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MEMBER SPOTLIGHT & MEMBERS IN THE
NEWS ANNOUNCEMENT

The Membership Committee is pleased to announce two new features that will be added to the SCP newsletter, The Clinical Psychologist, and to the SCP website. Starting with the April newsletter, each quarter a member will be featured in a Member Spotlight and several members' accomplishments and news items will be featured in Members in the News. The goals of these new features are to recognize SCP members' accomplishments across all career stages, to highlight the diversity of our membership, and to help SCP members feel more connected by learning more about each other.

To ensure the success of both new features, we need your help identifying members to highlight. To nominate a colleague, mentee, or yourself, please complete the brief online nomination which can be found on the SCP website. Nominations of members at all career stages including Students and Early Career Psychologists are welcome! The Membership Committee will review nominations on a quarterly basis, and selected members will be contacted by a Committee member and interviewed for the feature, if they agree to participate.

We are currently accepting nominations for the Member Spotlight and Members in the News features in the April edition of The Clinical Psychologist.

Nominations are due by 2/15/18 and can be submitted online at:

Member Spotlight nomination:

<https://www.div12.org/member-spotlight/>

Members in the News Nomination:

<https://www.div12.org/members-in-the-news/>

Please consider nominating someone for one or both features! It is a great way to recognize a colleague's (or your!) accomplishments and to help our members know more about their fellow members.

Please contact Claire Collie at clairecollie@hotmail.com with any questions about the Member Spotlight or Members in the News features.

We are excited to bring you these new features and we look forward to receiving your nominations!

Jonathan S. Comer, Ph.D. - Editor

Empowering Sexual Minority Clients (and Their Therapists) Through Evidence-Based Principles of LGBT-affirmative Practice

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U Sexual minorities, including those who identify as lesbian, gay, and bisexual (LGB), face some of the largest mental health disparities of stigmatized groups, and are on average 2-3 times more likely to develop mood or anxiety disorders, substance use disorders, and to attempt suicide than their heterosexual peers (King et al. 2008; Marhsal et al., 2011). Studies using diverse methodologies such as interviewer-based assessments (e.g., Meyer, Schwartz, & Frost, 2008), population-based sampling (e.g., Mays & Cochran, 2001), and measures of structural stigma (e.g., Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010) have traced these mental health disparities to the disproportionate level of stigma-related stress faced by sexual minorities compared to heterosexuals.

The stigma-related stress faced by sexual minorities, also known as minority stress, can take many forms. For example, governmental policies that amplify stigmatizing attitudes have been linked to sexual minority health disparities in the localities that pass them (for review, see Hatzenbuehler, 2018). Victimization and discrimination have also been shown to drive sexual minorities' disproportionate experiences of mental health problems. Further, sexual minorities are more likely than heterosexuals to experience rejection from peers and family (Balsam, Rothblum, & Beauchaine, 2005), and everyday forms of discrimination from strangers (e.g., Mays & Cochran, 2001), all of which have been linked to mental health problems. Together, these minority stress experiences can prompt sexual minorities to chronically anticipate rejection (Pachankis, Goldfried, & Ramrattan, 2008), internalize homophobic attitudes towards themselves and other sexual minorities (Newcomb & Mustanski, 2010), exhibit exaggerated biological stress responses (Burton, Bonanno, & Hatzenbuehler, 2014), and struggle to enact a healthy repertoire of coping

and emotion regulation behaviors (Hatzenbuehler, 2009).

To help clinical psychologists address manifestations of minority stress commonly seen in treatment, we review the underlying principles of one treatment program, called ESTEEM (Effective Skills To Empower Effective Men).

The ESTEEM treatment adapts the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (Unified Protocol, 2010) to address the clinical features most commonly associated with sexual minority stress and mental health disparities. Preliminary tests of ESTEEM's treatment efficacy, derived from a waitlist control trial, indicated that it was effective at reducing young sexual minority men's depressive and anxiety symptoms, alcohol abuse, and sexual risk-taking behaviors (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). Moreover, improvements in these domains appeared greatest among patients presenting with greater implicit negative biases against their own sexual orientation (Millar, Wang, & Pachankis, 2016), suggesting that a minority stress-focused intervention might work best among individuals who experience more minority stress. The treatment has also been preliminarily tested with HIV-positive gay and bisexual men (Parsons, Rendina, Moody, Gurung, Starks, & Pachankis, 2017) and is currently being tested in a multisite, multi-arm randomized controlled trial and developed for sexual minority women and for group delivery.

Convincing arguments have been made elsewhere that the main products of randomized controlled trials – intervention manuals – often do not provide the most clinically useful guidance in actual practice given the complexity of real-world cases (Goldfried & Eubanks-Carter, 2004; Pachankis & Goldfried, 2007; Westen, Novotny, & Thompson-Brenner, 2004). Therefore, our hope is that by outlining ESTEEM's underlying treatment principles, clinical psychologists can flexibly apply these principles across their sexual minority clients' diverse presenting concerns. These principles derive directly from the accumulated wisdom of practicing clinical psychologists and the stated treatment preferences of sexual minorities themselves (Pachankis, 2014). We outline each of these principles below, discuss their rationale, and provide practical recommendations for each principle's implementation in practice.



