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PRESIDENT'S COLUMN

Gratitude

Annette M. La Greca, Ph.D., ABPP

Fall is in full swing, and the holiday season is right around the corner (or has already arrived judging from many retail stores!). As we approach the holidays and reflect on the past year, this is the perfect time to ask: What are you grateful for?

Certainly, the COVID-19 pandemic has been a challenge for youth and adults. And it is still ongoing. Many have experienced the loss of a loved one or of economic, food, or housing security. All of us have encountered significant life disruption and uncertainty. Not surprisingly, data indicate that many youth and adults report elevated levels of stress and other mental health concerns, such as symptoms of anxiety and depression. In my previous column, I focused on prevention strategies that psychologists might use to address stress and mental health issues (resulting from disasters and also from the pandemic) that may be affecting so many individuals. Today, I'd like to focus on another beneficial concept – recognizing and expressing gratitude.

Gratitude is making a conscious effort to count one's blessings – and to express appreciation for what one has. Gratitude is something that can be cultivated, and evidence indicates that practicing gratitude can increase happiness and promote better physical and mental health. Gratitude exercises might include keeping a diary in which one expresses gratitude for people and things in their lives and then shares these expressions of gratitude on a regular basis. For inspiration, there are various websites that provide examples of how to identify things to be grateful for.

In keeping with the gratitude spirit, I'd like to share a few things that I am grateful for this year. One is the opportunity I've had to serve as President of the Society of Clinical Psychology (SCP). It has been a privilege to work with and get to know the many, many individuals who work enthusiastically and diligently on behalf of SCP. This includes (but is not limited to) our current Officers (Elizabeth Yeater, Kalyani Gopal, Paul Arbisi, Chad Kelland); our Council Reps (Kim Penberthy, Michael Otto, Kathryn McHugh, Jonathan Weinand) and Member at Large (Randy Salekin) as well as the many Section Representatives to the SCP Board. It also includes the editors of our journal

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(Art Nezu), newsletter (Shannon Sauer-Zavala), and website (Damion Grasso) as well as those who chair and participate in SCP's various committees (such as Membership, Education and Training, Science and Practice) and the Diversity Task Force. Finally, a special call out of gratitude and thanks goes to Tara Craighead, our Director of Operations, who somehow manages to keep us all on target and making progress, even in a challenging pandemic-affected year.

I am also grateful for the presence and support of my family and friends. Although it has not been possible to see those who live at a distance, the availability of Zoom, Facetime, and other online platforms has made it possible to have routine happy hours, movie nights, and even heart-to-heart chats with those I care about – including those who live on the other side of the world. The social connectedness that technology affords has been a life saver in this era of social distancing and restricted travel, generally helping to reduce loneliness and increase social support. (Relatedly, I'm grateful that I have the skills and equipment needed to engage in online social connections, which is not the case for many individuals.) Still, I do look forward to returning to more frequent in-person contacts.

Finally, I'm grateful that we are now making the seasonal transition to autumn. Since I'm living in South Florida, this doesn't mean crisp days with spectacular fall foliage, like those that graced my childhood in New York and my graduate work in Indiana. Instead, it means that the weather is less incredibly humid and rainy; that overnight and in the morning it may "cool down" to 70 degrees, making outdoor activities more appealing; and that we are almost out of hurricane season (yeah!). And you can be grateful that I won't remind you of this weather when you are experiencing snow and ice storms up north this winter!
Now that I shared some of my gratitude, perhaps you can do the same. What are you grateful for today?

If you would like to get started on gratitude sharing, click on this link!

We will share your anonymous replies in 2022! Ψ

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LEAD ARTICLE

Conducting Impactful Research in HIV and Mental Health: Showing up, Centering Participants, Learning, and Paying it Forward

Sannisha K. Dale, PhD, EdM

Associate Professor of Psychology

Director, SHINE (Strengthening Health through INnovation and Engagement) Research Program

University of Miami

sdale@med.miami.edu
https//shine.psy.miami.edu

Sannisha K. Dale, PhD, EdM

Early in my career the single most important advice I heard from community mentors in health advocacy was to "show up" and "be present". Showing up includes attending community meetings, events, and celebrations that may have nothing to do with your specific research aim or data collection, but has everything to do with valuing community and building connections and relationships. It also includes asking and findings ways that you can contribute or assist in the execution, planning, or wrapping up post event. For me that has ranged from making "goodie bags" (e.g. with condoms, lubes, information), setting up tables, greeting attendees, and serving food to making handouts of mental health resources, giving requested presentations on mental health and HIV, and providing resources when called upon as a clinical psychologist and researcher. Being present also entails arriving as person (not just a psychologist or Dr. Dale) with a genuine interest to participate in the activities, help, engage with others, and listen. I recall an outreach event led by a department of public health and a few community partners that entailed packing and distributing condoms. There was no speech to be given or data to collect, just simply volunteer, but that day as we walked and distributed condoms to people walking or driving by I met someone who became one of my strongest community partners in this work.

In the context of research studies that are conducted in house (at clinical or academic settings) there is also a need to be present in terms of building rapport with participants, responding to needs that arise, and ensuring that procedures are being carried out in a manner consistent with valuing participants. Every study that I have led as a principal investigator (P)I thus far I have directly interfaced with participants ranging from calling to screen potential participants, welcoming participants and getting them situated for visits (e.g. offering coffee and snacks), administering measures, facilitating intervention sessions, checking in with participants in person or via phone if a need arises (e.g. participant disclose struggles with food, housing, access to care). While much of these tasks can and are also delegated to team members including research assistants/coordinators, graduate students, and postdoctoral fellows, helping to conduct these tasks results in participants learning that the PI is an individual with a vested interest in the participants and the research being done. I recall an interaction where I was facilitating a one-on-one behavioral medicine intervention session and the lid to the participant's coffee cup fell on the floor. I paused, picked up the lid, and offered to get her a new one. After that she said to me "you're not doing this just for the money, you really care". When participants have interactions with study leadership, they also feel empowered to reach out to leadership directly and provide feedback or address any issues that arise.

Centering Research Participants

Connected to the showing up and being present, centering the participants as human beings deserving of being welcomed, understood, and affirmed is essential. In the context of human subject's research which often asks about personal topics, the human beings are key. Without our participants there would be no data, no research grants, no paid positions (PIs, RAs, Postdocs), and no acquisition of knowledge to advance our field. As such we need to communicate that value in our interactions with participants. This appreciation for their contribution to research can be communicated through words (thank you), taking steps to minimize inconveniences and barriers (e.g. providing transportation), attending to their needs in the context of the study (e.g. refreshments, snacks), and providing information on resources for issues that arise (e.g. housing, accessing other care) that may be unrelated to the study. In addition, this may also entail using our positions of power to advocate as needed on the participants' behalf. For instance, in the context of conducting research and speaking with participants during COVID lockdowns in Spring 2020 we learned from some participants that they were running out of medication and were unable to reach providers. Often an email from me (as a PI and faculty at a major institution) to their provider helped to resolve the issue. In addition, putting effort into creating physical spaces that participants feel comfortable, welcomed, and affirmed in, is beneficial. We intentionally decorate study rooms with décor that feels affirming for the Black individuals we engage daily and participants consistently comment on this as something positive. In fact, when the SHINE Research Program was initially established at the University Miami and we set up our first study room, participants and other coordinators working on the floor commented that they had never previously seen a PI put such effort in creating a welcoming space. Lastly, and especially in the context of working with minoritized communities who are often subjected to daily microaggressions our team is prepared to greet our participants and intervene if situations arise from the moment they arrive at the building location to the moment they reach your team. For instance, on a couple of occasions we had participants call and inform us that they were being asked unnecessary questions by someone upon trying to enter the building to which we responded by immediately going to meet the participant and speaking with the person.

Learning

Through showing up and centering participant, they have shared invaluable information about their lived experienced both through qualitative interviews and quantitative surveys. As a result our team has been able to learn important information among Black individuals living with or placed at risk for HIV on a) the impact of psychosocial and structural factors including microaggressions, discrimination, and poverty b) developing effective prevention and intervention strategies to promote resilience and good health outcomes and c) engaging community members and stakeholders in research.

