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## Inside The Issue

# PRESIDENTIAL COLUMN

## Can we do better?  Addressing structural barriers to increasing diversity in clinical psychology

### Carolyn Becker, Ph.D., Trinity University

According to the National Science Foundation (NSF), 1,149 clinical psychology doctoral degrees were awarded in 2017. Of the 1,044 awarded to US citizens or permanent residents (for which race/ethnicity data are available) 68 degrees (6.5%) were awarded to Black students, 99 (9.4%) to Latinx students, and 77 (7.3%) to Asian students. With regards to the diversity of our field, these numbers are grim given that a) these three ethnic/racial groups comprise almost 40% of the current US population, b) this portion of the US population is growing faster than we are expanding our production of clinical psychologists in the respective populations, and c) diversity is needed if we ever hope to address the treatment gap (Kazdin & Blase, 2011).

I am going to argue, however, that from clinical psychological science perspective, the picture is much worse. According to the APA report on student and faculty statistics in accredited doctoral programs, between 2001-2009 (I was unable to find more recent data), it appears that approximately 47% of clinical degrees came from PsyD programs, which largely do not provide robust training in psychological science. Assuming Black students attend PhD programs at a similar rate to the overall population of clinical doctoral students, this means that the field only gained 36 Black PhD clinical psychologists in 2017 (i.e., 53% of 68). Unfortunately, the previous assumption is likely unfounded. According to the 2017 APA summary report on student demographics in graduate school, Black psychology graduate students are overrepresented

in free standing professional schools (15.8%) relative to university-based programs (6.1%). The opposite is true for White students (58.0% versus 75.1%). This suggests that Black students may be somewhat more likely to end up in clinical doctoral programs without a strong science focus. In summary, in all probability, the diversity problem that exists generally for clinical psychology is even worse if we focus on clinical psychological science.

So what are we to do? Certainly, the field has made efforts to increase the diversity of the field. One indicator is the increasing availability of diversity "weekends," during which top programs invite underrepresented students to visit their program and learn about the application process. Yet, despite these programs and other efforts, we simply are not seeing the diversity we both want and need. Clearly there are structural barriers we are not addressing.

One barrier to the diversification of clinical psychology appears to be the GRE.  The rationale put forth by advocates for dropping the GRE is simple. First, the GRE is widely acknowledged to be a biased assessment measure that benefits White students over underrepresented students of color (e.g., Garces, 2014, Smith & Garrison, 2005). Indeed, according to the 2012-2017 report by Educational Testing Service (ETS), which owns and administers the GRE, Black women on average score lower than any other race/ethnic/gender group on the GRE. Miller and Stassun, who are both physics professors, argued in Nature (2014) that the GRE is "a better indicator of sex and skin colour than of ability and ultimate success." They are not alone in their assessment of the GRE. Garces argues that admissions committees need to reassess their reliance on standardized tests because they are inadequate indicators of success for underrepresented students of color (2014). Posselt (2016), in a comprehensive look at graduate admissions, also notes that many graduate admissions committees rely on criteria that maintain inequities.

Second, the GRE represents a financial barrier for students who have decreased economic resources. Third, the GRE is increasingly being recognized as a poor predictor of academic success in STEM graduate programs (e.g., Miller, Zwickl, Posselt, Silvestrini, & Hodapp, 2019). Interestingly, in a recent study investigating the degree to which GRE scores predicted success in STEM PhD programs, the main finding was

that men who dropped out of their programs had significantly higher GRE scores than those who completed (Petersen, Erenrich, Levine, Vigoreaux, Gile, 2018). The lack of predictive power for PhD completion is acknowledged by ETS staff. For instance, David Payne, an ETS vice president, has been quoted as saying that the GRE was "never intended to predict PhD completion" (Halford, 2019).

## "We simply are not seeing the diversity we both want and need... Clearly there are structural barriers we are not addressing."

One might expect clinical psychological science programs to be a leader in a) using evidence to guide selection of assessment measures, b) generating testable hypotheses about the impact of using, or eliminating, a particular measure, and c) testing those hypotheses. As best I can tell, this is largely not being done. Instead, other fields are more actively debating the impact of the GRE and changing their practices (hopefully they will also test the impact of changes). For instance, 200+ STEM graduate programs have dropped use of the GRE. Most fall within biological science/neuroscience fields (Langin, 2019; see google docs link at end of column for a list of programs). Chemistry, however, appears to be starting to follow suit (Halford, 2019), and colleagues in physics report that many in that field are actively contemplating reduced reliance on the GRE. Interestingly, between the time I wrote a draft of this column and the time I received feedback on it from colleagues, Princeton dropped the GRE as requirement for 14 programs including psychology, which does not have a clinical program (Aronson, 2019). All of this leave me wondering – is it time for clinical psychology to step back and take a new look at our reliance on the GRE?

In addition to the above arguments, my question is partly fueled by witnessing the tremendous power the GRE can exert in blocking underrepresented students' admission to graduate programs in clinical psychology. Take, for example, the case of Jordan. Jordan is a Black woman, who spent over two years working in my lab at Trinity University. Jordan was an outstanding member of my lab. Indeed, the overall quality of the work in my lab dropped markedly when she graduated because Jordan set the bar so high that she elevated everyone's performance. To this day, Trinity science students can thank (or curse) Jordan for their 24-hour access to our science buildings. The university president changed the building access rules after Jordan complained she was unable to start working on a research project at 6 am because the building wasn't open.

In large part because of very poor GRE scores[1], Jordan initially applied to research-oriented masters programs with the aim of boosting her credentials for admission to a doctoral program. Yet, despite very strong letters of recommendation, great research experience, and a GPA that exceeded all of the masters programs' GPA requirements, Jordan was rejected from every program to which she applied. I called colleagues at several programs to confirm my suspicion that this pattern was based on her GRE scores; consistently I was "confidentially" informed me that their admissions committee considered her scores unacceptable.

At this point Jordan believed her desired career was over. However, Assumption College, which runs a very strong CBT-focused masters program, long ago abandoned use of the GRE for admissions and their deadline had not yet passed. Jordan initially chose not to apply to Assumption because of its heavy clinical focus. Once he heard what had happened, however, the director of Assumption's program offered have Jordan to do a thesis with him so as to help her prepare for a doctoral program. Long story short – Jordan thrived. She graduated with a 3.87 and defended her oral exam with distinction. I should note that by this point, Jordan had several publications as well.