Charles L. Burton

Principles of ESTEEM

Contextualize clients' symptoms as common responses to minority stress.

Sexual minority clients might perceive their disproportionate need for professional services as indicative of personal shortcomings rather than the societal shortcoming of minority stress. Thus, one of therapists' initial primary objectives in working with sexual minority clients is to explore any potential connection between minority stress and mental health in collaboratively building a case formulation. While experiences of minority stress differ from client to client, introducing the minority stress framework can be a highly effective tool for treatment planning.

For instance, therapists might wish to simply share the fact that sexual minorities are disproportionately affected by poor mental health as a result of minority stress, as this information can help normalize sexual minority clients' experiences and help build motivation for treatment engagement. In doing so, therapists can frame therapy as an opportunity to explore the ways in which minority stress affects clients' lives and might contribute to their current concerns. This creates an open invitation for clients to understand the link between early and ongoing stigma-related experiences and current maladaptive behavioral patterns. Because the impact of stigma on mental health is often subtle, presenting the minority stress framework through an exploratory lens invites active self-reflection, mitigates defensive behaviors, and builds motivation for developing empowering correctives to stigma-driven difficulties.

Identify and rework minority stress-driven thoughts.

Experiences of discrimination can profoundly shape a person's characteristic ways of thinking. For instance, sexual minorities are likely to develop self-critical attitudes and perceive their environment as threatening (Feinstein, Goldfried, & Davila, 2012). These cognitive biases start early and can persist through later life (D'Augelli, Grossman, Hershberger, & O'Connell, 2001). Because such biases are often automatic and subtle, psychologists working with sexual minority clients might help them explicitly identify stigma-driven themes in their thought processes.

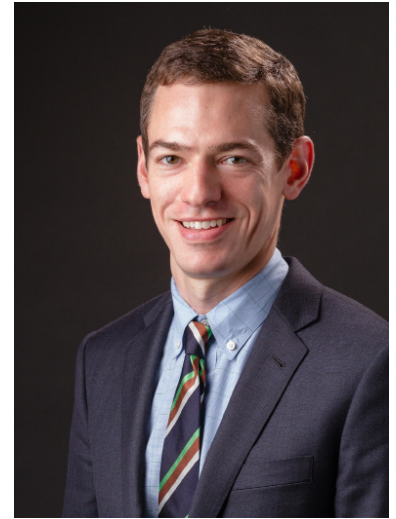
Careful exploration of a sexual minority client's developmental social environments can yield important information regarding critical events that might have shaped their current clinical presentation. For instance, many sexual minorities engage in gender non-

conforming behavior earlier in life (Roberts, Rosario, Slopen, Calzo, & Austin, 2013), but dominant gender role norms can lead sexual minorities to believe that gender non-conforming behavior is inferior and wrong and can lead to self-monitoring and anxiety (Skidmore, Linsenmeier, & Bailey, 2007). Indeed, many sexual minorities are likely to anxiously anticipate and readily perceive rejection due to their sexual orientation, even in ambiguous or supportive environments (Pachankis, Goldfried, & Ramrattan, 2008). These fears of rejection might manifest as clients intentionally shaping their speech and mannerisms to come across as heterosexual, as well as avoiding being seen in public with other LGB persons.

Once clients are able to connect their early stigma-related experiences to their current stress responses, therapists can help clients begin to explore and adjust stigma-driven schemas that are no longer functional or helpful. For example, a gay male client who fears cooking for others because he was once scolded for enjoying "girl stuff" as a child can be helped to challenge such thoughts in the context of a supportive friend group. For therapists who work with clients in high-stigma environments where threat-based perceptions are realistic and help the client avoid harm, the therapist can still help the client shift some of the client's automatic negative self-evaluations (e.g., "I have to be careful what I say around them because I'm a bad person") to more flexible and contextually accurate assessments (e.g., "I have to be careful what I say around them because they're homophobic").

Empower clients to communicate assertively.

Early and ongoing minority stress experiences can instill in sexual minorities a belief that their personal desires are wrong or less important than the desires of others, which may cause clients to believe that expressing their wants will be perceived as selfish, or may even result in the loss of a relationship. Research has shown unassertiveness among sexual minorities to be associated with decreased relationship satisfaction, substance use, and risky sexual behaviors (Hart & Heimberg, 2005, Semple, Strathdee, Zians, McQuaid,



John E. Pachankis

& Patterson, 2011). Thus, assessing unassertive cognitive and behavioral patterns among sexual minority clients can identify crucial treatment targets.

