2008]; Collaborative Assessment and Management of Suicidality [CAMS; Jobes, 2016]; Dialectical Behavior Therapy [DBT; Linehan, 1993]). Not surprisingly, these interventions are among those with the strongest evidence-base in reducing negative crisis-related outcomes (e.g., suicide attempts, suicidal ideation, self-harm behavior). Less skilled assessment conducted in non-mental health contexts has been shown to lead to patient feelings of invalidation and disrespect (Ganzini et al., 2013). Medical providers also describe significant time pressure, a lack of privacy, and discomfort with the topic of suicide as factors that compromise effective assessment and trust-building with patients (Petrik et al., 2015).

In addition to concerns about rapport and trust, disposition planning may also suffer from lack of training. In our suicide prevention program, one of the most common requests we receive from medical providers tasked with suicide risk screening is for a flow chart telling them what to do if patients endorse specific risk factors. This question makes perfect sense in a medical setting! Medical practices are rife with "if this, then that"-type interventions. Patient beliefs, emotional states, and rapports with their providers do not affect whether their blood iron levels fall in or out of normal levels, or whether their biopsies reveal normal or abnormal tissue. The complexities of suicidal crises, however, defy such actuarial approaches to assessment (Marsh, 2016).

Effective risk assessment and disposition planning depend upon patients' willingness to accurately report their past and present experiences, cognitive capacity to anticipate future experiences, and willingness to follow present and future clinical recommendations. It requires experience and training to navigate the complex thoughts, feelings and behavior that may impact a patient's responses to risk assessment. Expressions of suicide are sometimes contingent on psychosocial needs being met, or serve a communicative purpose. High false positive rates with screening measures can have damaging consequences for patient rights and trust of the healthcare system, so even extra-conservative approaches to risk mitigation can be harmful (Bryan & Rudd, 2006). Further, our patients frequently report fatigue with the frequent as-

sessment of suicidality they encounter in healthcare settings, so much so that they alter their responses to avoid lengthy risk assessments, worried providers, or (most often) the risk of hospitalization. Despite the possible positive outcomes of casting a wider net with which to catch individuals struggling with suicidality, a public health approach to suicide risk screening thus runs the risk of turning off the many patients who are ambivalent about seeking out help.

True, asking more patients about suicide may get more answers—but are they the right answers?

Public health approaches to suicide risk screening, assessment and intervention are becoming more and more widespread. It is no longer a question of whether or not healthcare systems should implement more universal risk screening: we are left with the question of how to do so in the most effective, least harmful manner. It is critically important that researchers do the hard work of qualitative studies to examine potential costs and strategies that can make universal screening more effective. For example, Nasir et al. (2017) laboriously examined audio recordings of therapist-patient contact to find that therapists' complexity of speech increased during the use of a risk assessment tool, which impeded patient self-reported alliance. Ganzini et al. (2013) surveyed patients to learn about their experiences with primary care-based suicide risk screens at VA hospitals: in doing so, they discovered real implications for accuracy of reporting and likelihood of treatment engagement when patients did not feel connected to the assessor. Petrik et al. (2015) identified important barriers and facilitators to effective risk assessment by asking emergency department providers open-ended questions about their own experiences and then carefully categorizing the responses.

Traditional empirical studies that examine the gross outcomes of implementing widely used screening tools may be able to tell us whether increasing screening is associated with a reduction in suicide rates. These studies will not give us more granular information about what would make the tools or implementation more effective. Could changes in wording encourage more accurate disclosure or treatment engagement? Are screening tools most effective in the hands of trained mental health clinicians, or are they just as effective when administered by medical staff? What training procedures increase effectiveness? Given the scale on which risk assessment tools are currently being implemented, these questions require answers if we are to avoid major therapeutic errors and a widespread loss of trust among our patients.

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About the Author:

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Student Perspective

In Defense of Teaching: Strategies for the Busy Graduate Student
Natasha April Tonge, M.A., Washington University in St. Louis

As clinical scientists in training, we are asked to become adept at wearing multiple hats. How often we put on our research hat depends on the institution but invariably the amount of research we do as part of our training defines aspects of our professional identity. Whether we are scholar-practitioners, scientist-practitioners, or clinical scientists is predicated on how much research we conduct or consume. Our clinical hat is the one that sets us apart professionally. All psychology subfields have research as a component of professional identity, but usually it is only clinical psychologists that get to be involved in treatment of mental health concerns. It is understandable then that we as trainees become drawn into our roles as some combination of future scientists and future clinicians. Unfortunately, the training binary of clinician and scientist leaves out an important third hat that we must often wear – our teaching hats.