After hiring a GRE tutor (at vast expense) and studying extensively, Jordan once again took the GRE and once again – she performed terribly. Jordan, however, is nothing if not resilient, and she decided she would rather fail than not try to pursue her dream career. Ultimately, she went on 2 interviews and was admitted by a great program that has no minimum GRE criteria. Today, despite having to live in one of the most racially charged areas in the US, Jordan is flourishing in her graduate program. Indeed, by the end of her first year, she had already written and been awarded a small grant to support her research.

While Jordan's story ultimately has a happy ending, there are a few things to keep in mind. First, Jordan came from an undergraduate program with a great track record in student admissions to clinical psychological science programs. From 2013-2018, 20 Trinity students applied to clinical psychology PhD programs; 95% were admitted to any program and 90% were admitted to a program with a clinical psychological science focus. Approximately 30% of these students were Latinx or Black. Second, Jordan applied to work with eating disorders mentors, and I am former president of the global eating disorders association. Thus, she

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1  It is worth noting that Jordan's poor GRE scores were 5 points above the mean for Black women. Based on 20 years of data that I have collected on our students who apply to doctoral programs, if Jordan had been a White man and scored 5 points above the mean for White men, those scores would have been completely acceptable to most clinical doctoral programs.

largely applyied to work with people I know very well; some of whom had already admitted other successful students from Trinity. Third, several of my colleagues informed me that they fought their admissions committees to invite her for an interview, but couldn't overcome "the GRE issue." Fourth, I also learned that her interview at the program where she was not admitted went well and that some faculty wanted to accept her. But once again – they could not overcome "the GRE issue." Fifth, another colleague informed that to this day she would not be able to get Jordan admitted to her program because her chair would argue against accepting someone who did not have "everything we want" when they had candidates who did meet that bar. This rationale, however, is highly problematic if one of the desired metrics is biased.

So to recap, a Black woman with a 3.87 masters GPA and several solid publications, who had numerous posters at ABCT, extensive clinical psychology research experience, good CBT training, super strong letters of recommendations by well-known professors, solid advising, and a successfully completed a masters thesis, was denied admission by every clinical science program to which she applied, except the one that did not require a minimum GRE score.

**So I have to ask – how many other Jordans, who have the drive, the determination and the ability to succeed – and who have the fortitude to survive the racism that remains endemic in higher education – are being denied entry to our field because of the GRE?**

This is my last presidential column; hopefully I have given you something to think about. But even if not, I want to thank the membership of SSCP for allowing me to serve as president. It has been an honor and a pleasure.

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**To see the ongoing list of schools in the bio/biomedical sciences dropping the GRE go to:**

https://docs.google.com/spreadsheets/d/1MYcxZMhf97H5Uxr2Y7XndHn6eEC5oO8XWQi2PU5jLxQ/edit#gid=0

# JOIN US AT ABCT IN ATLANTA!

**Clinical Psychological Science Special Interest Group (SIG) meeting**

**Saturday, November 23
4:00PM-5:30PM**

Embassy D, Embassy Level

Please email the SIG organizers if you plan to attend:
Nick Perry: nicholas_perry@brown.edu
Diana Bennett: Diana.Bennett2@va.gov

You're invited to the

**SSCP** Social

at ABCT

Friday, November 22
4:30 - 6:30pm

TAQUERIA
**TIN LIZZY'S**
CANTINA

121 Perimeter Center W
Atlanta, GA 30346

# Diversity Corner

## Diversity Spotlight: Dr. Natalie Watson-Singleton

### Yara Mekawi, M.A., and Joya Hampton, PhD

A California-native, Dr. Natalie Watson-Singleton's journey in academia started at the University of Dallas for her undergraduate degree in psychology, then to the University of Illinois at Urbana-Champaign for her doctorate in clinical-community psychology, and then back south to Atlanta, where she is currently an assistant professor at Spelman College. Dr. Watson-Singleton's expertise centers on Black women's mental health, a passion she has been pursuing ever since she learned about and was "hooked" on the concept of intersectionality in college. You can find her work in outlets such as Cultural Diversity and Ethnic Minority Psychology, the Journal of Counseling Psychology, and the Journal of Black Psychology. Right now, she is focused on implementing a study funded by the National Institute on Minority Health and Health Disparities entitled, "Culturally Responsive Stress Reduction: A Mobile Mindfulness Application to Support Health Promotion for African Americans." When she isn't busy piloting culturally-responsive mobile health apps for African Americans, mentoring students, or teaching, she enjoys practicing restorative yoga, getting soothing massages, and eating good food with good friends. We are so excited to have had the opportunity to sit down with Dr. Watson-Singleton and talk to her about her research and approach to diversity across scientific, clinical and pedagogical contexts.

## 1. What is your definition of intersectionality (or diversity)?

Intersectionality recognizes that intersecting identities (e.g., race, gender), along with intersecting forms of oppression (e.g., racism, sexism), contribute to different experiences and health trajectories for individuals. Also, consistent with the initial theorizing of intersectionality by Black feminist theorists, such as the Combahee River Collective, it's important to me to highlight how intersectionality's original aim was to examine multiple marginalized identities specifically rather than multiple identities generally. Although this application of intersectionality has been debated, I think it is imperative to focus on multiple marginalized identities because I have seen research employ the "buzzword" of intersectionality while conducting research with the most privileged members of marginalized groups (e.g., white women) when this approach is what Black feminists were trying to problematize and challenge.

## 2. From your perspective, how is intersectionality (or diversity) relevant to the field of clinical science?

First, clinical science aims to expand scientific knowledge in the field of clinical psychology in order to reduce the pervasive and persistent burden of mental illness. Yet, in our discipline, there is limited scientific knowledge and research on the experiences of marginalized groups who are affected by intersecting "–isms" (e.g., racism, sexism), like African American women, poor women, and sexual minority people of color. Therefore, intersectionality becomes a clarion call to remind us of the gaps and blind spots in our scientific knowledge base; blind spots that can cause us to overlook and to not address the disproportionate rates of mental illness and barriers to treatment for diverse groups. Second, clinical science values delivering empirically-based services, and when this value is combined with intersectionality's key questions of, "Who is included?" and "Who is not included?", we are encouraged to examine for whom our services were designed to serve and for whom are services treat best. For example, research indicates that African American women experience more health benefits when they are treated with culturally-tailored interventions. Yet, despite this information, African American women are not routinely offered culturally-responsive behavioral health care. Also, African Americans are less likely to receive evidence-based medication therapy or psychotherapy. Therefore, when the field does not prioritize making treatment decisions or using treatments that are scientifically grounded, underrepresented communities suffer the most. Third, intersectionality provides a useful heuristic for understanding how individuals' identities and lived experiences are negotiated via direct contact with sociocultural factors, like institutional practices, politics and practices, and societal values. This focus ensures that we, as clinical scientists, encompass multi-level variables within our understanding and treatment of mental health for marginalized populations.