Changing unassertive behaviors first requires helping the client identify the function of their unassertive behaviors. Thus, in scrutinizing personal examples of unassertiveness, sexual minority clients are likely to find that not expressing themselves helps them avoid feelings of anxiety and/or anger that come with openly communicating their emotional and/or sexual desires of which they may have been previously ashamed. The therapist can help the client weigh the short-term benefits of such avoidance (e.g., avoiding anxiety they might feel by bringing a same-sex romantic partner to a family reunion) to the long-term costs of that avoidance (e.g., feeling alone at the reunion or skipping it entirely). Weighing these pros and cons can help clients feel more entitled to their needs, and motivate them to further develop their assertiveness skills. Role-playing in the therapy session and experimenting with assertiveness outside the therapy office can then help clients tolerate the uncomfortable (but temporary) emotions associated with assertiveness, and master their ability to express their desires openly and effectively.

Validate sexual minority clients' unique strengths.

The ESTEEM treatment model emphasizes helping sexual minority clients draw upon personal and community strengths that might otherwise remain unacknowledged across sexual minorities' development. While many minority groups (e.g., racial and ethnic minorities) typically possess the same stigmatized identity as their parents, sexual minorities typically lack any formal introduction to the history and culture of their minority community that is typically transmitted through family (Crocker & Major, 1989; Rothblum & Factor, 2001). Sexual minorities sometimes also lack a sense of the personal strengths required to form a minority identity in relative isolation (Pachankis, 2009).

For sexual minority clients who struggle to see their personal strengths, therapists might reflect the courage and resourcefulness the client displayed by exploring and adopting an identity that is often relatively invisible to young people and society as a whole. Such clients might also benefit from considering the remarkable resilience displayed by the LGBT community itself. Indeed, the LGBT community has launched one of the most impressive civil rights movements in recent history (Herrick et al., 2011) while also fighting the HIV/AIDS epidemic (Trapence et al., 2012), shaping models of non-heterosexual romantic and sexual

relationships (Parsons, Starks, DuBois, Grov, & Golub, 2013), and forging new models of family structure after rejection from families of origin (Weeks, Heaphy, & Donovan, 2001). Helping clients identify both personal achievements as well as the achievements of the broader LGBT community can model self-agency and foster hope for the future.

Affirm expressions of same-sex sexuality.

Unlike heterosexuals, sexual minorities typically do not receive appropriate or useful formal sex education during adolescence (Feinstein, Thomann, Coventry, Macapagal, Mustanski, & Newcomb, In Press; Kubicek, Beyer, Weiss, Iverson, & Kipke, 2010). Through lack of information, as well as internalized negative attitudes towards same-sex sexual behaviors, sexual minority clients can face a variety of sexual health challenges (Bancroft, Carnes, Janssen, Goodrich, & Long, 2005; Missildine et al., 2005). Sexual minority clients might thus benefit from a sex-positive approach that affirms their sexual needs as normal and as an important part of their overall health and wellbeing. Therapists can take several steps to adopt this approach. First, therapists can broach topics of sexual health, particularly when they perceive that clients feel uncomfortable or ashamed about discussing sexual content in session. Indeed, a simple follow-up query such as "How did it feel to answer that question?" can be a powerful opportunity for the client to observe how their sexual shame can actively inhibit their health-related goals, while also providing the therapist an opportunity to explicitly validate the client's sexuality and affirm that such conversations are welcomed and encouraged during therapy sessions. Therapists should also look for other mechanisms through which sex-related shame can influence the client's health, such as relying on alcohol or substances during sexual activity to overcome the shame and anxiety sometimes associated with same-sex sexual behavior (Pachankis, Rendina, Restar, Ventuneac, & Parsons, 2015; Rendina, López-Matos, Wang, Pachankis, & Parsons, 2018).

Facilitate clients' development of supportive relationships.

The final principle in the ESTEEM treatment model prioritizes helping clients develop supportive social networks. Sexual minorities, compared to heterosexuals, are more likely to face social isolation and receive less support across the lifespan (Plöderl & Fartacek, 2005; Safren & Heimberg, 1999), which can have significant implication for psychological well-being (Burton et al., 2014; Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009). For some clients, expanding their

social resources may involve helping them improve their current relationships through the principles listed above, such as assertively communicating their wants and needs, and challenging automatic appraisals steeped in historical minority stress, rather than more supportive current relational contexts. Another goal may be to forge new relationships. As some sexual minorities find that interacting with the LGBT community itself can be stressful (Pachankis, Clark, Burton, White-Hughto, & Keene, 2018), therapists can help clients brainstorm ways of meeting other sexual minorities in supportive, rather than stressful, LGBT-focused context. Structured activities such as LGBT special interest groups or community advocacy organizations can be particularly helpful by providing a context that can be less intimidating for depressed or anxious clients. Outside the LGBT community, therapists can encourage clients to seek heterosexual allies at school, work, or other settings. Exposure exercises can help clients who feel anxious interacting with heterosexual peers. Reducing situational anxiety in these cross-group interactions can also facilitate the quality and depth of clients' relationship with heterosexual peers, thereby further challenging internalized feelings of social stigma.