Weight of Intersectional Oppression

We have learned through stories shared by Black women living with HIV (BWLWH) that the weight of intersectional oppression including racism, sexism, HIV discrimination/stigma, poverty, and trauma/violence is heavy and has negative consequences for their mental health and ability to access competent care, adhere to HIV mediation, and strive (Dale et al., 2018). For instances, many women shared stories of multiple traumatic experiences across their lifetime, experiencing race- and HIV-related discrimination and microaggressions at the interpersonal and institutional level, and gender-related stressors and expectations to care for others and often sacrifice their self-care in roles they occupied as mothers, grandmothers, daughters, partners, and friends (Dale et al., 2018). Quantitatively we found that gendered racial microaggressions contribute uniquely to post-traumatic stress disorder symptoms, barriers to HIV care, and depressive symptoms, above the contribution of race- and HIV-related discrimination. Using daily text messages to capture microaggressions among BWLWH, we also found that microaggression-related distress increased from 52% at baseline/October, peaked at 70% during the holidays (November/December), declined to 55% in March when COVID-19 social distancing began, then increased following the murder of George Floyd in May 2020 and peaked to 83% in June/July 2020 during widespread Black Lives Matters protests (Dale et al., 2021).

Strength and Resilience

However, in the midst of intersecting adversities BWLWH remind us of their strength, resilience, and adaptive coping strategies. For example, women shared that they coped with (a) past trauma/violence by utilizing spirituality, social support, counseling/psychotherapy, enjoyable/adaptive activities, (b) racism through awareness, assertiveness, caution, and strategic avoidance of certain people and places, (c) HIV discrimination/stigma via selective/non-disclosure of their HIV status, social support, gaining and sharing education/knowledge, and strategic avoidance, and (d) gender-related stressors through prioritizing the self, self-love, spirituality and continuing to help others(Dale et al., 2018). Women and community stakeholders also echoed that an essential source of BWLWH's resilience came from their village - children, grandchildren, other family members, friends/peers, and caring providers - who helped them in the context of or following adversities and supported women in focusing on their health (e.g. adhering to medication, going to appointments) and overall well-being (Dale & Safren, 2018). Consistent with this we found that higher social support from friends and significant others predicted lower HIV viral load (good health indicator) (Reid & Dale, 2021).

Social support also moderated the relationship between substance use disorder and HIV medication adherence in that substance use disorder predicted low HIV medication adherence in the past two weeks only for women low in social support from friends or overall (across relationship types) (Reid & Dale, 2021). We also found quantitatively that higher resilience (trait and coping) was associated with higher general self-efficacy, higher self-esteem, higher post-traumatic growth, lower post-traumatic cognitions, lower trauma symptoms, and lower depressive symptoms (Dale et al., 2019). Additional findings indicated that resilience was associated with higher HIV medication adherence and lower odds of having a detectable HIV viral load (negative indicator) and that resilience was especially important for higher medication adherence among women with histories of sexual or multiple abuse (Dale et al., 2014).

Developing Meaningful Interventions

Beyond broadening our understanding of adversities and resilience among BWLWH through intervention development studies, we have also learned that BWLWH and Black woman placed at risk for HIV are eager for, appreciate, and respond well to HIV and mental health interventions that are culturally relevant, consist of content and approaches that honor their intersectional experiences, and are delivered by culturally competent clinicians. We have developed two interventions for Black women living with HIV (Dale & Safren, 2018) and at risk for HIV (Dale, 2020), contributed significantly to the development of an intervention for Black MSM living with HIV (Bogart et al., 2018), and is currently assessing the acceptability and feasibility of an intervention for transgender women living with HIV and histories of trauma. STEP-AD (Striving Towards Empowerment and Medication Adherence) for BWLWH, is a ten session intervention to improve medication adherence for Black women living with HIV by combining evidence-based strategies (e.g. cognitive behavioral therapy) for trauma symptom reduction, strategies for coping with racial and HIV-related discrimination, gender empowerment, problem solving techniques for medication adherence, and other resilient coping techniques. Qualitative interviews (Dale et al., 2018), an open pilot trial (Dale & Safren, 2018), and a pilot randomized control trial (RCT) have indicated high acceptability and feasibility and positive outcomes. We have seen similar evidence of acceptability, feasibility, and positive outcomes for Motivational Interviewing to Increase Motivation for PrEP (Pre-exposure Prophylaxis to prevent HIV) (MI-PrEP) via an open pilot trial and pilot RCT. MI-PrEP is a brief two-session intervention that combines information on PrEP, motivational interviewing techniques, and light case management (e.g. information on PrEP facilities, programs covering the cost of PrEP) in a culturally-informed manner to promote PrEP uptake among Black women placed at high risk for HIV.

Context and Environments Matter

Our work has also reiterated the importance understanding the impact of contextual, socioeconomic, and neighborhood factors on the lives of women living with HIV. For instance, recent findings using spatial analysis indicated that within-neighborhood characteristics and neighboring characteristics (employment, education, crime, income, number of religious organizations, low-income housing) significantly related to intersectional stigma/discrimination, mental health, HIV viral load, and medication adherence among BWLWH. For instance, within-neighborhood higher education was associated with lower HIV viral load and higher likelihood of HIV viral suppression (good health indicator) and higher low-income/subsidized rental housing within neighborhood was associated with lower HIV microaggressions. However, higher median income in neighboring areas was associated with higher gendered racial microaggression appraisal and higher traumas (Wright et al., 2021, under review). Another set of findings among BWLWH utilizing network analysis to assess the associations among discrimination (race- and HIV-related), microaggressions (gender and race), trauma, socioeconomic status (income, housing, education), mental health, and HIV outcomes indicated that the four most central factors in the network were, income, housing, and gendered racial microaggressions suggesting that these factors need to be addressed via policies and interventions to improve the wellbeing of BWLWH (Sharma & Dale, 2021, under review).

Partnering with Community Members to Effect Change

Moving beyond what we have learned about the key role of communities and the context of the lives of BWLWH, we have established strong community partnerships and launched a community engaged research effort in partnership with community consultants, businesses, and community-based health organizations that simultaneously has an impact and continue to advance our knowledge. Funded by Ending the HIV Epidemic supplements from NIMH, in 2019 we launched the Five Point Initiative which is currently in its third year (Dale, 2020). Over the course of this initiative our team has (1) partnered with five venues (barbershops, hair/beauty salons, laundromats, corner stores/grocery, and mechanics/car wash/gas station) in Miami Dade zip codes with the highest number of Black individuals living with HIV (2) closely collaborated with community health organizations and (3) hosted outreach activities in which community members complete a brief electronic survey (on mental, sexual, and physical health) and HIV testing in exchange for a service/voucher (e.g. free laundry wash and dry) at a venue with the cost being covered for by the supplement and are offered condoms and information on Pre-exposure Prophylaxis (PrEP). The essence of our approach is to meet people in their communities and at venues that they frequent. Our approached has demonstrated acceptability and feasibility with praises from community residents, consultants, businesses, and health organizations. In the context of COVID-19 and in response to community needs our team has also offered COVID-19 testing and vaccine via our Five Point Initiative. Thus far we have conducted over 39 outreach events, partnered with 55 businesses, and engaged over 2000 residents.

From left Roxana Bolden, Nadine Gardner, George Gibson, Alecia Tramel, Dr. Sannisha Dale, Kalenthia Nunnally, Gena Grant

Paying it Forward through Mentorship

Along my personal journey as someone who is Black, woman, first-generation student, first generation immigrant, and from a low socioeconomic background, I have stood on the shoulders of mentors in community and academia. One of whom, Past APA President Dr. Jessica Henderson Daniel, would remind me to "pay it forward" when I expressed my gratitude for her mentorship. In addition, my experiences have proven time and again that the mental and sexual health needs of minoritized communities will not be adequately addressed without hiring, accepting into programs, training, and mentoring and sponsoring individuals with lived expertise of the conditions and inequities driving mental and physical health disparities and those with a demonstrated commitment to communities disproportionately impacted. Central to my research program is a commitment to facilitating access along the pipeline to minoritized scholars. The vast majority of mentees I attract are Black or otherwise racially/ethnically minoritized and coming from underserved communities. I mentor graduate students, undergraduate students, community members/partners, postdoctoral fellows, and sometimes high school students. Further, given the importance of research experience and publications to successfully get into doctorate programs, I mentor all my research staff with aspirations of pursuing PhD/MD. Previous research assistants have been accepted to doctoral programs in clinical psychology, public health, and medicine. Given prior barriers to research exposure I often mentor my mentees on their first abstract/poster and first manuscript publication. For instance, I have mentored undergraduate mentees on first-authored publications. In addition, I actively work to sponsor and elevate community members with lived

Members of the SHINE Research Program

experiences through consultancy roles, staff positions, paid speaking engagements, and writing/publishing (Phillips, under review). Similarly, I also mentor junior faculty (physician and PhDs) as they submit their first grants or develop research ideas around HIV, mental health, and marginalization. Beyond the mentees who are members of SHINE, I am a multiple principle investigator (MPI) and Co-Director of an NIMH funded training grant (T32) entitled CHANGE (Culturally-focused HIV Advancements through the Next Generation for Equity), focused on training the next generation of scholars committed to addressing HIV and mental health disparities in Black, Latinx, and LGBTQ communities.