For many, teaching requirements can be the most burdensome. After all, being in a class takes away from research time or from clinical work, preparing for a class can be exhausting, and standing up in front of a room full of undergraduates or peers can be terrifying. When I talk with my peers about their own interests in teaching, I detect responses along the continuum of "I can't wait until I never have to do that again" to "I guess I can put up with it." I often see so much more enthusiasm conveyed for working with a particular therapy client or working on a paper than for refining a lecture. For a while, I considered that perhaps teaching is just a specific interest or something that comes naturally to some people and not others but I decided not to privilege that hypothesis. If some people are just born to be teachers or inexplicably drawn to pedagogy then there is no room for growth and no reason to work at acquiring new skills. Instead, I came up with a different hypothesis: teaching clinical psychology just needs a positive reframe. Instead of being seen as a burden or an interfering task, teaching can be framed as an opportunity to reinforce skills in other areas of training. When viewed as a part of training in this way, I think it is possible to look forward to teaching in the same way we might look forward to making progress with research or clients.

After all, despite my general enthusiasm, there are certainly days where I want to hang up my teaching hat and do something – anything else. There are still plenty of moments of dreading getting up in front of a class and lecturing or moments where I just want to get back to my research instead of holding office hours to review something that was in the syllabus anyway. More often than not, however, teaching has been something I looked forward to and continue to look forward to doing, not just because I find it meaningful as an activity unto itself, but also because I often connect the experience to other parts of my training that I value. If you are reading this article with your own sense of dread at the prospect of having to be a teacher on top of a scientist and clinician, hopefully some of these suggestions can help make teaching clinical science feel as worthwhile and productive as other parts of your graduate training.

Why teach (Clinical science)?

In Mark Edmundson's book "Why Teach", the English professor argues that learning in college should be a matter of gaining a better understanding of or changing oneself. He speaks from the perspective of a humanities scholar, but the idea of teaching to help students self-reflect is especially true for teaching clinical science. Many students initially come to psychology to learn about abnormal behavior and clinical disorders and are thus very motivated to hear what we have to say. Psychology, in general, prompts students to learn about their own experiences but clinical psychology prompts students to think specifically about their own mental health. Rates of lifetime mental illness are high enough that it is unlikely students will go through their lives without experiencing or witnessing someone close to them struggle with a mental health problem. As teachers of clinical science, we are not only working with undergraduates who choose to take our class, but also educating future consumers of mental health services. Mental health awareness might be increasing around the country but when we teach about clinical psychology as a science, we are transforming aware consumers into informed consumers. Too often, the science of clinical science is lost or ignored in popular psychology postings which reinforces the idea that mental health treatment is an alchemical process. Making a commitment to teaching clinical science allows us to help students learn about the systematic nature of diagnosis and treatment and demystify the world of therapy. On those days when I have asked myself "why teach about clinical psychology when I have client work that needs to be done," I try to think of what I wish my clients and research participants knew about clinical science before I worked with them. By communicating some of those concepts to my students, I make my teaching have some meaning beyond fulfilling a course requirement.

Making teaching personal

So you find yourself stuck TAing for a class that isn't related to your research or isn't even a clinical psychology class. It's frustrating because everything you do for the class seems completely irrelevant. I would argue, however, that even when you have no interest in a subject area, you

would be hard-pressed to find a subject in psychology that is completely irrelevant to clinical work. The inverse is true as well: I challenge you to find a subject in psychology where clinical experiences aren't at all relevant. Cases that offer a counterpoint to "normal" functioning can often help students who find material to be too theoretical have an important real-world application of the theory. For example, when teaching my own Introduction to Psychology class, I had to cover some decision making and heuristics studies. When lecturing on the base rate fallacy I could have used the textbook's more economics-derived examples but instead talked about how I, as a clinician, need to be weary of committing the base rate fallacy when doing differential diagnoses. In other words, I made the connection to clinical decision making to ensure that the material had some relevance to my clinical and research interests. Finding a topic that has personal relevance, makes it easier to lecture on or even grade work related to that topic in the future. A side effect of this strategy is that it can often help reinforce material I want to know anyway by placing the material in a different context.