Summary

As noted throughout this article, sexual minorities face a host of social and psychological risk factors rooted in stigma. These six underlying principles of the ESTEEM treatment model underscore relatively simple but important elements of working with sexual minorities who present for mental health services. These principles are both derived from clinical and community wisdom (Pachankis, 2014) and supported by accumulating research evidence regarding the stigma-related source of sexual minorities' disproportionate mental health problems (e.g., Hatzenbuehler, 2009). While our understanding of sexual minorities' mental health needs has dramatically expanded in the past two decades (Cochran, 2001), ongoing research efforts can further clinical psychology's aims of creating effective interventions for this vulnerable population. For example, future research can provide clinical psychologists with specific evidence-based guidance for implementing these principles with diverse segments of the sexual minority community, and might determine whether additional principles are needed when working with clients whose sexual identities intersect with other diverse identities. Future research should also strive to uncover clinically useful, "how-to" guidance, possibly derived from psychotherapy process research, regarding when, how, and for whom to deliver various session-level interventions (e.g.,

responding to in-session client and therapist sexual orientation disclosures, managing alliance ruptures, and developing optimally healthy minority stress narratives). Ideally, future research will embrace the two-way bridge between research and practice that represents the highest promise of our profession (Goldfried, 2011). As the principles outlined here derive from clinical wisdom, so too do we hope that future research will return clinically useful empirical findings to our professional community, who is entrusted to empower this increasingly visible segment of the treatment-seeking population. ♣

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'What Should I Do?' Seeking Ethics Consultation from Colleagues

Adam L. Fried, Ph.D.
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Midwestern University



Psychologists are trained to be beneficent, discerning and perform their duties with competence and integrity, whether it be assessment, treatment, teaching, consultation or research. As emphasized in the APA Ethics Code (APA, 2017), consultation can be an invaluable method to ensure that their work continues to reflect these core professional values. Psychologists are likely aware that consulting with other professionals is an important component of ethical decision-making but there may be barriers that prevent them from using this tool. In this column, we plan to discuss some of the factors that may prevent psychologists from seeking input from colleagues and some consultation-related considerations and recommendations.

The stress associated with experiencing clinical and ethical dilemmas can cause personal anxiety and also interfere with one's ability to carry out duties competently and effectively (Gottlieb, Handelsman, & Knapp, 2013). Consulting with colleagues may alleviate some of this distress and allow the psychologist to chart a more informed course of action. Through consultation, a psychologist can gain a different perspective on a situation, which can be critically important when personal feelings may be clouding judgment. Consultation can also provide specialized knowledge about a particular issue, shed light on risks not previously considered, provide a wide range of actions, and help prioritize issues and goals (Gottlieb, 2006; Gottlieb, Handelsman, & Knapp, 2013).

It should be noted that consultation may not be limited to specific dilemmas, but also may be used to inform policies and procedures. For example, should psychologists charge fees for cancellations and missed appointments and what exceptions should be made (e.g. patient/client illness)? Without realizing it, some practice policies can also become ethical decisions. It's also helpful to differentiate between informal and formal clinical consultations, the latter of which usually involves one professional seeking out another professional for the express purpose of consultation on

a particular case or issue. Depending upon the nature of consultation required (or severity of ethical concern), it may be brief, detailed, time-limited or ongoing. Many psychologists may seek more informal consultations, such as posting on listservs or Facebook groups or a "seeking advice" e-mail to a trusted colleague. The expansion of online communities of psychologists provides more opportunities to seek advice and opinions on dilemmas and policy questions.

Barriers to Consultation

While we aren't aware of data on the extent to which psychologists consult with colleagues about ethical questions, there are likely barriers that prevent at least some (or perhaps many) from seeking consultation about ethical issues. We discuss a few below.

Is this an Ethical Issue?

The complex and sometimes ambiguous nature of ethics may result in an inability to recognize the ethical aspects of a dilemma. For example, a therapist asked a closed online professional group whether sending out holiday cards to former clients and their families would be a good marketing strategy. A colleague gently advised against this practice, pointing out potential confidentiality risks. Psychologists may not consult others because they don't recognize the issue as an ethical one and, therefore, don't realize the need to do so. Relatedly, some may be unsure about the ethics of seeking consultation (especially over the Internet), including how to adequately protect confidentiality, how much detail to provide about a case, and how to interpret conflicting recommendations and the expertise of individuals providing feedback (we discuss some of these issues in the next section "Considerations and Recommendations").

Worry about "Perceived" Professional Competence:

Some individuals may view ethics as always having a clear right and wrong that should be obvious to everyone. These beliefs may lead to fears that by seeking consultation, they are really communicating that they do not know the "right" way and therefore may be viewed as lacking ethical competence. That is, for some psychologists, asking for ethical clarity may make them vulnerable to an imagined threat of incompetence. Certainly, we aspire to be proficient in our professional activities, particularly in a topic for which we believe that we are supposed to be well versed, such as ethics but there are certainly ethical situations that are impossible to predict and for which our training did not adequately prepare us. In these situations, seeking consultation and drawing on resources and expertise of those with

the appropriate knowledge is the true demonstration of ethical competence.