Insights for the field of clinical psychology

In showing up, centering participants, learning from the information they share, and paying it forward a few things have been echoed. Effective and lasting solutions that will have the most impact in communities facing the brunt of mental and physical health inequities will be informed by its members and the best role that clinical psychologists can play is in elevating, supporting, and partnering with communities in an equitable manner. The psychological tools and strategies that we have at our disposable can be largely beneficial if we are honest enough to (a) acknowledge their limitations when the evidence base has been acquired in primarily White and/or otherwise privileged demographics and be bold enough to (b) fund efforts led by minoritized scholars with appropriate expertise to obtain evidence in minoritized communities (c) recruit, retain, and matriculate students with lived expertise and academic promise, (d) support and value minoritized faculty and protect them from institutional harm that is common when they occupy spaces as the "only", have research or teaching focused on oppression and equity, and/or provide service (e.g. committees, diversity initiatives, shadow mentoring) that is emotionally demanding.

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Diversity Spotlight on Laura Kohn-Wood, Ph.D.

by Amy Weisman de Mamani

The current spotlight is on Dr. Laura Kohn-Wood whose work focuses on race, ethnicity, and culture with a particular emphasis on race-based protective factors and the promotion of positive coping and mental health among African Americans. Dr. Wood received a B.S. in Psychology from Howard University in 1990. In 1996, she completed her doctoral degree in Clinical Psychology with a specialization in Community Psychology at the University of Virginia (UV). During her training at UV, she was awarded a prestigious Ford Foundation Pre-Doctoral Fellowship.

Dr. Kohn-Wood is a professor in the Department of Educational and Psychological Studies at the University of Miami (UM). She has been at UM since 2009 and is currently serving as the Dean of the School of Education and Human Development (since 2018). Dr. Kohn-Wood previously served as the Chair of the Department of Educational and Psychological Studies from 2014-2018, as well as both Associate (2016-2018) and Interim Vice Provost (2018) of the University of Miami's Office of Institutional Culture, and the Inaugural Co-Chair of the University's Standing Committee on Diversity, Equity and Inclusion from 2015-2018.

Dr. Kohn-Wood has received numerous awards for her service and teaching. Examples include the Faculty of the Year Award from the University of Miami's Office of Academic Enhancement, the Engaged Faculty Fellow Award from the Office of Civic Engagement, the Outstanding Faculty Member Award from the Association of Greek Letter Organizations, and she was also a member of the Spring 2015 Initiation Class of the Iron Arrow Honor Society at UM. She received the "Spirit of Service Learning Award (Higher Education)" from the Returned Peace Corps Service Members of South Florida and the "Unsung Hero Award" from the University of Miami's Division of Student Affairs.

As if all of this was not enough, her research is of equal caliber, so much so that we wanted to highlight and share it through the Clinical Psychologist Spotlight. Dr. Kohn-Wood has conducted extensive community-based participatory action research and intervention projects with community and faith-based organizations in urban areas such as Detroit, Michigan and the Liberty City area of Miami, Florida, including the development of a successful collaborative service-learning program for undergraduate students. She has published numerus empirical articles with an emphasis on African Americans. Many of these papers examine factors that contribute to health disparities, improve cultural competence of treatment providers, and better understand effective coping mechanisms in African Americans. Dr. Kohn-Wood is also interested in ensuring that the psychometric properties of scales are relevant for African Americans and recently co-authored a paper examining the factor structure, reliability, validity, and measurement invariance of the Daily Life Experiences scale in African Americans.

Laura Kohn-Wood

Dr. Kohn-Wood imparts her empirical knowledge to her students by teaching a variety of courses focusing on race, ethnicity, and culture. Examples of courses that she has taught at the Graduate level include Cultural Diversity and Mental Health, Community Well-Being and Change-Theory and Practice, and Multicultural Communities in a Globalized Society. Examples of courses she has taught at the undergraduate level include Community Psychology and Development, Insanity and Humanity: Society, Services and Stigma, and Intergroup Dialogues. She is a highly regarded and beloved teacher with consistently outstanding evaluations. Her students describe her courses as engaging and interesting, and describe her as warm and enthusiastic, with several stating that she is the best professor that they have to date. Her commitment to mentorship is also reflected in the fact that she lived on campus among undergraduates where she served as Associate Resident Faculty and later Senior Resident Faculty at UM from 2009-2019. As part of her role, she oversaw the development of educational programs for the undergraduate residents in addition to mentoring and socializing with students.

Dr. Kohn-Wood's service also extends outside of UM. She has served on the Executive Committee for Division 27 (Society for Community Research and Action) of the American Psychological Association (APA), as well as elected Chair of the Division 27 Council on Education. She currently serves as a Corporate Advisory Board Member for East Ridge of Cutler Bay, and is a member of the Miami-Dade County Public Schools Ethics Advisory Committee. In addition, she is a Board Officer for the Council of Academic Deans from Research Education Institutions (CADREI) and a founding member of the Coalition of Black Education Deans.

In light of her research and outstanding and needed service, I posed the following four questions to Dr. Kohn-Wood:

1) Given your expertise on race, ethnicity, and culture, with an emphasis on African American populations, in your view, what are the two or three most important things that we, as clinical psychologists and researchers, might be able to do to help reduce the mental and physical health disparities that African Americans currently and historically have faced in this country?

As a clinically trained community psychologist, I believe we need to focus on root causes. Too often we are concerned with treating outcomes that are a consequence of inequality – because outcomes are more easily identifiable and more easily addressed than targeting the source of disparities. After spending my career investigating race, ethnicity, and mental health – and following the work of others, it is clear that racism, individual and structural, is the root cause of racial differences in well-being. I have also, however, spent a good deal of time trying to understand and unpack the fact that despite negotiating virulent denigration for centuries, African Americans have not just survived but thrived. There is great strength and joy in the Black community. Yet, until we eradicate racism disparities will persist. Convergent evidence shows that significant disparities in resources and power have negative consequences for everyone, even those with the greatest wealth and social capital. Currently we are living during a period when resources are concentrated among very few and the opportunity for social mobility has been vastly curtailed. Concomitantly, this is also a time of sharp divisiveness, major violence and an inability to engage in cohesive action, as in how to manage a pandemic.

2) You are such a productive scholar, administrator, and teacher, and your commitment and contribution to community service is enormous. What tools have you developed to balance so many demands?

Thank you! Being productive in academia is the ultimate goal – though I find productivity looks different depending on the day, the task, and the role. Part of the balance may be recognizing that a contribution at one point could consist of solving a staffing problem, and at another point it could be solving a structural equation modeling problem. Some days I feel productive when I have helped a student resolve a distressing situation. I think one tool is practicing the ability to be fully present with people and/or with tasks. It's hard to be a truly effective multitasker. Your energy is different if you can really sit with whatever it is you are doing. Also, I think it's important to recognize your work style and then try to "do you" as maximally as you can. For example, I am quite episodic as a writer. When I have the time and head space, I can go for hours. But there are major stretches in between my periods of go-time. There is no point in feeling bad about the writing I am not doing, and instead I just focus on a different kind of task. It is also important to completely disengage sometimes. Finally, I try to never, never, ever have my self-identity be too tied to my work. I think academia pulls for people to derive great self-worth from what they do, since our work is intellectually driven. I like my work, I chose this career specifically because I wanted to enjoy what I do and to feel it has meaning, but I am more than my job.

3) What advice do you have for young people (particularly of color) who might want to follow in your footsteps?