**3. From your research, what are some major themes lessons learned about African American women's mental health and help-seeking behavior?**

**#Blackwomenscholarshipmatters**

As an African American woman doing research on African American women, I sometimes felt I had to go above and beyond to justify the importance of my work. There have also been times when there seemed to be an implicit devaluing of topics related to women of color, especially if this work was being conducted by women of color. Despite not always feeling welcomed within the academy, whenever I would discuss my research about strength and its impact on African American women's health, I would watch as my friends' and family members' eyes would widen with excitement. They were moved to know that someone cared enough to do research on a topic that was relevant and meaningful to them. These experiences validate and affirm the importance of my work, and they further motivate me to conduct psychological research that reflects the importance of context and culture.

**Culture matters – like, it really matters.**

Given my research and clinical interests, I spend a lot of time talking to African Americans about how to create and develop culturally-responsive behavioral health interventions. I truly enjoy this work, and one of the things that has continued to surface is the importance of culture. Culture – the socially shared values, norms and beliefs reflected in our everyday practices, institutions and artifacts – imbue our perceptions, behaviors, and attitudes regarding mental health. For most of the people I talked to, it was important to see their cultural values and practices reflected in behavioral health interventions and provided by people who understood their cultural background. Therefore, for many of the African American clients and research participants I have spoken to, there is a desire to engage in interventions developed "for us by us." I have learned that if we – clinicians and researchers alike – truly and meaningfully attend to culture in its complexity, we can create interventions that promote comfort, validation, and a sense of belonging among diverse communities, including African American women.

**Culture matters, but it's not the only thing that matters.**

Because of my research and clinical interests, I not only talk to African Americans about how to develop culturally-responsive behavioral health interventions, but also I provide consultation on how to tailor interventions to meet the needs of diverse groups. One of the challenges of this work has been to emphasize the importance of culture and culturally-relevant factors while also protecting against the tendency to overly rely on cultural stereotypes. Therefore, I am continuing to learn about the importance of helping people to understand the salience of cultural values while also attending to meaningful within group differences.

**4. How do you utilize research about African American women in a clinical context, in terms of assessment and case conceptualization?**

In my research, I am repeatedly reminded of the clinical relevance and impact of the Strong Black Womanhood Schema – a multidimensional dispositional style that reflects women's distinct intersectional race-gendered experiences – in African American women's lives. Many women adhere to this schema's expectations, like suppressing emotions, taking on multiple roles and responsibilities, forgoing emotional support from others, and prioritizing others' needs over their own. I am especially attuned to how this unique socialization for African American women gives way to prescribed attributes and behaviors that foster inner strength and self-efficacy as well as may influence emotion regulation difficulties. For example, this schema's expectation to suppress emotions to avoid appearing 'weak' can lead to chronic emotional inhibition, nonacceptance of emotions, and limited emotional awareness. These emotion regulation processes may lead to unhelpful coping strategies and harmful health outcomes in the context of individual stressors, like trauma and gendered race-related discrimination. Therefore, as a multiculturally-oriented clinical scientist, I approach assessment and case conceptualization by attending to prominent, empirically-validated theories of psychopathology (e.g., models of emotional regulation) as well as individual-level (e.g., trauma history) and sociocultural-level factors (e.g., gender socialization) that influence presenting concerns and barriers to effective action.

**5. What unique barriers or stressors might graduate students of color face in clinical science doctoral programs? What strategies do you think faculty members and administrators can employ to reduce these barriers?**

*BARRIER 1:*
As an African American woman doing research on African American women, I often felt like I had to go above and beyond to justify and/or explain the importance of my work. Growing up I witnessed how my mother, grandmother, and aunts displayed a quiet strength as they cared for others. They persevered in the midst of hardships, forever "keeping it together" for the sake of family and work life. Experientially, I knew that African American women were utilizing life management strategies that were a response to marginalization and that were negatively impacting their health. Yet, I was not satisfied with what the (lack of) research had to say about this phenomenon. When I decided to study this phenomenon, I received support from some. Also, I regularly received questions like, "Is this phenomenon generalizable to all women?" "What are the implications of solely focusing on African Americans/African American women?" These kinds of questions about my research made it difficult to disentangle which questions/concerns were indicative of the desire to enhance my research's scientific merit versus indicative of an implicit devaluing of topics related to communities of color. Meaning, when students conduct research with European American samples do they routinely receive similar questions about

the (lack of) generalizability of their findings? Therefore, I think some graduate students of color may feel that the kinds of questions they're interested in are devalued and discouraged.

**• Hire more faculty of color who conduct research on diverse communities.**
I learned how to respond to questions about the inherent value of my work through modeling what I observed and saw from my academic mentors – most of whom were women of color with strong and active programs of research. Because my mentors had navigated similar struggles, I was able to learn from their experiences. This validated what I went through and it also provided me with the ability to produce strong, scientific work and challenge questions and concerns about my research that were inherently microaggressive.

**• Provide monetary support for students of color to travel to conferences.**
When I was a graduate student at University of Illinois, each year I received financial support to attend conferences. This allowed me to attend conferences, like Division 45's Biennial Conference, Association of Black Psychologists (ABPsi) annual conference, and Division 27's Society for Community and Action Research Biennial Conference. Being in these spaces afforded me the opportunity to meet others in the field who were conducting similar research and who appreciated and valued my work, which provided me with the necessary inspiration and strength needed to stay the course.

*BARRIER 2:*
For many graduate students of color, we are the first ones in our families to attend graduate school. We may internalize pressure to make our families and communities proud. It also means we have limited social capital and/or personal examples of what it looks like to successfully navigate academia on this level. This can lead to self-doubt, unclear expectations, and isolation.

**• Provide all students with clear benchmarks that should be achieved each year**.

**• Provide all students with clear, action-oriented strategies on how to achieve those benchmarks**.
This does not need to be an exhaustive list, but faculty and former students can be polled to provide recommended strategies that helped them achieve the expected benchmarks.

**• Provide support and resources for students to achieve those benchmarks.**
In my graduate program, each year, students from underrepresented groups received monetary support to attend conferences and collect research. This allowed me to add paper and poster presentations to my CV and to maintain an active program of research that resulted in publications.