Embarrassment:

Possibly worse than being perceived as incompetent are the associated feelings of embarrassment or shame that some experience when seeking advice. We have all had situations (think college or graduate school) where we refrained from asking a question or commenting for fear of embarrassment. On the positive side, online platforms, such as listservs have allowed for some degree of anonymity, which may allow one to ask questions that could be difficult to do in-person. On the negative side, anonymity may encourage others to share opinions more freely, which can come across as demeaning. A psychologist recently shared that the specialty listserv for which she is involved has been so contentious at times that it has become an inside joke to suggest “posting to the listserv,” as criticism from colleagues is almost a guarantee.

Ignorance is Bliss:

Somewhat surprisingly, we have heard from some therapists who admitted that they refrained from consulting as they did not want to receive advice that may be contradictory to their preferred course of action. In other words, responses to consultation requests may include advice that will require the psychologist to invest more time, energy, and work that the psychologist would rather avoid. While this concern may be understandable in settings where time and resources are extremely limited, it's important to note that this type of approach increases the risk of a negative outcome, one that may require considerably more time, effort and resources to address.

Considerations & Recommendations

Below are some recommendations and considerations for responsible consultation and to address some of the aforementioned barriers.

Confidentiality.

Confidentiality may be an overlooked concern when seeking consultation. For example, a therapist posting on a listserv may erroneously believe that simply withholding the last name of a child client is sufficient, but provides other identifying information, such as the name of the client's school or the name of the parent's employer. It's important to note that most Internet-based communities, such as listservs and Facebook groups (even those that are “closed”) should not be considered “confidential,” especially since for many, there are often no explicit rules about (or mechanisms

to control for) re-posting or forwarding messages to individuals outside of the group (See Behnke, 2007 for an interesting discussion of issues related to seeking consultation over listservs).

When seeking consultation, especially over the Internet where posts can reach a wide range of people and may be disseminated to others without the writer's permission or knowledge, it's important to consider the confidentiality rules outlined in Standard 4.06 (Consultations) in the ethics code: “When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)” (APA, 2017).

“Safe Person” and Colleague Communities.

Several psychologists we spoke with did not feel comfortable posting their ethics questions on listservs, but have a specific colleague they go to informally when they have an ethical dilemma (one person described this their “safe person”). This is a trusted colleague who can serve as a confidential sounding board, ask clarifying questions, provide advice alternative viewpoints and, most importantly, listen without judgment. These colleagues may be an invaluable resource for an informed perspective or specialized knowledge on a topic or question. Consultation may also occur in communities of colleagues that meet on a regular basis who provide resources and support for ethical issues. Whether in groups or with a “safe” colleague, it's important at the outset to discuss issues related to confidentiality. For example, groups may want to establish rules regarding confidential information in case discussions and to ensure information is not disseminated to those outside of the group.

Limits of Consultation.

Consultation can be an important but insufficient method of ethical decision-making. The advice of colleagues may provide a snapshot of another perspective, which can inform, but not necessarily dictate, one's decisions. In other words, the informal advice of a colleague should not be the only consideration, for several reasons. First, when soliciting feedback, especially from a large group of individuals, it may be unclear whether the person providing the advice has sufficient competence in that particular area. A second reason


is that informal consultation requests may include very limited information about the situation and, as a result, recommendations may not take into consideration key aspects of the situation or case (Behnke, 2007; Fisher, 2017). Consultation may be most useful when it is part of an ethical decision-making model or guidelines, such as those offered by Fisher (2017), Barrett et al. (2001) or Younggren and Gottlieb (2004).

Offering Consultation.

While this column has largely focused on those seeking consultation, there are also important considerations for those who are asked to offer their opinions. For example, when being asked for advice, consider whether you have the competence and whether a personal relationship with the individual may impede your ability to give opinions (Gottlieb, 2006). For example, a family member who also happens to be a psychologist may not be able to provide unbiased advice. (See Gottlieb (2006) and Gottlieb, Handelsman and Knapp (2013) for excellent discussions of these topics.) Finally, responses and feedback that are respectful, sensitive, and acknowledge the limitations of the individual providing consultation (in terms of competence and lack of all relevant information) are often the most helpful and likely encourage individuals to have open and honest dialogue where disagreements are viewed as professional discussions rather than personal attacks. For example, some closed social media groups have an explicit “no bullying” policy to encourage supportive interactions and prohibit demeaning or disparaging comments.

Conclusion

Consulting with others in the field remains a key component of good ethical decision-making and, in our opinion, should be encouraged, especially in the training of future generations of psychologists. A trusted colleague may serve a critically important role as a non-judgmental provider of resources, issue clarification or even a sounding board and stress reliever. Additionally, technology, including the Internet, continues to expand ways for psychologists to connect and exchange information, solicit information, feedback and recommendations on a number of clinical and ethical issues. It's important to acknowledge, however, that increased access doesn't always mean increased comfort, and many may avoid soliciting consultation due to fears of being perceived as incompetent, receiving negative feedback for how they have handled the situation or even for just finding themselves in a particular situation. Moreover, for those who do seek consultation, it's important to remember the potential limits of peer consultation and the unique confidentiality

considerations, especially when using the Internet, that should be addressed. 