We need you. Higher education research institutions produce and disseminate knowledge. If there is a limited set of social identities and life experiences among the people who are asking the questions, designing the studies, analyzing the results and disseminating the findings – then the knowledge being produced will be limited, the science will be constrained and our quest for truth will be shackled. We actually know very little in psychology about the dynamics of our diverse humanity because for so long, and unfortunately still, our institutions have not been inclusive. I am tired of walking into rooms and being the only person of color or the only African American woman. It is 2021. The other advice is for those of us who are academics. Stop acting like you are so busy, so stressed, and enduring such great duress in the professoriate. Being a professor is not a bad gig. At all. Compared to other potential jobs, some of which I experienced while working my way through college, being an academic is relatively flexible and autonomous. We are paid for asking and answering questions that we care about. When we act like our jobs are horrific, we dissuade students from seeing academia as a viable or desirable option.

4) Finally, what do you like to do in your spare time (should you have any with the schedule you keep)?

I re-started practicing meditation, which has been helpful over the past year (understatement). I like to read anything not related to work, especially autobiographies/memoirs of interesting people (currently – Ashley C. Ford; Jacob Tobia; Rebecca Carroll). Nine months ago, I started trying to be serious about learning Spanish; my tutor and I disagree on how successful this is going (she thinks it's progressing nicely; I wonder why it still takes me so long to hold a conversation). I must work out for sanity and balance. I like to hang out with my husband. I like to try to decipher my teenage son, and I like to visit my adult bonus son and his fiancé. And since we added a puppy to our family during the pandemic, I am spending a lot of time training and socializing my new fur baby.

SCP Member Spotlight on Mark A. Reinecke, PhD

Please provide an overview of your work

The primary focus of my work over the years has centered on CBT with children and adolescents, with a focus on child depression, anxiety, and suicide. While in graduate school my professors talked of training to become a "triple threat"---accomplished in research, teaching, and clinical practice. Over the years their vision has framed my work. For 14 years I served on the faculty of the University of Chicago, and for 18 at Northwestern University. During that time I've directed labs, taught a variety of courses, supervised trainees, and served in a number of administrative roles, including Director of Training and Chief Psychologist. The variety of roles and tasks has been enjoyable, interesting, and fulfilling, if somewhat taxing. Many years ago I received an End-of-the-Year Award for "Faculty Member with Most Pots on the Stove". A fair observation. More recently I've become involved in public policy and program development.

Where did you complete your training (graduate school and area of emphasis, internship, post doc, etc.)?

I grew up in rural Northern California and completed my undergraduate studies at Stanford. While there I worked with John Flavell (infant development) and Walter Mischel (social learning theory). I also completed a Master's degree in Biology, where we studied neural transmission in crayfish. These foci—developmental psychology, social learning theory and cognitive psychology, and neuroscience—have informed my thinking since. I received my PhD from Purdue, where I worked with Jerry Gruen and Alan Fogel, and completed an internship in pediatric psychology at Henry Ford Hospital. I subsequently had the great fortune of completing a post-doctoral fellowship with Tim Beck and his colleagues at Penn. My experiences at the Center for Cognitive Therapy in many ways defined the arc of my career as a clinician and researcher.

What is your current position/occupation?

In 2019 I retired from Northwestern (I'm now Professor Emeritus). I now have a small practice, am supervising several students, and working on a new book.

Can you describe the ways that your career has taken shape over time? How did you get to where you are today?

Life takes us all in unexpected directions. I started college as a physics major, then moved to psychology, neuroscience, human development, and philosophy. During my second year of graduate school my advisor, Jerry Gruen, asked me to "write a clinical paper…on any topic you like." I wrote a review of the literature on biomarkers for depression among prepubertal youth. It wasn't particularly good, but it did touch upon an important set of questions. It set me to thinking about affective disorders among children and adolescents and their treatment. Years later, during my post-doc at Penn, I became familiar with CBT models of psychopathology and treatment. All of my previous experiences—in infant development, neuroscience, social, learning theory, and evidence-based practices came together in a synergistic, coherent manner. I was on my way.


Mark A. Reinecke, PhD

How long have you been a member of Society of Clinical Psychology? Please indicate any past or present roles in Society of Clinical Psychology (e.g., leadership, committees, task forces, etc.)?

A long time! I've been a member of APA since 1988 and joined SCP shortly after. I've been a Fellow since 2004. In the past I've served on the Education/CE committee and as an APA representative on the DSM-5 Depression Taskforce. I'm very much looking forward to assisting with the Membership Committee as the incoming Chair of this committee.

Please describe any roles you have with APA or other national, state, or local organizations.

I've been involved with a range of organizations over the years including APA, ABCT, APS, NASP, and the Illinois Psychological Association. I've also worked with the Illinois Department of Mental Health in developing adolescent suicide prevention guidelines and with local school districts across the country in developing suicide prevention programs. I've served as a visiting professor at institutions in Europe and Asia, and have lectured on teen depression, anxiety and suicide at universities in over a dozen countries. Members of SCP have done terrific work in developing our understanding of psychopathology, prevention, and treatment. The task now is dissemination, making evidence-based practices more available. Those are the tasks I'm most interested in now.

What do you see as an important direction for the field of Psychology?

As clinical psychologists, my sense is that we need to recommit ourselves to the science of psychology and the ways in which translational and clinical research can inform our practice. At the same time, we'll want to have a critical eye to the limits of our understanding and think strategically about the areas of practice which will have broad impact. I've been impressed, for example, by DARPA, and their focus on transformational change rather than incremental progress. They've developed a collaborative, diverse system of academic, government and private partners to address specific, high priority problems. They're impressive. Perhaps this same approach could be applied in the social and behavioral sciences? The problems we face in our communities and clinics are many. Many of the problems we face seem intractable. To be sure, government and private funding agencies prioritize their objectives. Perhaps, though, we need new systems to support innovative, transformative research and practice.

What's something nobody would know about you?

Growing up I'd wanted to be a relief pitcher (unfortunately, I have little athletic ability) and I enjoy the Dead (I'll go to any show I can).

What are your hobbies?

Gardening, running, and reading thick biographies.

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Ethics Column

“I’m Afraid to Ask”: Anticipating and Addressing Trainee Ethical Concerns about Assessment

Adam L. Fried, Ph.D. & Jessica Powell, Psy.D.

Assessment is a cornerstone of psychological practice. The demand for psychologists who conduct assessments, in particular neuropsychologists, is expected to increase over the next decade and assessment appears to be a growing interest of many students entering into clinical psychology programs. Many assessment specialties are honed at the post-doctoral level but initial training experiences begin in the predoctoral program through coursework and practicum experiences. Assessment supervisors provide an invaluable service to trainees by teaching them how to administer, score, and interpret test batteries. Further they demonstrate how to conduct interviews and socialize them into the discipline both through direct mentoring and by modeling best practices in the field.

Assessment supervision differs from psychotherapy supervision in important ways. Unlike psychotherapy, assessments are usually time-limited and do not involve an ongoing relationship that is comparable to a therapist-patient/client one (Iwanicki & Peterson, 2017). Assessment supervision often focuses on selection and administration of testing methods and materials, scoring, interpretation and communicating results (Patel, Tarlow, & Tawfik, 2020; Wright, 2019). Certain types of assessment, such as neuropsychological, focus on specific areas of functioning and may be conducted in specific settings, such as hospitals (Stucky, Bush & Donders, 2010). Despite providing regular opportunities for supervision, supervisors may not always be aware of ethical questions and conflicts experienced by trainees. This column will highlight some of the reasons trainees may not feel comfortable approaching supervisors and describe dilemmas trainees experience but may not always share with supervisors.

“I’m Afraid to Ask”. Supervisees may struggle with negotiating an emerging professional identity with the increased demands of clinical work and graduate training (Turner et al., 2005). Lack of experience, lack of confidence, uncertainty about performance, and novel treatment and ethical dilemmas may also uniquely contribute to graduate student stress (Pakenham & Stafford-Brown, 2012). There are a number of reasons why supervisors may not always be aware of their trainees’ experiences. Trainees may not feel that they have a comfortable outlet to discuss experiences of stress or they may have uncertainty about the quality of their professional work. They may also fear that asking for help or admitting they are unsure about procedures may be disappointing to supervisors who may see them as more independent than they feel or truly are. For example, a trainee who upon scoring realizes they have administered a test incorrectly may fear telling a supervisor and try to “cover” their mistake. These fears can be compounded by the knowledge that supervisors or faculty have grading or other evaluative authority. Below we highlight a few ethical issues that may not always be brought to the attention of the supervisor across various stages of the assessment process.

