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The Association of Psychology Training Clinics (APTC) is a professional organization for directors of doctoral-level psychology training clinics and interested associates and affiliates. The organization is affiliated with the American Psychological Association (APA).

APTC has established a multipurpose mission and specifically seeks to:

- ***promote high standards of professional psychology training and practice in psychology training clinics;***
- ***facilitate the exchange of information and resources among psychology training clinics that provide doctoral-level practicum training in professional psychology; and***
- ***interface with related professional groups and organizations to further the goals of APTC, including influencing the establishment of standards and guidelines on service delivery and training of future psychologists.***

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DIVERSITY STATEMENT

The Association of Psychology Training Clinics is dedicated to furthering cultural awareness, competency, and humility through supportive learning opportunities and environments. We are committed to engaging in training activities which increase an understanding of individual and cultural diversity, and focus on the inter-play between contextual factors and intersectionality among all people. We respect and celebrate awareness, appreciation, and sensitivity toward all and encourage an appreciation of how political, economic, and societal influences affect individuals' behaviors, particularly those from disadvantaged and marginalized groups.

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PRESIDENT'S COLUMN

Heidi A. Zetzer, Ph.D.

Diversity & Social Justice

/dəˈvərsədē,dīˈvərsədē/ /and,(ə)n/ /ˈsōSHəl/ /ˈjəstəs/

I was a child when Dr. Martin Luther King Jr. delivered a sermon at the 1964 commencement ceremony at Wesleyan University in Middletown, Connecticut, the text of which President Obama had woven into the carpet of the Oval Office. It was the first time King evoked a familiar adage, paraphrasing the words spoken in 1853 by the abolitionist minister Theodore Parker, into the inspiring quote, "The arc of the moral universe is long, but it bends toward justice."[1] The most essential part of this message is embodied in King himself. It is the importance of commitment, courage, and persistence. Positive psychologists might call this combination of characteristics hope or grit. Acceptance and Commitment Therapists (ACT) would remind us that values are expressed through action, not attitude.

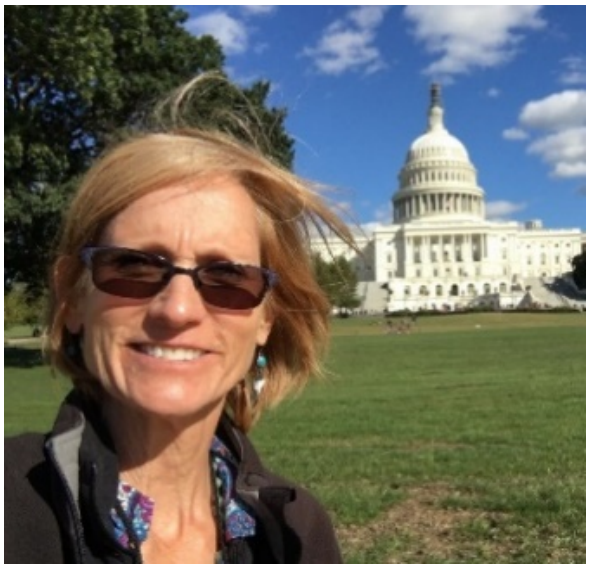
What do Dr. King's words mean for psychology training clinic directors? They are a call to renew our commitment to diversity and social justice, a reminder of the importance of fortitude, and recognition of how far we have to go. As we turn towards the winter holidays, cross into 2020, and celebrate Dr. Martin Luther King Jr.'s birthday on January 20th, let us consider the many ways that the training clinic community embraces diversity and enacts social justice as well as how we might lean into it even more. We will build on this contemplation and focus our

[1] https://www.huffpost.com/entry/opinion-smith-obama-king_n_5a5903e0e4b04f3c55a252a4

energies and intellects on the themes of Diversity & Social Justice when we come together for our Annual APTC Spring Meeting in Albuquerque, NM from March 26th-29th, 2020. I hope that you can make it. If you are unable to attend, please remember that you can find inspiration, information, and support for all your efforts including those grounded in diversity and social justice on the APTC listserv.

The 2020 APTC Annual Meeting will be held at the Hotel Albuquerque[2] in Old Town Albuquerque. We will have two wonderful keynote speakers, Dr. Steve Verney[3] from the University of New Mexico and our own Dr. Karen Fondacaro[4] from the University of Vermont. Both presenters will speak about providing culturally-attuned psychological services that promote health and wellness in the context of systemic health disparities and the slow arc of justice for Native American (Steve Verney) and refugee (Karen Fondacaro) communities. Dr. Verney's presentation is entitled "Sociocultural Considerations in Engaging American Indians and Alaska Natives: Implications for Assessment, Research, and Training". Dr. Fondacaro's talk is entitled "Psychology Training Clinics are Fertile Ground for Social Justice".

The conference starts with programming for New Directors. Be sure to request a mentor or sign up to be one and watch for an announcement about the mentor-mentee dinner. For more info go to: http://www.aptc.org



[2] https://www.hotelabq.com/
[3] https://psych.unm.edu/people/faculty/profile/steven-p-verney.html
[4] https://www.uvm.edu/cas/psychology/profiles/karen-fondacaro-clinical

COLLECTIVE WISDOM: ETHICS CORNER

Addressing Microaggressions in Supervision

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Therapy is a setting where the typical consequences of what clients say or do may not result in the reactions that would happen in the "real world." Clinicians can address problematic interpersonal style, content of communication, and/or overt behaviors with clients in order to help them build awareness around the problems, appreciate the consequences of the behaviors, and build skills to handle situations in prosocial and effective manners. Yet often, they do not respond to such behaviors (either overtly or through withdrawing from the relationship) in the same way as may happen outside the office. What behaviors should a clinician address and where is the line between something that is appropriate for a clinician to work on with a client and the point where a clinician should consider not continuing treatment or even taking other actions? What are the risks and benefits to directly addressing microaggressions in treatment? This matter is complicated when we are supervising trainees who are relatively inexperienced.