**• Create a peer-to-peer mentoring program, and provide peer mentors with a stipend for their service**.

Graduate students of color often bear the responsibility of mentoring other graduate students of color. This peer support is extremely beneficial, and in the spirit of equity, I believe these students should be compensated since they are often expected to participate in greater diversity-related service than their European American peers.

*BARRIER 3:*
In my experiences, academia has been designed to highlight all the ways we are not enough – the ways we have not published enough, the ways we have not written enough, the ways we have not done enough service nor secured enough grants, etc. This is difficult for anyone, and I think this is especially challenging for graduate students of color who may already feel as if they do not belong or as if they are navigating a space not designed with them in mind.

**• Provide consistent and systematic feedback highlighting the things that are going well.**

**• Promote greater transparency across faculty and students**. Part of what contributed to my anxiety about "not doing enough" is I didn't have actual data on how much my peers were actually doing. It seemed like everyone was busy, but there was limited objective data on how much people were publishing (or not), how may conferences they were attending (or not), etc. It could be beneficial for departments to provide yearly information on the minimum and maximum markers across different benchmarks. For example, in a given year, departments can report the minimum number of publications per student (e.g., N = 1) and maximum number of publications per student (e.g., N = 3).

**• Offer workshops and/or training on self-compassion, especially as it relates to perfectionism and productivity.**

**6. You graduated from a combined clinical and community program. How did your community psychology education influence how you think about clinical research and practice?**

I received invaluable training in my clinical/community program, and it has shaped my clinical research and practice in a number of ways. Because of this training, I am committed to adequately attending to the effects of institutional and social inequities that enable and/or perpetuate marginalization, and in turn, shape the health trajectories of marginalized group members. Therefore, my clinical understanding of any presenting problem, whether as a clinician or researcher, takes into account systems of equality and inequality. Relatedly, although my research agenda considers the necessity of access to and availability of culturally-responsive behavioral health interventions for diverse groups, I understand the inherent limitations of treating behavioral health concerns at the individual level. Therefore, I am an advocate for social justice initiatives that aim to create policies and institutional practices geared towards enhancing the lives of diverse communities.

# Clinician Perspective

## How to adopt the scientist-practitioner model outside academia

### Anahí Collado, Ph.D. Alvord, Baker & Associates, LLC.

There is a long-standing and well-documented "chasm" between academics and clinicians across disciplines. In clinical psychology, the tenets of the scientist-practitioner model ascribe an equal value to the contributions of research and practice and guide psychologists to ensure that each aspect informs the other. Although the scientist-practitioner model is the dominant approach in forming clinical psychologists, tensions between the camps have transformed the training model into an abstract aspiration that is oftentimes difficult to internalize and realize. Experts have noted that these tensions seem to be rooted in generalized beliefs from academics that practitioners waver in adhering to the guidelines of evidence-based care, and from practitioners that academics recruit samples and utilize research methods that do not represent a much more complex "real-world."

Personally, my aim of achieving scientist-practitioner status became more tenuous during the later stages of my graduate training. I felt an implicit pressure to identify as a future practitioner or an academic. I also held the belief that if I chose one over the other, that decision would be definitive and I would be forced to surrender all work on the unchosen path. Graduate students often discussed that it was easier to transition from the research to clinical work than the other way around. The idea of choosing one over the other further reinforced my belief that the two paths were mutually exclusive. Therefore, I decided to be safe and seek pre- and postdoctoral experiences that aligned with my type-casted view of what research environments valued. Now, since I am writing the Clinician's Perspective and not the Clinical Science Early Career Path article of this issue, you may have guessed that things did not turn out the way that I had belabored in my head.

### "I believe that I am a better researcher because I am actively involved in clinical practice and vice versa... My choice is not to choose."

Once I was in the anticipated "job market" stage, I learned of environments that reconciled the academic's vision with the practitioner's insight. Not only did these seemingly mythical and remote places accept the tenets of the scientist-practitioner model, but undertook the until-now unconceivable task of upholding its spirit, and breathing it. I am fortunate to be a part of a group practice whose mission is to provide high quality men-

tal health care supported by research. I would like to explain how this occurs in practice drawing on three main examples:

1. To espouse the scientist-practitioner model broadly, the director of the practice at which I work, Dr. Mary Alvord, developed an intensive 2-year training institute that provides instruction and practice to professionals from various disciplines across the U.S. on the provision of empirically-supported treatments for a variety of mental health care needs among youth. These training practices allow the continuous transfer of up-to-date knowledge that encourages true inter- and multidisciplinary collaborations and partnerships. It is also noteworthy that various mental health providers in the practice maintain active affiliations with various academic institutions. To solidify the communication between scientists and practitioners, the practice invites numerous treatment and psychopathology experts to lead continuing education seminars. People interested may join the seminar in-person or remotely using videoconferencing technology to disseminate the information widely.

2. Through the practice, I am part of a very active research team whose goal is to establish the effectiveness of the Resilience Builder Program® (Alvord, Zucker & Grados, 2011) in improving socioemotional competencies in youth with elevated internalizing and/or externalizing symptoms. Consistent with the stages of treatment development (Carroll & Nuro, 2002), data were first collected in pilot and feasibility trials in a clinical setting. Stage 2 involved clinical psychologists providing RBP in school settings and comparing the outcomes to a waitlist control condition. Currently, Dr. Alvord has founded a not-for-profit organization (Resilience Across Borders, Inc.) to assess the trans-

portability of the treatment in school settings with children from historically underserved communities. The results thus far are promising and suggest that children who receive the RBP report a significant increase in emotional control and a significant decrease in negative emotion (Rich et al., 2018). This research endeavor is only able to be successfully accomplished through constant dialogue between academics, scientist-practitioners, school personnel, and the community, which includes children and their parents. Through this true multidisciplinary collaboration, the scientist-practitioner model is able to come to fruition.

3. At a smaller level of analysis, and in accordance to the suggestions of those who have attempted to bridge the gap between researchers and practitioners, my colleagues and I construct case formulations with information about clients' histories (familial, social, cultural, religious), course of illness, self- and interpersonal factors obtained via an intake. The case formulation is refined and enriched as clients progress in their treatment plan through a data-driven process. Specifically, we collect client data periodically to assess improvement through a comprehensive assessment that measures adaptive and problem behaviors across various settings. Much like a clinical trial, proposed mechanisms of change are targeted throughout the course of treatment. Progress (measured by these assessments) informs treatment selection and necessary treatment modifications. The case formulation process is also supported by weekly individual and group case consultation.