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Welcome to the Diversity Corner!

For the inaugural diversity corner, our committee decided it would be fitting to hear from someone who represents the future of our profession- a student!! Thus, we invited a student to write and submit our first diversity corner piece. We will hear from not just any student, but an extraordinary student, Jen Martinez, who was our first annual Student Diversity Award winner in 2017. In these turbulent and uncertain times, I feel hopeful knowing that psychologists like Jen are out there- doing amazing, groundbreaking work, helping to shape the future and promote the importance and significance of diversity! Please enjoy this submission.

Best,

J. Kim Penberthy, Ph.D., ABPP

Inaugural Piece

Jen H. Martinez, M.A.

University of Massachusetts Boston



My name is Jen H. Martinez, and I am a doctoral candidate at the University of Massachusetts Boston (UMB), as well as the inaugural recipient of Division 12's Distinguished Student Diversity in Clinical Psychology Award. It is an honor to be recognized for my commitment to diversity, as my commitment is not solely a research specialty or a badge I wear, but can be found in the multicultural lens with which I approach my work, and my value to make Clinical Psychology a field that truly addresses the experiences of individuals from marginalized statuses.

Most noticeably, my commitment to diversity can be found in my research, which focuses on the impact of race and racism on anxiety outcomes. This work has included evaluating the effectiveness of evidence-based treatments among people of color, and barriers to mental health care among people of color. My Master's thesis investigated the effects of cognitive strategies (specifically emotional acceptance and external, systemic attribution) as buffers in the relation between racial discrimination and Social Anxiety Disorder among

people of color. Most recently, my dissertation will be a randomized waitlist control study using a brief culturally-adapted mindfulness- and acceptance-based program to address coping with racism, coupled with an ecological momentary assessment study on the effectiveness of strategies for coping with racism.

My clinical work is also reflective of my commitment to diversity.

I chose clinical practicums that aligned with my commitment to providing care for underserved populations, which included working at a community mental health center and doing on-campus outreach for UMB's racially diverse campus. In these contexts, I gained experience translating scientific findings regarding cultural sensitivity and barriers to care into my clinical practice. Most recently, I have been working with DACA and undocumented student advocates to create psychological supports to address the specific needs of these vulnerable students on campus. I have also developed a resource website that identifies culturally-competent clinicians in the Boston area who are willing to see undocumented clients' pro bono or on a sliding scale. I also provide multicultural and LGBTQ sensitivity trainings and workshops for university organizations.

As a Ford Foundation Fellowship recipient, I am also committed to mentoring and supporting students of color in academia. As an instructor, I make sure my teaching is inclusive, so students could see themselves in the field of psychology. I include images of people of color in my lecture slides, and integrate discussions about oppression and marginalization within my Social Psychology course. I also guest lectured for a large Psychology 101 class on institutionalized power, privilege, microaggressions, and ways to cope with or support people who have experienced discrimination. After these lectures, many students thanked me for naming and validating their experiences, and showing them how psychology can address their lived experiences. I also provide individualized research mentoring to students of color in the context of my research team, helping undergraduate students to critically appraise research methodologically and culturally.



Jen H. Martinez

Together, these experiences are pieces of an ambitious long-term pursuit of conducting culturally sensitive research, examining strategies to reduce mental health disparities, and disseminating research. Further, an overall goal of my academic work is to change the higher education experiences for other underrepresented students by making coursework and research relevant to their experiences, allowing them to see themselves represented in the field, and to have places of support to feel included in academia.

Again, I am truly honored to be recognized for my work and commitment to diversity. Engaging in this type of work can be emotionally challenging, especially as a queer woman of color, and in the context of difficult national and political events. For this reason, I feel that this award above all honors the resiliency and tenacity required for pursuing an integration of multicultural and clinical research, and am grateful to be the inaugural recipient of this important and meaningful award. 🙏

Recently Added SCP CE Webinars!

Developmental Principles and Guidelines for Empirically Supported Assessment: Child and Adolescent; Treatment Planning; and Forensic Practice Perspectives

January 25, 2018

Panelists: Drs. Robert Patrick Archer, Michael Bagby, and Eric Youngstrom

Moderator: Dr. Paul Arbisi

Overview: Over the past decade attention has been focused on recommendations for the adoption of empirically supported psychotherapies and treatments in clinical practice. In contrast, there has been relatively little attention directed toward adoption of empirically supported techniques in psychological assessment. Since psychological assessment is a foundational component of clinical psychology as a discipline and a core competency in clinical practice, this webinar will discuss components that constitute empirically supported assessment and examine barriers to establishing principles and guidelines for evidence based assessment across three practice domains within clinical psychology: Child and Adolescent; Treatment Planning and Outcome; and Forensic.