Trainee Comfort and Competence in Administration. The supervisor has both responsibility for and independence in determining the appropriate methods for training. Although supervisors assume overall responsibility, the guidance is less clear on how or who should be training these students. Within assessment settings, some supervisors may include formalized didactics with multiple rounds of practice, followed by “check-outs” where the student must show a certain level of competence with test administration prior to being able to assess a patient/client (which is also observed). On the other end of the spectrum, some supervisors may assume knowledge, skills, and comfort have been solidified through the academic courses a trainee has completed and may, therefore, include only a brief overview of testing accompanied by an assignment to read through manuals and familiarize oneself with protocols, which is quickly followed by assessing a patient/client in a “sink-or-swim” experience. This approach carries a much higher risk for errors. Supervisors should be aware that trainees may not feel comfortable telling a supervisor that they don’t feel proficient with a particular test or battery.

Beyond the method of training, in larger practices, it is often a psychometrist or testing assistant who may guide the training and signals the “green light” for students to proceed. While these individuals achieve competence in administration and scoring of assessments, they are not licensed psychologists, nor do they typically hold a degree in a clinical field. In general, recommended practices include offering ongoing skills assessments and using a variety of training methods (including live and recorded supervision of assessment experience, didactic instruction and hands-on practice of administration, scoring, and interpretation) may help to increase competence and foster trainee self-confidence and comfort (Patel, Tarlow, & Tawfik, 2021). In addition, training guidelines with benchmarks to assess competence could be of benefit to protect patients/clients as well as practitioners (APA, 2015).

Recognizing and Responding to Patient/Client Distress. Another unique aspect to consider with testing is the patient/client’s assent and the right to withdraw that assent. For example, many patients/clients are receiving a neuropsychological evaluation because they are experiencing cognitive decline. For some patients/clients, the testing experience can be incredibly discouraging as their weaknesses (and fears about decline) are highlighted throughout the evaluation. As many experienced supervisors will attest, there are ways to address patient/client discomfort through the assessment without causing excess stress, but trainees often lack the experience or knowledge of how to navigate these delicate situations.

For some patients/clients, this discouragement can grow to significant anguish where the clinician may need to consider terminating and/or postponing testing altogether. Moreover, the patient/client may not be able to overtly state their desire to discontinue, but the student clinician needs to be able to recognize when the benefits of testing are outweighed by the patient’s misery. For trainees, this in-the-moment decision can be very stressful and their lack of experience makes them ill-equipped to make this decision. This judgement call can be even more difficult when they feel pressure from their supervisor to complete the evaluation.

Ideally, the student will be able to access their supervisor in these moments to discuss and decide together how to best proceed. Sometimes the supervisor may ask the student to continue, despite the trainee feeling this may not be in the best interest of the patient/client. This discordance can cause a moral dilemma where the trainee is faced with following their supervisor’s clinical decision at the expense of the patient/client’s immediate psychological well-being. Thankfully, these scenarios are the exception and not the norm, but recurrent experience of this type of moral dilemma could cause early burn-out for a student trainee. Later in this paper, we’ll discuss some strategies that may help supervisors facilitate discussions about these issues and hopefully prevent these types of dilemmas.

Report Writing Uncertainty. Reviewing trainee work is always paramount and there are several review components regarding assessment given the scoring, norming, and written report. The students scoring and norming may include a meticulous review with extensive feedback or could consist simply of a cursory review and “spot check”. Undoubtedly, a less thorough review offers more opportunity for error and can be ethically problematic. As trainees progress, they may be begin drafting reports for the patients/clients they assess. Similar with scoring, review varies with some supervisors choosing to use these as shadow reports in which they never become a part of the patient’s records, while others may simply briefly review and swiftly upload the work into the patient/client’s chart. The latter is fraught with ethical concerns for several reasons and causes the most angst for students (beyond student discomfort, inadequate review of reports used for patient/client care by supervisors is in and of itself a serious ethical concern to be addressed in a separate discussion). Certainly, students recognize their limitations with conceptualizations that often takes years of hands-on experience to grasp. Subsequently when supervisors opt to use student reports with little to no feedback, there can be an unnerving fear that the patient/client is not receiving competent care. Trainees may often feel like they are in a bind; they want to demonstrate confidence in their report-writing but also feel uncomfortable making interpretations and recommendations with far-reaching consequences. This is amplified if students are uncertain that their supervisors are thoroughly reviewing their work given a lack of feedback.

Considerations for Supervisors. Below we describe some broad recommendations for supervisors to consider in their practice that may help facilitate open and honest discussions with trainees about ethical questions encountered during training.

1. Supervision is often thought of as occurring during regularly scheduled times but assessment supervision may also require more availability on the part of the supervisor, especially during the beginning of training. In addition to scheduled supervision, having an open-door policy and being available for “on the fly” supervision may help avoid serious mistakes, increase the likelihood that a trainee will seek help right when it is needed and help the trainee to feel more comfortable asking questions.

2. It’s always a good time to examine policies and procedures regarding supervision in terms of what’s working and what may be improved, leaving room for the possibility that there may be problems that trainees are experiencing but not bringing to the supervisor’s attention. Some research has highlighted issues of inadequate and harmful supervision. In a study of 363 supervisees, the vast majority reported receiving inadequate supervision and more than a third reported “harmful” supervision, meaning that the supervisee was harmed by inappropriate supervisor actions (Ellis et al., 2014). Consultation with other supervisors about best practices, and implementation of discipline-specific recommendations, such as Guidelines for Clinical Supervision in Health Psychology (APA, 2015) may help supervisors to improve supervision processes. Similarly, promoting an environment where a trainee feels more open to seeking help or admitting a mistake can also greatly improve the supervisory experience.

3. Encouraging open communication with supervisees may go a long way in terms of helping to improve trainee performance and highlight areas for additional instruction and training. For example, in addition to didactic instruction, assessing trainee comfort level in terms of specific issues related to administration and scoring or testing under unique conditions, such as teleassessment (see Patel, Tarlow, & Tawfik, 2021 for an excellent discussion of issues related

to assessment supervision for telehealth) or in highly distracting environments, may yield helpful information and proactively address trainee errors in administration, scoring, and interpretation. In addition, trainee self-evaluations can also help to provide valuable feedback to supervisors about areas of perceived strength and growth (Stucky, Bush, & Donders, 2010).

4. Consider providing other opportunities to facilitate discussion among trainees. For example, certain approaches, such as the Multilevel Assessment Supervision and Training (MAST) approach (Tawfik et al., 2016), enlist advanced trainees to serve as “peer supervisors” for trainees with less experience. These methods, in addition to formal supervision from licensed professionals, can provide beginning trainees with additional opportunities to discuss questions and ethical issues in an environment that may not elicit as much anxiety. In addition, these programs can provide advanced students with valuable supervision experiences that are often lacking in training programs.

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Section Updates

Section II: Clinical Geropsychology

Brian Yochim, Ph.D., ABPP

This is an exciting time to specialize in Clinical Geropsychology. By 2030, all Baby Boomers will be over 65 years old and one in five Americans will be 65 and over. By 2034 older adults will outnumber the number of Americans younger than age 18 (U.S. Census Bureau, 2018). In a recent article in the APA monitor, (https://www.apa.org/monitor/2021/06/career-demand-geropsychologists), a striking gap was pointed out between the proportion of psychologists who specialize in Geropsychology (1%) and the proportion of the U.S. population that is age 65 or over (13% in 2010, projected to be 20% in 2030). This shortage results from several factors, including a small number of Geropsychology faculty available to train students, and prevalent ageism in American culture. This article also discusses how the COVID-19 pandemic has particularly impacted older adults, while also demonstrating the resiliency of older adults. The article quotes several SCG members who are making strides to provide training for psychologists who work with the increasing numbers of older adults.