The idea that being involved in the clinical practice of psychology could undermine my efforts to become a scientist-practitioner seems so foreign and confusing. I believe that I am a better researcher because I am actively involved in clinical practice and vice versa. I look forward to continuing to embrace my most recent identity as a scientist-practitioner who is dedicated to enhancing professional practice and clinically-informed research to help others find a sense of belonging, recognition, and connectedness. My choice is not to choose.

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# Early Career Perspective

## Lessons Learned in How to Intentionally Spend Your Time

### Brooke Ammerman, PhD University of Notre Dame



I am currently in my second year as an Assistant Professor at the University of Notre Dame. My path to academia was somewhat circuitous. After taking a leave from my initial undergraduate institution after a few short weeks of being a pre-law student, I enrolled in the university nearest to where I was then living, North Dakota State University. I was fortunate to have mentors that helped me find, and facilitate, my interest in psychology. This interest and my work experience as a full-time mental health technician wasn't enough, however, to grant me acceptance to a doctoral program. Hoping to gain clinical skills (as that was my desired career path at the time), I began a master's program at University of Northern Iowa. There I found that research was my true passion. I was suddenly determined to end up in academia, and attempted to gain as much research experience, across the board, as possible. Lucky for me, and my wallet after re-taking the GRE several times, I was accepted at Temple University. I felt like I had finally "made it" to the next step and promised myself I would work as hard as needed to achieve my next goal. I spent all of my time doing that typical graduate school routine: classes, research, practicum, lab work, etc. After completing my internship at the VA Puget Sound, Seattle Division, I began my position at the University of Notre Dame. All of this felt like whirlwind, and at times, somewhat tireless. But, I thought, now that I've truly "made it", I will have the chance to slow down, to work less, to enjoy more aspects of life.

Despite being told the first few years of faculty are the hardest, I didn't have a realistic expectation of what life was now going to like. Moreover, I wasn't prepared for the fact that this was now my life; that is, during graduate school, it was easy to tell myself that this is just how things are for now, but, beginning as faculty, there was an acceptance that this is how things could be for the rest of my career. That acceptance process forced me to reflect upon what I thought being a faculty would be like, how is it different than that, and how I can find a sustainable middle ground.

## "Only you can choose how to spend your time."

The first step was realizing that being a junior faculty is hard. There are more demands on your time, and always "more balls in the air", than I imagined. I think in my early graduate school years, I had assumed that as a faculty member I would have an incredible amount of time to work on my own research and, consequently, the bandwidth to make great strides and shape my field, all before tenure. Plus, I fully anticipated that I would have more control over my evenings and weekends (at least compared to graduate school) to develop and maintain extensive hobbies and successful relationships. I admit this was a rather rose-colored glasses view (we have to get through grad school, somehow, right?), but I don't think an uncommon one. While this picturesque experience may be the case for some faculty, I have quickly learned, I don't think this is the norm. After surviving my first year as an Assistant Professor, I finally took a step back to consider, why did the learning curve of time and stress management feel so steep? I thought I had done a decent job of these things in graduate school and yet, here I was, constantly feeling behind and like I was short-changing the majority of my responsibilities, work-related and not.

After some serious reflection on how to find a sustainable middle ground between what I expected from being a faculty and what the realities were, I realized that during graduate training I didn't have enough practice or persistence in setting healthy and appropriate boundaries. We all hear about this being important to our professional development, but no one really talks about what this actually means, so we assume that if we aren't miserable all of the time, then we must be fine! However, I would like to advocate for that not being the case. Start learning to set boundaries. This might be with others at work, your friends / family / significant

other, or, and perhaps most commonly, yourself. There will always be more demands for your time than you have; a fact that only becomes more true the farther along and successful (I assume) you get in your career. Indeed, there will always be work that "needs" to be done, someone asking you to help out with a project or to provide feedback on a manuscript, and a friend / family member you've been meaning to connect with.

> **"I would encourage every graduate student to develop a better sense of their personal identity, both related and unrelated to their career goals, and try to begin prioritizing their time in accordance."**

While this will never change, it will become increasingly clear that only you can choose how to spend your time. It will also become evident that, as your demands increase any way you choose to spend your time will have, at some level, consequences – each day only has 24 hours and if you opt to spend your time one way, you are choosing not to spend it another. This is the key piece that I didn't begin to fully understand until becoming a faculty member, when I started having more responsibilities not directly linked to my own research and career goals (which, for the most part, is a shift from graduate school). It has required me to have a new level of intentionality with my time. Moreover, it has forced me to figure out what: (a) I need to be a happy and healthy person; (b) I need to do to keep enjoying your job; and, finally, (c) I need to do to consider myself successful in that job. In that order. I am still working on figuring out all three, but here are few thoughts on what I have learned so far.

**A. I've learned that I need an identity outside of work.**

For me, this comes through hobbies and relationships. During graduate school I was attainable through the built-in social network of cohorts and my new-found passion for running. Once I started as a faculty, however, this became much harder. For a while I believed that since I had finally obtained the career I wanted, I shouldn't need anything else. This came at a detriment to my overall happiness, in addition to negatively impacting my work. It took me a while to realize this, but since, I've started carving out time for these aspects of my life. Even on the days that I don't think I have the time. It has been incredibly important for me to have another meaning. Not every day (or week) at work is going to be a good day and having other domains as part of my identity is key for me as a buffer against burnout.

**B**. **I've learned that I need to protect what it is that I enjoy most about work.**

For me, this is falling down a "dark hole" on a project, spending several hours trying to solve a problem or formulate a new study design. This was much easier to do in graduate school. Now, I rarely have a multiple hour block free in my schedule, and if I do, I tend to look at my to-do list of "have"-to's versus "want"-to's. After not prioritizing the research projects I wanted to be working on for the majority of my first year, I found that the joy of going to work was starting to fade. It's has been key for me to block time on my schedule each week that is dedicated to working on only the things I want to, regardless of what else is on my plate. I will admit that this one is still a work in progress, but, I am improving and happier at work as a result.

**C. Finally, I've learned that I need determine my definition of success**.

For some, it might be the image we all have of large lab, with numerous post-docs, graduate students, and research assistants, all supported by grants. But, for others it might not be, whether it be due to the institution they are at or what they value. And that's okay. There is no right answer, nor is this answer likely to be stable. However, in forcing myself to consider "what would it mean to be successful?", I've had an easier time prioritizing all of the extra demands that attempt to take my time and, moreover, have felt a greater investment in the way I do choose to spend that time.