Setting training goals

Teaching your own class can be daunting. We often receive far more supervision on our clinical work and far more mentorship for research than we ever receive for teaching. Although plenty of resources exist to teach better teaching, there isn't unlimited time to peruse all of them, and few are specific to clinical science. My solution to this problem was to integrate some of my research and clinical training goals with teaching goals. If I was working on giving clear, concise feedback as a peer reviewer, I practiced making clear arguments when grading papers. If I was working on being comfortable with silence in the therapy room following a question, I practiced leaving longer silences after posing a question to the class. If I was having trouble discussing research in a clear way for a lay audience, I practiced giving similar sorts of explanations of research to my students. By setting goals for teaching that overlap with training goals in other areas, working on teaching can feel just as productive as work in other areas.

Concluding thoughts

As clinical graduate trainees, we are inevitably busy and pulled in many directions. I remember early in my graduate career that I was told to integrate my roles whenever I could to lessen the weight of the workload. Hopefully some of these suggestions are helpful as you find your own way to think of teaching as an opportunity to integrate other aspects of training, and maybe even get excited about the process of communicating clinical science to students.

Natasha April Tonge, M.A., is a doctoral candidate at Washington University in St. Louis. Natasha's research focuses primarily on social anxiety disorder and the effect of the disorder on relationship development and maintenance. She is also interested in social impairment more broadly. She has taught and TA'd for Introduction to Psychology, the Psychology of Learning, and Experimental Psychology and enjoys coming up with ways to make teaching fun for herself and her students.

About the Author

Clinical Science Early Career Path

Andrea Kass Graham, Ph.D., Northwestern University

I am a clinical psychologist and health services researcher, and my program of research aims to increase access to high-quality health care for individuals with eating disorders and obesity using scalable technologies.

A sixth-grade health class video sparked my interest in eating disorders. During high school, I began to soak up information about this illness and started to think about a career in this area. I attended college at Washington University in St. Louis, and early in my freshman year, I joined Reflections, a student organization that trained peer educators to promote awareness of eating disorders. I enjoyed working with others in the organization to improve our peers' understanding of eating disorders and to help destigmatize the illness. As a double major in English Literature and Psychology, I also explored clinical research. I spent the summer between my sophomore and junior years at the University of Florida coding parent-child interaction training videos on inter-rater reliability for a graduate student's dissertation. I loved the experience, and was convinced I was changing science! (It was years later before I realized that the culmination of my involvement would result in a single statistic in a Methods section…)

Back at Washington University that fall, I had my first introduction to eating disorders and obesity research through an intern position with Dr. Denise Wilfley, where I continued to work through my senior year of college. I also spent time working on research during a semester abroad at the University of Sussex in Brighton, England. Looking for things to fill my time outside of class, I began to volunteer in a lab that was studying eating behavior. My first assignment was helping with a study assessing satiety following a lab-based lunch. And I made the ravioli. Although not a glamorous role, I was happy to be involved. By the end of the semester, I was invited to run a study and was listed as a co-author on the subsequent publication. That experience taught me the valuable lesson that no research task is too small, and that saying "yes" (in this case, to making pasta!) can go a long way.

After college, I worked as a research assistant for two years at the Harris Center for Education and Advocacy in Eating Disorders at the Massachusetts General Hospital (MGH). The position provided an exciting fit for bridging my interests in studying eating disorders with my investment in increasing public education. I worked on the largest naturalistic study assessing eating disorder course and outcome and developed critical research skills related to writing and team science. I also helped organize Harvard University's annual public forum for eating disorders and observed a state hearing in which my PI testified to the Massachusetts legislature in support of an eating disorders bill. It was invaluable to see how science can inform policy changes that directly impact the care that people can receive. I continue to infuse this focus on the public health impact of our science into my program of research.