Dr. Margaret Norris: Expanding Your Practice to Include Work with Older Adults

January 30, 2018

Overview: This webinar is informed by Dr. Norris' prior pre-convention APA workshops: 1) Managing a Professional Practice with Older Adults (What Psychologists Should Know about Working with Older Adults), conducted at the APA annual conventions from 2008 to 2014, and 2) Medicare Reimbursement Rules and Ethics in Geropsychology Practice (Expanding Your Practice to Include Older Adults), conducted at the APA annual conventions in 2015 and 2016.

CE Credits Available: 1

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To register, go to: <http://www.div12.org/dashboard/webinar-series/>

Kaitlin P. Gallo, Ph.D. - Editor


Section II: Society of Clinical Geropsychology

Submitted by Victor Molinari, Ph.D., ABPP



In 2017, SCG has been busy trying to fulfill its own mission and that of SCP. Some of the main achievements and projects we continue to work on are listed below.

1. **An action plan to increase SCG membership** has led to a recent increase in membership over the last few months but we are monitoring the situation closely. These actions included the development of promotional materials to highlight benefits of membership in SCG, and setting up a separate link to PayPal for new/renewing members.
2. **Just wanted to once again celebrate the 2017 SCG award winners:**
 - M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology: Michelle Karel, PhD, ABPP
 - Distinguished Clinical Mentorship Award: Daniel Segal, PhD
 - Award for Excellence in Gerodiversity: Nancy Pachana, PhD, FAPS, FASSA
 - Student Award for Excellence in Gerodiversity: Catherine M. Escher, BA
 - Student Research Paper Award: Elissa Kozlov, PhD
 - Student Research Paper Award, Honorable Mention: Allison Midden, MS

3. **SCG Mentoring committee** has added 3 new members. It is meeting monthly to work towards a number of proposed committee goals which include: submission for a special journal issue on mentoring in different career paths, submission of a Gerontological Society of America symposium on mentoring in different career paths, creation of a mentoring section/page of the new SCG website, and creative opportunities to link mentors to mentees.
4. **APA specialty application renewal.** A subgroup of SCG members was formed to assist in writing the renewal of the Professional Geropsychology specialty application. The renewal application was submitted to CRSPPP December 2016 and was approved at the 2017 CRSPPP meeting.
5. **Defining core competencies for psychological practice with older adults.** The Pikes Peak competencies for professional geropsychology practice define a broad range of competencies for specialty geropsychology practice. However, many professional psychologists who work with older adults are not pursuing specialty geropsychology training. SCG members have been working with the Council of Professional Geropsychology Training Programs (CoPGTP) to delineate foundational knowledge for psychological practice with older adults. A subgroup of SCG members led by Dr. Greg Hinrichsen conducted and analyzed the results of a survey of geropsychologist members which included links to the Society of Clinical Geropsychology. There was good consistency regarding rankings of a number of the foundational competencies and their behavioral referents. It is hoped that the findings of this survey are a first step towards the development of a more systematic sequence of CE offerings yoked to the varied training levels of the Geropsychology Taxonomy Grid developed by the Geropsychology Specialty Council. 

BECOME A DIVISION 12 MENTOR

Section 10 (Graduate Students and Early Career Psychologists) has developed a Clinical Psychology Mentorship Program. This program assists doctoral student members by pairing them with full members of the Society.

We need your help. Mentorship is one of the most important professional activities one can engage in. Recall how you benefited from the sage advice of a trusted senior colleague. A small commitment of your time can be hugely beneficial to the next generation of clinical psychologists.

For more information about the mentorship program, please visit www.div12.org/mentorship to become a mentor today.

The Clinical Psychologist is a quarterly publication of the Society of Clinical Psychology (Div 12 of the APA). Its purpose is to communicate timely and thought provoking information in the domain of clinical psychology to the Division members. Also included is material related to particular populations of interest to clinical psychologists. Manuscripts may be either solicited or submitted. In addition, The Clinical Psychologist includes archival material and official notices from the Divisions and its Sections to the members.

Inquiries and submissions should be sent
to the Editor, Jonathan S. Comer, Ph.D. at: jocomer@fiu.edu

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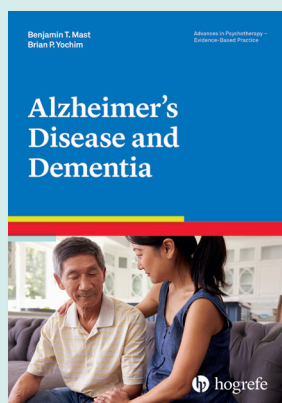
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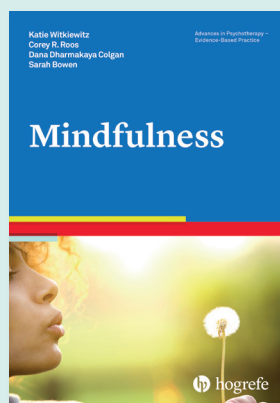