Being a junior faculty is hard, but can also be incredibly enjoyable and rewarding. Based on my transition from grad student to faculty thus far, I would encourage every graduate student to develop a better sense of their personal identity, both related and unrelated to their career goals, and try to begin prioritizing their time in accordance. Eventually, you will no longer be chasing a tangible end goal (i.e., successfully obtaining employment), and instead you will have to determine how to spend your time, day in and day out. Why not start practicing now?

# Student Perspective

## Meta-analysis made (somewhat) painless

### Marissa Bowman, MS University of Pittsburgh

Meta-analysis is a powerful method to help scientists draw robust conclusions. Specifically, it is a quantitative method to aggregate findings from many published articles to more precisely estimate the observed effect size between two variables of interest. This method is critical to ensure that medical and psychological treatments are evidence based using the aggregation of available empirical data. A meta-analysis can account for sample sizes and study error, does not rely on study p-values, and can both introduce new quantitative evidence of an overall effect size, as well as moderators of the effect size. While these studies cannot fulfill the same editorial, perspective-driven roles of review papers, meta-analyses can help us to quantitatively summarize what may seem to be inconclusive fields of research.

## "A meta-analysis is only as good as the question that it is designed to answer."

When presented with the option to perform a meta-analysis or to write a review for my comprehensive exam at the University of Pittsburgh, I chose a meta-analysis for a few reasons. First, I was excited by the opportunity to learn a new statistical method within the context of a milestone. I believed it was important to push myself to learn techniques that will help me answer complex questions within my field, and the deadline of a milestone would help me to complete the meta-analysis in a timely manner and avoid re-running the search terms if too many new articles are published. Second, I had a research question ("What do several dimensions of sleep look like across the lifespan among healthy individuals?") that would be answered more effectively by meta-analysis than by literature review. This is not always the case, especially in fields that are less well-established (i.e. few studies) or are highly cross-disciplinary.

There are some excellent resources (e.g. Borenstein, Hedges, Higgins, & Rothstein, 2011; Higgins & Green, 2011) that discuss conducting a meta-analysis with clarity and significant depth. Here, I provide an overview of the process of performing meta-analysis, with resources and suggestions that I have found useful in my personal experience.

**(1) Identify your question.**

A meta-analysis is only as good as the question that it is designed to answer. To test whether your question is appropriate, I recommend the following tests:

• Is this question best answered by a meta-analysis? This is the case when the answer is an overall effect size. For example, a meta-analysis would be helpful for understanding the overall effect of insomnia on risk for developing major depressive disorder. In contrast, a meta-analysis would not be recommended for researchers interested in integrating diverse literatures testing the multiple plausible mechanisms linking insomnia and depression.

• Has your question been previously answered by a meta-analysis? To find out, explore the extant literature, as well as in-preparation projects on the international prospective register of systematic reviews (PROSPERO; https://www.crd.york.ac.uk/PROSPERO/).

**(2) Develop your search terms**

Meta-analyses are supposed to be unbiased, so they rely on systematic screening of scientific literature using specific, pre-determined search terms. For this step, librarians are your best friends. I have been working with an experienced librarian who has helped me to learn:

• which databases are required to search (per Cochrane review guidelines, Higgins & Green, 2011) and which may be topic appropriate (e.g. PsycINFO),

• how to develop search terms across the databases, and

• how to test the results of different search term strategies to obtain optimal results.

**(3) Pre-register your meta-analysis on PROSPERO**

PROSPERO has an excellent series of questions you must answer for the pre-registration. This structure forced me to carefully think through the parameters of my meta-analysis in advance, e.g. what effect size types I would include, which study designs I would include, which moderator variables I would track, etc. Pre-registering increases the transparency of your analyses and (hopefully) stakes your claim on your question and method before others can beat you to it.

**(4) Organize your screening flow, and choose a good software to do so**

In a meta-analysis, there are three steps for evaluating articles for eligibility:

• Evaluate the titles and abstracts of articles for eligibility based on the description of the study. In my case, I could tell from titles and abstracts alone whether a study's design was wholly ineligible. I excluded articles based on phrases like "meta-analysis" or "systematic" or "narrative review." I could also quickly exclude studies where sleep was manipulated without data collected for baseline.

• Read the full-text articles that "pass" the first evaluation step, to determine if the publication reports on the effect size of interest (e.g. the association between age and sleep.)

• Extract the data from articles that you need to perform your meta-analysis.

For this critical step of article screening and data extraction, I strongly recommend using a management software designed for this purpose. Some good options include DistillerSR (which I used, thanks to a membership through my university library), Covidence (which has a mobile app for screening on-the-go), and Rayyan (which is free, albeit a little less user-friendly, in my opinion).

**(5) Recruit colleagues to serve as independent raters**

Independent raters are recommended for the title/abstract screening and the data extraction stages to decrease rater bias. For example, because I had so many (7,000+) title/abstracts to screen, I noticed that some days I was feeling more conservative about excluding articles than others.

**(6) Perform your pre-designed screen.**

This step takes the longest of all of the steps of the meta-analysis – not only because of the sheer volume of articles involved, but also because extracting data will require tedious follow-ups and potentially emailing authors for data. The more lab members and colleagues who can contribute to these steps, the less painful this will be.

**(7) Do your meta-analysis!**

Once all of your relevant data are finally extracted (congratulations!), you will finally be ready to carry out the quantitative portion of your meta-analysis. There are several programs designed this purpose, e.g. Comprehensive Meta-Analysis (CMA) and RevMan, as well as syntax available online for more general-purpose statistical packages (e.g. SPSS, Stata, and R).

While completing my meta-analysis has been academically rigorous, the biggest challenge I have faced has been myself. It has been tedious and often exhausting, and I have certainly felt my fair share of stress at each step. So, if you are planning to perform a meta-analysis, I have one piece of advice as a clinician-in-training that is relevant throughout the whole process: take care of yourself. Step away from the computer every once in a while. Do other things – professionally and personally - besides screening articles and troubleshooting the quantitative analysis. Get a good night's sleep as often as you can. Even if you're working against a deadline, it is better to take more time to ensure that the work is solid. This will hopefully be one of the strongest contributions you will make to your field – enjoy it!

References

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**About the Author**

Marissa is a fourth-year Clinical-Health psychology PhD student working with Dr. Martica Hall at the University of Pittsburgh. In the Mechanisms and Moderators of Sleep Health (MMoSH Pitt) lab, she is fascinated by the research questions "why do we sleep?" from a health perspective and "why can't we sleep?" from a clinical perspective. Clinically, she has most enjoyed her training in brief behavioral treatment of insomnia with Dr. Brant Hasler, as it has been exciting to see how rapidly effective the treatment can be for long-standing difficulties falling or staying asleep.