In 2009, I returned to Washington University to pursue my PhD in clinical psychology and to continue working with Denise Wilfley. I was appointed to a NHLBI-funded T32 predoctoral fellowship, through which I received training on screening, prevention, and treatment of eating disorders and obesity. I worked on research to implement online interventions into high schools and colleges locally and across the US; we pursued this research in collaboration with Dr. Barr Taylor at Stanford University, who became a wonderful mentor to me as well. I also was a clinician on a trial that tested weight loss maintenance interventions among families with overweight or obesity. From this work, I became interested in and began studying factors that affect the adoption of behavioral interventions, and I learned that intervention costs can pose a significant barrier. For my dissertation, I compared the cost-effectiveness of a behavioral weight loss intervention to standard care using data from a large clinical trial involving youth and their parents. Lastly, during graduate school I had the opportunity to continue work in advocacy. Complementing my experience at MGH, I provided expert testimony to the Missouri legislature in support of eating disorder reform. Transitioning from observing to testifying to improve access to mental health care was an empowering and meaningful experience in my career development.

I completed my internship in the Department of Psychiatry & Behavioral Neuroscience at the University of Chicago, and was fortunate to stay on at the university for a postdoctoral fellowship. Given my interests in health care delivery and the costs of care, I sought a position on a T32 fellowship, funded by the Agency for Healthcare Research & Quality, focused on health services research. The fellowship was housed in the Department of Medicine, which meant that I was a less obvious choice from previous fellows with a medical degree. I made a case for the benefits of broadening my training beyond eating disorders and obesity and was appointed to the following cohort.

The fellowship provided a terrific opportunity for training outside of our field. My primary mentor was a physician health economist, and I had access to collaborations with scientists from a variety of disciplines and the flexibility to explore diverse and interesting research projects. For example, I helped develop and implement a behavioral health group for individuals at high risk of hospitalization as part of a clinical trial to test an integrated inpatient-ambulatory care intervention compared to standard care. I also worked with a pediatrician and family medicine physician to train providers who work with underserved communities in childhood obesity treatment via a web-based platform, collaborated with a team of investigators to validate a computerized adaptive test to screen for depression and anxiety in primary care, and co-authored a paper examining the start-

up costs of implementing an obesity intervention in primary care. The challenge of participating in a fellowship outside of psychology was that the onus was on me to ensure I continued to build expertise in eating disorders and to accrue supervised hours for licensure. I was fortunate to continue to collaborate with mentors from graduate school as well as with the new director of the Eating Disorders Program at the University of Chicago, Dr. Jennifer Wildes.

During the first few months of my fellowship, I was encouraged to apply for a F32 National Research Service Award. I proposed a project to expand my dissertation research and deepen my expertise in evaluating the cost-effectiveness of behavioral interventions for obesity. Excitingly, I was awarded the grant, which provided me with postdoctoral funding for an additional two years.

In early spring 2017, I received an email advertising a faculty position in Dr. David Mohr's Center for Behavioral Intervention Technologies (CBITs) at Northwestern University. The job description perfectly matched my interests, and I jumped at the opportunity to apply. In April 2018, I became Assistant Professor at CBITs in the Department of Medical Social Sciences in the Feinberg School of Medicine at Northwestern University. It has been great collaborating with investigators at CBITs and the Northwestern community on digital mental health and health services research. I also was fortunate to receive a K01 award from the NIDDK this past September, which will support my career development for the next five years as I design and optimize a digital intervention to address obesity and binge eating.

Combined, these experiences have provided wonderful "take-aways" and influences on my career development. I have enjoyed the opportunity to pursue creative training experiences, and I appreciate that a career in academia allows us to be flexible and open to new opportunities. I also have found great joy and satisfaction from working on teams. I am grateful to have mentors who have invested in my training, helped me integrate into multi-disciplinary research teams, and supported me in pursuing research experiences that seemed fun and exciting, rather than solely for that "next step" or a line on my CV. Similarly, I am grateful to have a network of peers who provide invaluable friendship, collegiality, and support.

I look forward to continuing my efforts towards increasing access to care for individuals with eating disorders and obesity, and I am excited for what this next career stage holds!

About the Author:

Andrea Graham, PhD, is Assistant Professor in the Center for Behavioral Intervention Technologies and the Department of Medical Social Sciences at the Northwestern University Feinberg School of Medicine. She received her PhD in clinical psychology from Washington University in St. Louis and completed a clinical internship and postdoctoral fellowship at the University of Chicago. Her program of research is focused on increasing access to care for individuals with eating disorders and obesity using scalable technologies.