The need for geropsychologists is clear, and resources are becoming more and more available for those wanting to increase their knowledge in the area. Members of SCG recently collaborated to produce the Hogrefe text, Psychological Assessment and Treatment of Older Adults. This book, edited by Nancy Pachana, Victor Molinari, Larry Thompson, and Dolores Gallagher-Thompson, contains 11 chapters written by some of the leading experts in Clinical Geropsychology. The book is aimed toward those who are transitioning to working with older clients, to those who want to improve their knowledge, and for those just entering the field of Clinical Geropsychology. Topics include assessment and therapy approaches (including CBT, ACT, IPT, and DBT) for conditions such as depression, anxiety, and PTSD; working with patients with dementia and their caregivers; working in long-term care settings; decisional capacity evaluations; ethical and legal responsibilities regarding elder abuse; palliative care; and bereavement. Like other texts in the Hogrefe book series, the book is rich with case examples and recommended additional readings.

The SCG Committee on Science and Practice recently hosted a conversation hour as part of its process of providing input on upcoming revisions to the 2013 Guidelines for Psychological Practice with Older Adults. The Committee had also provided input in the creation of the 2021 APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change. Its task force was chaired by Benjamin Mast, PhD, Past-President of SCG.

If you are interested in joining the dynamic membership of the Society of Clinical Geropsychology, please visit https://Geropsychology.org!

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“Why Are You Even Here?”

Relational Reverberations of COVID on a Pediatric Inpatient Unit

Sharmila B. Mehta, Ph.D.

Jennifer Fauci, Ph.D.

I walked into the group room and listened to the door click behind me. This was my eleventh month wearing personal protective equipment (PPE) and leading psychology groups on the adolescent psychiatric inpatient service, but it would be my first group in which every teenager had COVID. Swathed in a yellow gown and blue gloves, an N95 and plastic shield covering my face, I felt much more like a hot and anxious astronaut than a clinical psychologist.

The patients in the group looked at me with disdain. I looked back at so many angry, tired teenage faces, straining to breathe, struggling to keep their masks on. I slid my chair backwards about an inch, maybe two, straining against its heaviness because all inpatient chairs are weighted heavily so that they are less likely to be thrown. I could feel my temperature rise and my heart beat faster.

The girl who spoke first was one I had come to know well during her hospitalization. She looked right at me, her eyes searching and disappointed: “Why are you even here?” she said. Her friend backed her up, “You know you don’t want to be here.” One of the boys chimed in, too: “Oh I see... you pulled your chair back….do you want to move away more?”

I took a deep breath. I knew these kids. They knew me. I started to put words together: “Ok you guys, let’s get group started.” One of the girls wiped her nose gingerly, overtly in pain and sweating. “Why are you even here? You don’t want to be with us.” I looked back at her, letting her know that I was taking it in. “I do want to be with you, and I want to run group,” I responded. “Don’t fucking lie,’ she said, angry and despairing.

“I’m here. I’m with you. I’m ready. You guys are ready.” I tried to start where we usually do. It was a group I’d lead hundreds of times, one that is fertile ground for the honest expression of emotion. “Who has an issue they want to talk about?” I tried calmly. “You moved your chair back,” said one. “Why are you wearing that shit?” said another.

A flurry of thoughts about everything I wanted to say was swirling in my head. There were urges to deny and challenge their assertions, to remind them of our relationship before this moment, to declare what I was sacrificing to be there to prove my commitment to them. But I knew none of these were real options. All of them would miss the painful, fleeting opportunity I had to meet them in this excruciating moment. I took another deep breath. I tried to use the most regular voice I could muster: “Hey guys, is it okay that I don’t want to get COVID?” I asked. “You know me, right? Right now I don’t think I have COVID – I mean maybe I do, but I think that there is a chance that I don’t. And I’d really like to keep it that way because having COVID isn’t going to help me help you. Is that okay?”

They stared at each other angrily, exhausted. “Is it okay that I want to wear this stuff, and scoot my chair back a bit, so I can be with you and run group, even though you all have COVID?” They murmured dismissive acceptance, resignation. Some were so tired, they could barely focus on me, but were insistent on staying with their peers. I thought I had an opening and tried to continue.

They looked at me intensely, fury barreling through waves of fatigue and fear. “You don’t even want to be here. You don’t want COVID so you don’t even want to be here. That’s how it is. No one wants to be with us. You don’t want this hell but it’s your job so you have to do it,” one said sullenly. The others rallied, incensed by shared anger. They were agitated, fists clenched, and three were on their feet and advancing towards me. It became eerily quiet. These young people I knew and cared about deeply, and with whom I regularly enjoyed connection and laughter became desperate. Another voice came from the group: “We can give you COVID. We can take that crap off of you and cough in your face and you will have COVID.” There was silence as tears fell and no one moved, even the youth who were out of their seats.

“And then no one will give a shit about you either.”

Inpatient psychiatry serves as the “intensive care unit” of mental health. We have remained open in the COVID pandemic because the youth we treat are those at imminent risk of danger: they have tried to kill or seriously harm themselves or others, or plan to do so if there is not an immediate intervention. When they arrive at our doors, we assess as rapidly as possible to try to understand what underlies these acute risks and what we can do to restore some sense of safety. An inpatient psychiatric service is a place where providers encounter unfathomable pain, but also where we have a critical opportunity to create turning points for the young people we serve.

For many of the child and adolescent patients that end up on our units, trauma is part of the story of why they are there. An event, often several, have overwhelmed their capacity to feel that they can survive their lives or keep their bodies safe. The types of trauma in our patients’ lives is varied; however, among the many storms that shape a child’s vulnerability to acute psychiatric crisis, one of the most destructive is related to early, severe, and ongoing attachment trauma. Such trauma not only rattles the foundation of a youth’s mental health, but often leaves those who know and care for them struggling to reach them through their fear, mistrust, and anger. These were the young people in the room that day.

Youth who have suffered attachment traumas have experienced harm or neglect early in their lives within the very relationships that were supposed to provide their foundation of safety in the world. These profound disruptions come in many forms, including severe instability in family relationships, physical, emotional, and sexual abuse by caregivers, chronic criticism for one’s disabilities, or victimization for aspects of one’s identity. Disruptions to safe caregiving relationships can also be shaped and compounded by social forces, such as poverty, incarceration, civil unrest, immigration and deportation. Furthermore, attachment traumas are often intergenerational—“passed on” from parent to child and related to family histories of violence, substance abuse, mental illness, and oppression.

Attachment disruptions make a child significantly more vulnerable to psychopathology because they overwhelm the brain’s stress response system, impair the healthy development of emotional regulation capacities, and disrupt a child’s ability to feel safe in their own body. Over time, these foundational traumas prime the young person to anticipate suffering and abandonment and to mistrust that they can seek support in relationships even when they desperately want and need it. They have endured things that people simply do not like to think about, and yet they have also managed to survive and sometimes thrive. However, when there is underlying vulnerability to mental illness or when these youth face continued hardship, they struggle to stay safe with their thoughts and emotions. In these unsafe moments, they are less able to trust that anyone could truly understand them and often do not feel worthy of the help offered. These are the youth that act out, avoid, reject, and who are highly suspicious of the idea that anyone “actually cares.” Any perception of difference or otherness—across class, culture, race, gender identity, or life experience—can magnify their experience or assumptions of disconnection. They often relate to the world as a place where they are truly on their own.

In this tidal wave of suffering, our short-term intensive care focuses on immediate stabilization, and supporting a potential turning point towards improved mental health. These turning points come in many forms; however, some of the most powerful and hard to quantify moments arrive when a provider on our units can help a young person feel that they are worthy of and able to accept help. To do this, it is critical for providers to understand how a youth’s attachment style shapes their ability to engage with others. Though psychological theories are often insufficient to describe the complexity of human suffering and potential, they offer a starting point to make sense of what we see. With an attachment lens, we can understand and respond to alarming behavior through a complex developmental and interpersonal context, allowing us to be better poised to disrupt painful patterns. One of the ways we do this is to be there with them during the moments they may expect others to turn away: Being an adult who can reflect back what they are feeling when they cannot put it to words. Being an adult who is truly delighted to see them when they have grown comfortable with not being seen. Being an adult who listens without judgment when they expect to be judged. Being an adult who can tolerate their pain, even as they are screaming, crying, threatening. Even if only by the narrowest of margins, these can be critical pivot points that change how that youth views their potential and worthiness for connection and security. In turn, this can shift the way they engage in the treatments needed to address their trauma related wounds, and access support that can help them live a life in which they want to stay alive.