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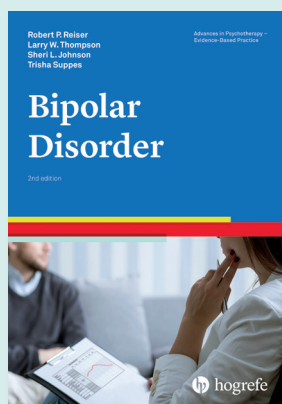


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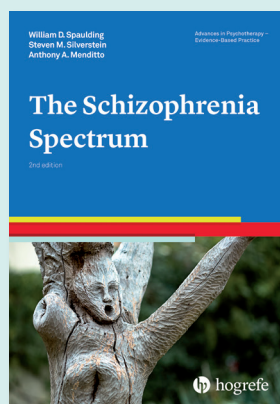


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- **ADHD in Children and Adolescents** by Brian P. Daly / Aimee K. Hildenbrand / Ronald T. Brown (2016)
- **Childhood Maltreatment** by Christine Wekerle / Alec L. Miller / David A. Wolfe / Carrie B. Spindel (2006)

Anxiety and Related Disorders

- **Obsessive-Compulsive Disorder in Adults** by Jonathan S. Abramowitz / Ryan J. Jacoby (2014)
- **Generalized Anxiety Disorder** by Craig D. Marker / Alison Aylward (2011)
- **Social Anxiety Disorder** by Martin M. Antony / Karen Rowa (2008)

Behavioral Medicine and Related Areas

- **Alzheimer's Disease and Dementia** by Benjamin T. Mast / Brian P. Yochim (2018)
- **Multiple Sclerosis** by Pearl B. Werfel / Ron E. Franco Durán / Linda J. Trettin (2016)
- **Chronic Pain** by Beverly J. Field / Robert A. Swarm (2008)
- **Treating Victims of Mass Disaster and Terrorism** by Jennifer Housley / Larry E. Beutler (2006)

Addictions and Related Disorders

- **Substance Use Problems, 2nd ed.** by Mitch Earleywine (2016)
- **Binge Drinking and Alcohol Misuse Among College Students Young Adults** by Rachel P. Winograd / Kenneth J. Sher (2015)
- **Nicotine and Tobacco Dependence** by Alan L. Peterson / Mark W. Vander Weg / Carlos R. Jaén (2011)

Sexual Disorders

- **Sexual Dysfunction in Women** by Marta Meana (2012)
- **Sexual Dysfunction in Men** by David Rowland (2012)

Other Serious Mental Illnesses

- **The Schizophrenia Spectrum, 2nd ed.** by William D. Spaulding / Steven M. Silverstein / Anthony A. Menditto (2017)
- **Bipolar Disorder, 2nd ed.** by Robert P. Reiser / Larry W. Thompson / Sheri L. Johnson / Trisha Suppes (2017)
- **ADHD in Adults** by Brian P. Daly / Elizabeth Nicholls / Ronald T. Brown (2016)

Methods and Approaches

- **Mindfulness** by Katie Witkiewitz / Corey R. Roos / Dana Dharmakaya Colgan / Sarah Bowen (2017)

Also available in the series

- **Heart Disease** by Judith A. Skala / Kenneth E. Freedland / Robert M. Carney (2005)
- **Problem and Pathological Gambling** by James P. Whelan / Timothy A. Steenbergh / Andrew W. Meyers (2007)
- **Chronic Illness in Children and Adolescents** by Ronald T. Brown / Brian P. Daly / Annette U. Rickel (2007)
- **Alcohol Use Disorders** by Stephen A. Maisto / Gerard J. Connors / Ronda L. Dearing (2007)
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- **Non-suicidal Self-Injury** by E. David Klonsky / Jennifer J. Muehlenkamp / Stephen P. Lewis / Barrent Walsh (2011)
- **Growing Up with Domestic Violence** by Peter Jaffe / David A. Wolfe / Marcie Campbell (2011)
- **Phobic and Anxiety Disorders in Children and Adolescents** by Aime E. Grills-Taquetchel / Thomas H. Ollendick (2012)
- **Language Disorders in Children and Adolescents** by Joseph H. Beitchman / E. B. Brownlie (2013)
- **Autism Spectrum Disorder** by Lisa Joseph / Latha V. Soorya / Audrey Thurm (2014)
- **Headache** by Todd A. Smitherman / Donald B. Penzien / Jeanetta C. Rains / Robert A. Nicholson / Timothy T. Houle (2014)
- **Women and Drinking: Preventing Alcohol-Exposed Pregnancies** by Mary M. Velasquez / Karen Ingersoll / Mark B. Sobell / Linda Carter Sobell (2015)

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| • Childhood Obesity | • Hoarding Disorder | • Posttraumatic Stress Disorder | • Panic Disorder and Agoraphobia |
| • Insomnia | • Body Dysmorphic Disorder | • Domestic Violence | • Persistent Depressive Disorder |
| • Dating Violence | • Bullying and Peer Victimization | • Internet Addiction | |