Updates from Student Representatives

Kelly Knowles, M.A., Vanderbilt University
Joya Hampton, Ph.D., Emory University

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

Conference and Networking Events

Please join us at the ABCT Annual Convention November 15-18, 2018 in Washington, D.C.! We will be hosting an SSCP Student Social for our student and postdoc members, as well as prospective members, at the conference. Come for the opportunities to meet with SSCP board members and fellow students, and stay for the free food and drinks! Date and Location: TBA. Keep an eye out for emails from the representatives regarding the social!

Student Award Announcements and Opportunities

SSCP Dissertation Grant Awards - These awards are intended to both recognize and support students who have already received approval for their dissertation project. Accordingly, in addition to the evaluation of the proposal as a whole, we will also consider what additional sources of funding have been received in the context of the overall estimated cost of the project. Awards will be in the amount of $500. It is anticipated that up to 5 grants will be funded. Eligibility requirements and application instructions are listed on the main SSCP website: https://societyforscienceofclinicalpsychology.wildapricot.org/page-18092. Applications must be received by November 27, 2018.

SSCP Student Outstanding Teacher Award - This award is intended to recognize outstanding graduate students who are providing exceptional contributions to the field of clinical psychology through their teaching. Students will be selected based upon their dedication to, creativity in, and excellence in teaching in the area of clinical science (this can include experience as a teaching assistant). Applications must be received by December 1, 2018. Complete guidelines and the cover sheet can be found on the student website: http://sscpstudent.blogspot.com/p/student-awards.html. Students may be nominated by their advisor or a faculty member for whom they have TAed, or may self-nominate. Please send nomination packages to Kelly Knowles and Joya Hampton at sscpstudent@gmail.com. Only graduate students (including students on internship) will be considered for this round of nominations. Graduate students must be student members of SSCP. The annual student membership fee in SSCP is $15. The membership application form can be downloaded or submitted on-line at: https://societyforscienceofclinicalpsychology.wildapricot.org/Membership

SSCP Student Poster Award Competition at APS Convention - The 2019 SSCP Student Poster Award Competition will take place at the APS Annual Convention, May 23-26, 2019 in San Francisco, CA. If you would like to have your poster considered for the award, select 'SSCP Poster' in the first step after you select poster and start new submission. Those receiving the top award receive $250, and winners of the "Distinguished Contributions" Award receive $100. The SSCP poster submission can deal with any area within scientific clinical psychology. The research and analyses presented in the poster submission must be completed. Please be sure to provide enough relevant detail in the summary so that reviewers can adequately judge the originality of the study, the soundness of the theoretical rationale and design, the quality of the analyses, the appropriateness of the conclusions, and so on. Complete submissions include a brief 50 word abstract and up to a 500 word summary of the work. Deadline for poster submissions is 1/31/2019. Please follow the link for a complete call for submissions: https://www.psychologicalscience.org/conventions/annual/call-for-submissions

Internship Resources

The SSCP Internship Hotel Match-Up allows interested students to complete a request for each date and location for which they would like to share a hotel during internship interviews. Students can then find other students with requests for the same date and location and contact them in order to make hotel arrangements. Once students complete their information, they will be able to access a google spreadsheet with other students' requests and information (please allow up to 48 hours for us to send the link). They then can contact other students who are requesting the same date(s) and location(s) to coordinate hotel plans! You can fill out the form multiple times for each your interviews. Link here: https://drive.google.com/open?id=1qil-YPIjSYP_gwRVSrf72BA5OCe-pGtWuBYEGZN3dEA

Note: We strongly encourage students to vet the people they are considering staying with (i.e., feel free to search for them on their university's webpage, ResearchGate, etc.). The Match-Up is open to non-SSCP members, so please feel free to share this resource with your friends who are also applying for internship!

Internship Directory Updates Coming Soon!

SSCP is committed to offering student resources regarding the internship application process. We will be updating our internship directory over the coming months. In the mean time, you can access our current resources here: https://society-forscienceofclinicalpsychology.wildapricot.org/internship

Contact Us!

We would love to hear from you with any suggestions, comments, questions, or concerns regarding SSCP student membership or resources for students, so feel free to email us! If interested in sharing ideas, please also visit our website under student initiatives and complete the "What else can we do to help?" form.

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