For the youth who come to us with deep attachment traumas, the COVID pandemic has been an earthquake, introducing yet another way in which their lives are in perpetual risk, and yet another way in which they feel unworthy of and unable to reach care, love and support. The most immediate reverberation our patients experienced was closure all around us. Programs that represent a “step down level of care”—the residential and community-based acute treatment programs—either halted or drastically reduced new admissions in the earliest months of the pandemic. Many have since opened but often must close due to infections in their patients or staff, delaying transfer for our patients rendering them effectively stuck on our unit for months. For patients with severe attachment traumas, this disruption left them feeling not only trapped, but also alone. Given their histories, it felt personal and was proof of their greatest fear: no one really wanted them.

Of course, over time, we have seen that COVID has not only rattled the mental health infrastructure serving our patients, it has also reverberated through homes and schools, propelling staggering waitlists for mental health treatment. Social isolation, disruptions in school routines, unemployment, and family illness are only some of the ways that COVID has magnified distress, and disproportionally so for impoverished families, Black and Brown communities, immigrants and English language learners, and children with special needs. So many outpatient therapists, teachers, and families have been agile and resilient in adjusting to this constrained, virtual reality; however, it has left so many feeling inadequate to meet youths’ needs. As COVID has reverberated through the most marginalized communities we serve, we are reminded that the level of risk they face has always been too much, and the structures to support them have never been enough. The COVID pandemic has magnified the crises bringing our most traumatized and marginalized youth to an inpatient level of care, demanding that we bear painful witness to cracks that have always been there and challenging us to find new ways of "being there with them."

The most constant reminder of COVID –our PPE—has been interpreted by some patients through the lens of their disrupted attachment. Instead of representing safety, PPE has been experienced as a rupture for some patients, highlighting their separation from care and connection. It is not uncommon on our units, and particularly on our child unit, for patients to communicate distress through physical aggression: yelling, kicking, punching, yanking a hospital badge, grabbing a desired item. Naturally, this now includes pulling off face shields, grabbing masks, knocking off goggles. At times, this is because there is just more to grab; however, the manner in which relationally traumatized youth relate to this equipment is indicative of deeper distress. For many patients, the "barrier" represented by our PPE is resolved by making a joke about what you really look like while they examine your badge photo. "Yes, this is how goofy I really look." For others, PPE is a tangible reminder that there is an unreachable distance between them and you. PPE makes you harder to know, harder to read, harder to trust. It is proof that you cannot really care about or love them. It is in-their-face evidence that they are in a hospital, and you can never be as close to them as they want you to be—or, as they have wanted others in their life to be. A cracked foundation revealed by the earthquake. One of our patients, a young boy struggling to feel connected to most people in his life, shared this sentiment abruptly, in the middle of a conversation. "Why are you isolating yourself from me?" he demanded, getting close, appearing upset, even ashamed that he had found the words to ask something he had felt in so many other situations.

Being asked to wear PPE holds relational weight as well. Many young people on inpatient units routinely struggle to meet basic expectations—part of why they are with us is that demands at school or home have become too difficult for them. In the world of COVID, this often extends to wearing masks. Though there are endless reasons why a patient may struggle to wear a mask, including discomfort, inattention, and ambivalence about their own health, some interpret the suggestion as a relational affront. "Why do you even care? You already have one on. I don't have COVID." They hear the encouragement to wear a mask as communication that they are untrusted or dangerous. Our very efforts to protect our patients by wearing and distributing PPE are received with seemingly upside-down responses.

The relational ruptures fueled by COVID took new force when the virus made its way on to our unit. Almost a year into the pandemic, after having avoided any patient infections, everything changed in the course of 24 hours. We learned that almost all of our adolescent patients had tested positive and some were beginning to show symptoms. All of our systems and psyches had to adjust once again. PPE was increased, providers were redistributed to prevent cross-over between units, and staff were scrambling to get tested and re-tested. Providers moved to hotels and quarantined from their loved ones, and all family visits to the unit (which were already severely restricted due to safety precautions) had to stop. This was an overwhelming and despairing time for all of us. Thankfully, none of our patients became severely ill and none had to be medically hospitalized. Though the physical consequences were only mild to moderate, the psychological and relational consequences were extraordinarily painful.

Again, the youth who were most psychologically destabilized were those with underlying attachment traumas and insecure attachment styles. Though they were already in the hospital, their safety gravely compromised by their psychiatric conditions, being physically ill with a virus that was shaking the whole world activated new desperation. The experience of being sick brings forth a deep need for nurturance in many people. For these youth, being sick was terrifying, but also left them feeling exquisitely vulnerable, wishing for a sense of comfort found in one's home—and perhaps one they never fully felt. The terror was shaped in part by their mental health vulnerabilities. Catastrophic thinking styles fostered debilitating fear of death and the potential for lasting health problems. Our suicidal patients wrestled with how to feel about death, openly declaring ambivalence about becoming part of the vicious death toll. Moreover, in the context of their disrupted attachment experience, being sick activated desperate fear that they would not be taken care of. In this state of heightened alarm, they were hypervigilant to any subtle differences in staff behavior that could be suggestive of abandonment. Every measure taken by adults to protect their own and patient safety could be interpreted as a relational rejection. Thus, experiences of providers wearing additional PPE, taking added precautions about limiting time in the exposed area around a patient, or making efforts to afford six feet of distance were terrifying.

These rumbling attachment fears were crystallized in group that day. In the throes of physical vulnerability, their perceptions of relational disconnection were unbearably magnified: an inch of movement was screaming rejection and the donning of extra PPE was proof of our desire to be anywhere but there. This group was not the first moment they felt such ruptures, but it was a chance to speak them out loud. Amazingly, they did. They could have stayed in their rooms as sick and tired as they were, resigned to their entrenched beliefs, anxiety and familiar alone-ness. Instead, they joined group and put words to the separation they felt in the sharpest terms. They voiced their deepest fears about being left alone in the only way they felt they might be heard. In the heat of the moment, this kind of expression can feel daunting, frightening, and devastating for providers. What do we do? Where do we start? An attachment lens does not resolve these painful feelings, instead it offers a compass to navigate them. It helps us to understand and disrupt the perceptions of abandonment— to stay present and to listen.

It helps us to consider the aching questions beneath their ultimate test in that room that day: posturing a significant threat of harm. In this moment when they were most scared of loss and most acutely felt the chasms between themselves and any hope of care, they put forth what they assumed would most surely push others away. In doing so, they revealed the most vital attachment question: Am I worthy of your care and concern no matter what? If I threaten you with COVID, if I scare you, if I harm you, if you know every monstrous thing I feel right now, will you still find me worthy? Or, is now the moment that you finally tell the truth and confirm that I never mattered to you at all? Severely traumatized youth have so very much to be enraged about, but they cannot imagine that people will stand by them if they truly express the extent of their rage. In making the most demonstrative and powerful threat, in speaking their truth in its rawest form, they were demanding to be seen and heard, and for answers to these most vital questions.

As mental health providers taking care of chronically traumatized and marginalized children, we constantly face the dilemmas created by attachment disruptions. In these desperate moments of protective and reactive expression, we have to find some sturdy ground to stand upon while we are being mistrusted, pushed away, criticized, or in the most extreme of situations, threatened or attacked. That day, in that group, they were shouting about PPE and inches, but they were also shouting about what we hear again and again. They are always shouting: "No one has protected me! No one has met my needs! Admit it!" And very often, for these most chronically traumatized youth, they are horrifyingly and excruciatingly right. And yet, here we are in our PPE (or across bad internet connections and virtual classrooms), trying as best we can to show up and meet their needs anyway.

During the pandemic, when literally showing up has also come with great uncertainty and risk, navigating the treacherous terrain of being misunderstood has been extraordinarily painful. As COVID quaked through our patients lives, exposing every crack, it has often left our efforts to be there dismissed or unregistered. Tolerating this mismatch in our efforts and the way we are received has been enormously challenging at times. In response to their assertions that no one wants to be with them, that no one cares about them, we want to yell, "I'm here! I am right here, right now!" We continuously stand across the chasms of disrupted attachment and we are pulled, like anyone who cares for, teaches, mentors, and loves these youth to say, "No, you are wrong! I am here!" In COVID, this pull has been stronger than ever. It is difficult not to scream: "We are wearing PPE not to get away from you, but to be able to be there with you!" Neighboring their attachment question of whether we deem them worthy of care is our question of whether any of our efforts can withstand an earthquake when we are already on such fragile ground. Will we ever actually make a difference in how safe and secure these youth feel? Will it even matter if the shaking would continue after they left our hospital?