# Awards & Recognition

## Outstanding Student Clinician Award

### Sarah A. Stoycos
### University of Southern California

Sarah A. Stoycos, M.A. is a 5th year Clinical-Science PhD candidate at the University of Southern California, training within the NeuroEndocrinology of Social Ties Laboratory with Dr. Darby Saxbe. Her research focuses on social and affective neuroscience and her clinical work specializes in the intersection of trauma and health psychology, with a particular passion for exposure therapy and increasing access to clinical services in acute care medical settings. Prior to USC, Sarah worked with Dr. Tracy Prout at Fordham University studying moderators for prognosis of people with schizophrenia spectrum disorders, with Drs. Jude Cassidy and Katie Ehrlich at University of Maryland studying attachment and parent-adolescent dyadic behavior, and with Dr. Abigail Marsh at Georgetown University studying the neural mechanisms of empathy, altruism, and aggression in children high in callousness and unemotionality and in adults high in altruistic behavior. Her prior experiences have informed her current program of research, studying first-time fathers during the transition to parenthood as a special population for understanding potential plasticity in the neural networks linked with empathy, helping behavior, and distress sensitivity. Clinically, Sarah is currently supervised by Dr. John Briere while working to bring services to the Los Angeles County + USC Medical Center Burn ICU and acute floor.

## 1. What are your clinical interests?

Broadly speaking, I am interested in how experienced and perceived distress influence human behavior and the body across the lifespan. Therefore, I sought out clinical training in both outpatient and inpatient trauma and health psychology, with a focus in out-of-office exposure therapy and evidence-based treatments (EBTs) across the lifespan and at varying stages of illness and injury. Additionally, early on in my training, I became passionate about critically examining the accessibility of EBT's and understanding what "has always been done" versus what "could be done" in order to adapt EBT's to meet the needs of traditionally underserved populations and settings.

## 2. Why is this area of clinical work exciting to you? What is the most rewarding part of your clinical experiences thus far?

Working at the intersection of trauma and health psychology in medical settings is really exciting to me because it allows me to work with the entire lifespan and it is where psychology meets medicine, which appeals to my central interest of understanding mind-body interactions during distress. For example, with burns, the limited research has found that greater in-patient psychological distress was associated with greater physical impairment and psychopathology one-year post-burn (Fauerbach et al., 2005). The thought of helping someone to reduce or prevent acute distress while hospitalized and that potentially being linked with long-term functional outcomes for their prognosis is really exciting to me as a clinician-scientist. My favorite aspect of this work is working as part of a multidisciplinary team. As professionals from neighboring fields, we can amplify each other's work and push the boundaries of how our individual fields have taught us to conceptualize and treat patients in order to optimize patient care and outcomes. I am thrilled to see the field of psychology transitioning to primary and acute care mental health integration and look forward to contributing to the advancement of services in primary care settings.

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

The support, mentorship, and supervision of Drs. Gayla Margolin and John Briere has been the backbone to my development as a clinician-scientist. Dr. Margolin taught me the value of a lifespan multi-system approach to conceptualization and treat-

# Awards & Recognition

## Outstanding Student Clinician Award

ment, and Dr. Briere gave me a foundation in how to work with an interdisciplinary team at the acute stage to treat severely injured and traumatized people. They both pushed me to think creatively about my own passions in understanding the complexities of human nature and then helped me translate that into applied work. Drs. Daniel Nation and Shannon Couture taught me the value of honing rapid and accurate assessment skills, communicating with precision and intentionality, refraining from extrapolation and sticking to the data, and the importance of always taking into account reliability, specificity, sensitivity, and base rates when making clinical judgments and interpretations. Dr. Beth Meyerowitz provides invaluable mentorship on how to create opportunities where I can merge trauma and health psychology. Attending Surgeon Dr. Haig Yenikomshian, through his continual efforts to understand and improve patient well-being, instilled in me a desire to fight for increased access to funded psychologists in medical settings. The entire LAC+USC burns team taught me the power of multidisciplinary care, team cohesion, and co-treatment in optimizing patient care and treatment efficacy. And lastly, thank you to the Director and Attending Surgeons of the LAC + USC Medical Center Burn Unit, Drs. Warren Garner, Haig Yenikomshian, and Justin Gillenwater, who saw the need and value in adding psychology services, didactics, and research to the unit's longstanding multidisciplinary care.

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

I recommend pushing yourself to take risks and to be vulnerable in the service of your learning and growth. This journey is long, complex, and requires an immense amount of delayed gratification and so I recommend investing time into discovering and fostering what builds up your resiliency, passion, and perseverance, and minimizing what depletes it. Lastly, when you are feeling depleted or stuck in your research or clinical work, I recommend seeking out alternative perspectives from neighboring fields, especially philosophy, anthropology, sociobiology, and history, to re-inspire you or to foster your creativity.

**CONGRATULATIONS TO OUR 2019 OUTSTANDING STUDENT RESEARCHER AWARD WINNER!!**

**Tommy Ng**
**Temple University**
Advisor: Dr. Lauren B. Alloy

Stay tuned for our winter issue featuring Tommy Ng!

# Awards & Recognition

## Call for SSCP Outstanding Student Awards!

### Accepting Applications for the SSCP Outstanding Student Teacher Award!

This award is intended to recognize outstanding graduate students who are providing exceptional contributions to the field of clinical psychology through their teaching. SSCP encourages candidates from all underrepresented and minority groups to apply.  Winners will be selected based upon their dedication to, creativity in, and excellence in teaching in the area of clinical science. Selected student will be featured in the Outstanding SSCP Student section of the SSCP Newsletter.

**Applications must be received by December 1, 2019.** Notification of awards will be made in January, 2020. Application Instructions: Please upload your cover sheet, a letter of recommendation, 500 word biography, and CV at the following link: https://tinyurl.com/y355pt9p

For more information regarding this award, please see email announcement on the SSCP student listserv or email the student representatives.

### Accepting Applications for the SSCP Outstanding Student Diversity Researcher Award!

This award is open to current SSCP graduate student members (including students on internship) and postdoctoral fellows. The goal of this award is to provide monetary support and recognition to students who contribute to diversity in clinical science. Applicants may be a member of a diverse group (broadly defined), engage in diversity related research, or both. Members of all underrepresented and minority groups are encouraged to apply. More information about award eligibility, the application process, and evaluation criteria can be found here: http://www.sscpweb.org/DivAward.

**The deadline for submissions is December 1, 2019.** Please submit all materials here: https://tinyurl.com/y6l97ddw.  If you have any questions, please contact Joya Hampton-Anderson (joya.hampton@emory.edu). On behalf of the SSCP Diversity Committee, we are very much looking forward to your submissions!

## Call for SSCP Poster Awards for the 2020 APS Conference!

SSCP students the call for abstracts for the 2020 Association for Psychological Science is open until January 31! APS will be held in Chicago from May 21-24th and we would love to see you and your data there! Multiple $200 and $100 awards will be given for the winners and distinguished contributions after posters are presented to SSCP member judges. If you would like to have your poster considered for the SSCP student poster session, select 'SSCP Poster' in the first step after you select poster and start new submission.

SSCP Global Mental Health Poster Competition!  Global mental health focuses on application of psychological science in the larger global arena. If you would like to have your poster considered for the SSCP Global Mental Health Poster Competition, also select 'SSCP Poster' in the first step after you select poster and start new submission.

To be eligible to submit an SSCP poster, the first author of the poster must be a student and must be a member of SSCP at the time of submission. **Submissions to the SSCP student poster session must be completed by January 31.** You will also be asked to provide a copy of the final version of your poster by May 11, 2020 so judges will have an opportunity to review your work before the live session.

If you have any questions about the SSCP Poster Competition at APS, please contact Thomas Olino at thomas.olino@temple.edu or Rosanna Breaux at rbreaux@vt.edu. If you have any questions about the SSCP Global Mental Health Poster Competition, please contact Daisy Singla at daisy.singla@utoronto.ca. Please put "SSCP Poster" in the Subject line to ensure your question is answered promptly.

# Updates and Resources

## Professional Training and Employment

Looking for a Postdoc? Need a study coordinator? Taking a graduate student this year?
Publicize and recruit on the SSCP Website!

The SSCP Membership Committee is providing a new resources for our members - undergrad through professional. We are compiling lists of faculty positions, postdoctoral fellowships, study coordinator/research assistant positions, and people taking graduate students for the 2020-2021 school year.

For faculty, postdoctoral fellowships, and study coordinator positions, you may include a brief (100 word max) description of the position along with any relevant contact information and/or link for the posting information.

For people taking graduate students, please include the name of your institution, your interests, and a link to your webpage and a link to that of your department/program.

Please email Rosanna Breaux (rbreaux@vt.edu) with any information you would like included on the website.

### Students and Postdocs
### Check out the Professional Training and Employment page to find your next job
There are already over 50 faculty positions and 25 postdoctoral fellowships listed
https://societyforscienceofclinicalpsychology.wildapricot.org/page-18108

## Virtual Clinical Lunch (VCL) Series

SSCP's Virtual Clinical Lunch offers an opportunity for the entire field to discuss clinical science research together. Programs in North America, Europe, and Australia are participating in the series, all watching the monthly talks as part of their programs' weekly colloquium or brown bag series.

**November**: Dr. Kate McLaughlin (Harvard University): "Neurodevelopmental Mechanisms Linking Childhood Adversity with Psychopathology"

Link: https://youtu.be/n5hvdnR4xks

**September**: Phil Kendall (Temple University): "Working with Anxious Youth: More action, less talk"

Link: https://www.youtube.com/watch?v=lmadY-ejzoI&feature=youtu.be



## Membership Drive

Exciting benefits for student and early career members:

1) Updated 2019 Internship Directory that provides unique information not available elsewhere, including research opportunities and training in empirically supported interventions.
2) SSCP Internship Hotel Match-Up to help students save money on interviews
3) Opportunity to find a clinical science focused postdoc or faculty position on the SSCP website
4) Multiple opportunities for grants and awards for student and early career members

Some details about the Membership Drive:

1) The drive will be held from October-December, 2019
2) Whenever a new member completes their Membership Application (http://sscpweb.org/Membership) there will be an item where they can say who referred them to SSCP
3) There are two separate competitions - student/early career members and full members
4) On January 1, 2020 – whichever student/early career member has the most new members who listed them as the person who referred them will receive will receive 2 free years of SSCP membership; whichever full member has the most new members who listed them as the person who referred them will receive will receive 1 free years of SSCP membership here.

# Updates from Student Representatives

**Joya Hampton, Ph.D., Emory University**
**Ana Rabasco, M.A., Fordham University**

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

## Networking Event

**ABCT Social -** We will be holding an **SSCP Social at ABCT on Friday, November 22, 2019 from 4:30-6:30pm**. It will be at **Tin Lizzy's 121 Perimeter Center West Atlanta, GA.**
This is a member's only event; however, if you have someone who is interested in joining SSCP, they can come to the social and become a member there (with you counting that referral towards the SSCP Member Drive). Hors d'oeuvres will be provided; this event is a cash bar. New student members at this event will receive a $5 discount on their first year of student membership. We hope to see you there!

## Internship Resources

**SSCP Internship Hotel Match-Up** – **Applying to internship this year?** We are excited to announce that the SSCP Internship Hotel Match-Up will be available to students again this year! The SSCP Internship Hotel Match-Up will allow interested students to complete a request for each date and location for which they would like to share a hotel.  Students can then find other students with requests for the same date and location and contact them in order to make hotel arrangements. An email with the sign-up for the internship hotel match will be going out on 11/10/19.

## Professional Resources

**SSCP Internship Directory:**
The 9th edition of the Society for a Science of Clinical Psychology (SSCP)'s Directory of Training Opportunities for Clinical Psychology Interns is here. Results were compiled from clinical internship sites during the Summer of 2019. The Directory provides unique information not available elsewhere, including research opportunities and training in empirically supported interventions. As a student member of SSCP, you can download the internship directory at our website: http://www.sscpweb.org/internship

**SSCP Student Listserv**:
Please email Evan Kleiman (ekleiman@fas.harvard.edu) to be added to the student listserv. This is a great resource of job, research, award, and training opportunities!

**SSCP Facebook Page**:
One our goals for this year is to improve networking opportunities for students. Please utilize our Facebook page (https://www.facebook.com/sscpstudent/) to keep up-to-date with announcements and for a space to start a dialogue about clinical psychology in the news. Similarly, we are always looking for ways to improve our social media presence and our website - if this is something that interests you, please reach out!

# 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!**

**Joya Hampton: joya.hampton@emory.edu**
**Ana Rabasco: arabasco1@fordham.edu**