Our search for sturdy ground has brought us to the repeated realization that we have to start with willingness to recognize the ways in which these young people are right about their lives. They were right that providers were wearing extra PPE, taking extra space, moving their chairs, and worried about getting COVID. They were right about the profound "otherness" they experienced. They were right that we could go home, that we do not live their lives, and that we did not have COVID. They were also right that staff were scared and traumatized as well – we all showed fear and overwhelm at times and we all avoided risk where we could. Though they were wrong about the meaning of many of their observations—to deny what they felt and observed would be to deny the histories behind these interpretations as one of their deepest truths.

The patients in group that day were not only yelling about COVID. They were also yelling about the lives that had got them to that moment—they were yelling about the fact that "no one gives a shit." Later in the group session, one of the patients revealed the torment underlying much of her fear. She said it plainly: "The world doesn't care about youth like us so we aren't going to be on the list of deaths that anyone cries over." On this fractured and familiar ground, the suggestion of an adult's care and concern is contrived and suspicious. It prompts powerfully enraging sentiments. How could you say that you care, or suggest that anyone has ever cared if you are actually paying attention to how little care I have received? Beyond the realm of COVID, these children need us to pay attention to and tolerate their profound suffering. This has always been true. To truly "be there with them," we must be willing to acknowledge the larger forces that have harmed them and left them feeling forgotten — mental illness, institutional neglect, poverty, family abuse, oppression. Sometimes this means naming the profound otherness they feel—we do not know the life you have lived, and yet, we are here, and listening. Sometimes this means sitting with palpable grief. It means saying—more with presence than words—that I see and feel your pain and I will stay here with you in this moment and try to bear it. We have to attune to their perceptions that "no one cares" and admit to the ways in which they are actually right about their world lens, to earn their willingness to consider that we could play a different role in their lives than the adults who have preceded us, even if just for that moment. From there, we can begin to find a pathway forward.

As providers, opening ourselves up to the profound ways in which our patients are "right" about their lives can feel powerfully debilitating. With the aftershocks still rippling, every "being right there with them" moment can feel almost ridiculously inconsequential. We are grounded and humbled when we remember that we are asking them to be right there too. Every day, we are asking them not to give up on their lives. We are trying to show them that, yes we see the cracks beneath their feet, and the ways they have been profoundly failed, and we will not be able to change most of that, but if they can let others in to know and support them, perhaps they will find steadier ground. We are asking them to believe that after all they have endured.

To do, this, we have to be willing to stay in the room with them and get so close that we are really with them. We have to get so close that we hear and feel the intensity of what they are telling us about their lives, so we are also standing over the cracks. In a way, this is the scariest work because it is not only when we really see how far they could fall but we also start to feel like we are going to fall with them. We have to show them: I know you are scared, I see that gaping crack, I know you have been down there before. I am right here, and even if just for this moment, I am staying here with you even though we are scared. I believe that we may not fall—if we trust each other, we might find a way through. I am staying here with you not to show you that I am the one that cares, but to help you learn that you are worth that care and you always have been.

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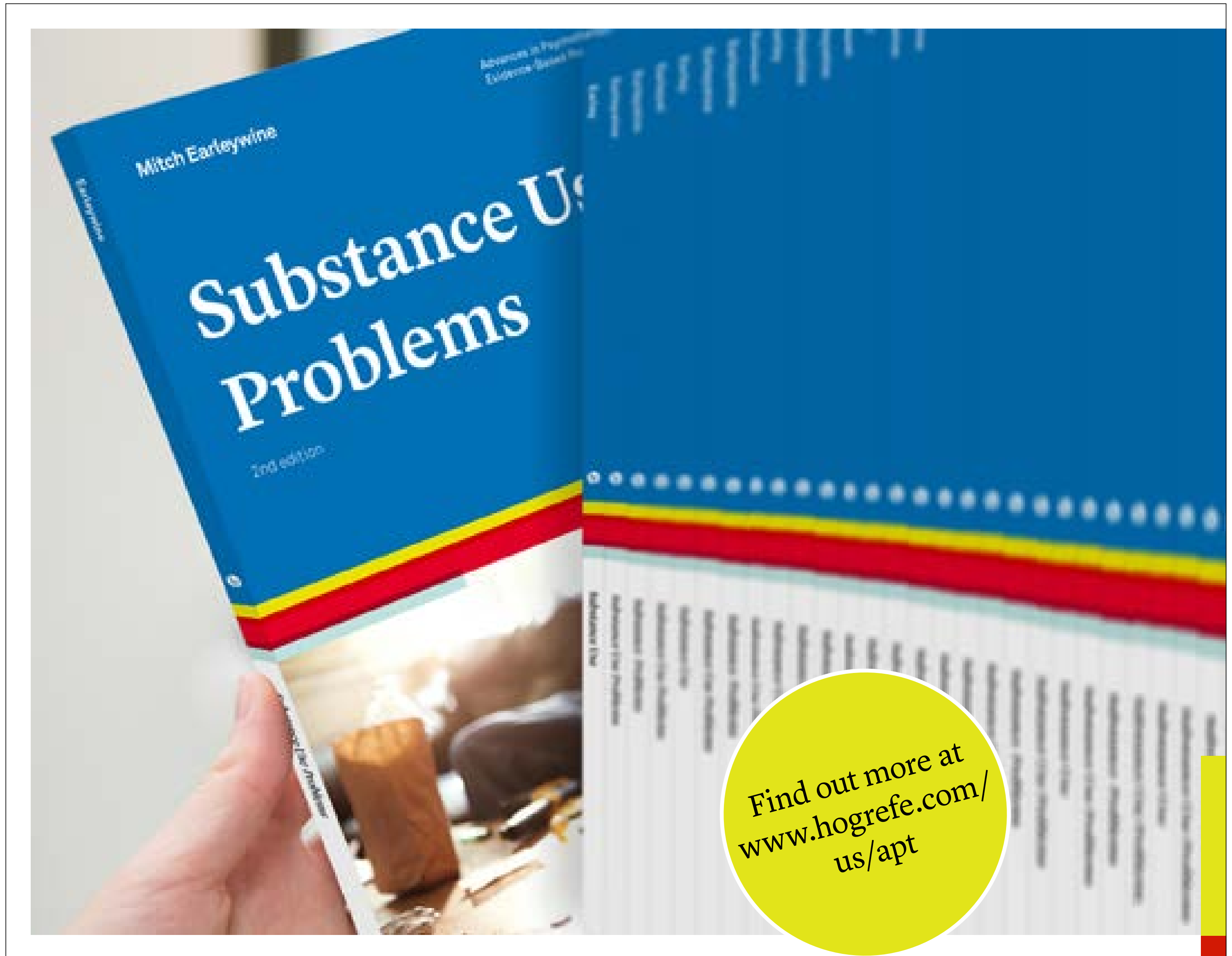

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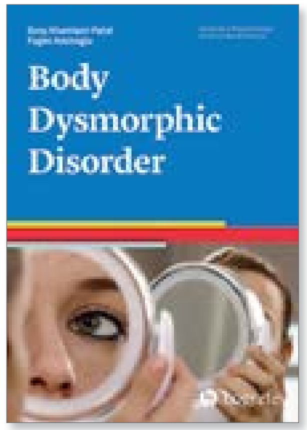

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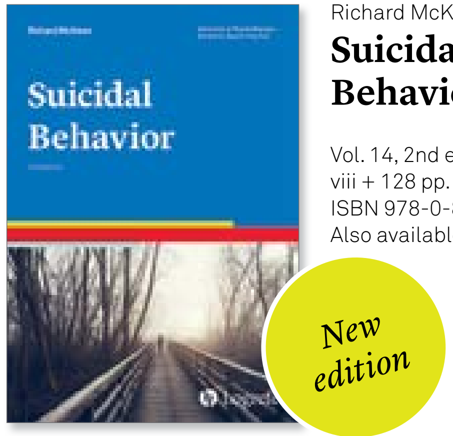

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