Rachael, a 25-year-old cis-gender, heterosexual, white trainee is treating John, a 55-year-old cis-gender, heterosexual, white man with presenting issues surrounding anger, underemployment, relationship problems, and dysthymic mood.

Consider the following scenarios and how your response might change across each one

John says to Rachael:

a. "You know why I can't get a good job, they give them all to those Spanish speaking guys."

b. "You're a little miss smarty pants aren't you?" – in regard to being presented with a model of treatment

c. "If only you weren't married, I'd be all into you." – Rachael mentions to her supervisor that this makes her very uncomfortable and the supervisor notices on the video that John seems to be focused on Rachael's legs and breasts during the remainder of the session.

d. Rachael notices John loitering in the convenience store across the street from her apartment, nowhere near where he lives or works.

Microaggressions are brief communications (e.g., verbal, behavioral), regardless of intention, that communicate insults, slights, hostility, or are otherwise derogatory and are often directed toward marginalized groups (Sue, 2010). Although microagressions are often not as overt as outright discrimination and/or blatant aggression, they are nonetheless damaging. Often the ambiguity of the statements leads the recipient of the comment to blame themselves (David, 2013). As the microaggressions become more overt (see vignette above), it becomes easier and easier to see the need for a response. However, should psychologists wait until there is a clear line crossed?

The Principles of the APA Ethics code provide guidance on this matter. According to the APA Ethics Code, the principles of Beneficience and Nonmaleficence, Justice, and Respect for People's Rights and Dignity encourage us to guard against factors that will compromise our own well-being and have deleterious effects on those we treat, to not "condone unjust practices," and not to "condone activities of others based on such prejudices." By addressing microaggressions when they are perceived, the clinician can create a forum to explore the client's behaviors in a venue that promotes dialogue, curiosity, discussion, and potentially behavioral change strategies. At a minimum, this promotes awareness of the impact of such behaviors on others and conveys to the client that the behavior/statement is not universally accepted as appropriate/truth. One could also argue that by addressing microaggressions as early as they are observed, the client is not led to believe that they will be tolerated; this can ward off behavioral escalation. For example, if examples "b" and "c" above are not addressed by the clinician, the client might be confused about an abrupt termination should he then do the behaviors in example "d." Should the clinician address example "b," head on, the client will be given a clear message about the objectification of the clinician, boundaries can be clarified, and consequences can be clearly delineated and hopefully avoided. This is consistent with Standard 3.04(a) (Avoiding Harm) and hopefully avoid reaching 10.10 (b) (Terminating Therapy when threatened or otherwise endangered by client).

As supervisors, what would you ask your advisee to say or do, in the moment or in the next session in regard to the vignettes above?

Please post responses on the listserve and let's discuss!

SUPERVISION AND DIVERSITY

Featured Article

A Humanistic Approach to Culturally Sensitive Clinical Supervision

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While preparing a presentation for agency supervisors on multicultural clinical supervision, I asked students in my supervision of supervision course, "What do you want community supervisors to know?" Without hesitation, the students replied, "Be sure to tell them about harmful supervision and help them understand the power dynamics of social location." "Can I tell them that you said this?" I asked. "Yes, please tell them," they replied.

The result of their recommendation was to create a presentation entitled, *A Humanistic Approach to Culturally Sensitive Clinical Supervision: Seeing, Witnessing, Prizing, and Fostering Personal/Professional Development of Therapists/Supervisees with Intersecting Multicultural Identities and Privileged and Subjugated Identities That Emerge from a History into a Sociopolitical Context and Are Infused with Experience, Resilience, Wisdom, and Strength*. Quite a title! It is long in form because of the complexity of this inherently relational pursuit. Luckily, with good preparation, and a deep reservoir of courage, supervisors can enter into and maintain multicultural relationships with supervisees that foster their development as highly integrated people and professionals. This happens not through psychotherapy, but through a humanistic approach to culturally sensitive clinical supervision.

The purpose of this article is to: a) describe the need for a humanistic approach to multicultural clinical supervision, b) describe the essential features of such an approach, and c) describe best practices for its implementation.

Inadequate & Harmful Supervision

In a two-part landmark investigation, Ellis et al. (2014) first developed an empirically-grounded taxonomy of minimally adequate, inadequate, and harmful clinical supervision and established criteria for each category. The latter two categories were further differentiated into self-identified (by the supervisee) and de facto harm (does not meet professional standard). *Minimally adequate supervision* meets basic standards of practice for clinical supervision (e.g., APA, 2015). *Inadequate supervision* occurs when a supervisor is "unable or unwilling to meet the criteria for minimally adequate supervision" (p. 439) and *harmful supervision* is defined as "supervisory practices that result in psychological, emotional, and/or physical harm or trauma to the supervisee" (p. 440).

Ellis et al. next conducted a survey of 363 supervisees with an average of 4.7 years of training and 1.5 supervisors, and found that about 61.4% of respondents reported receiving self-identified inadequate supervision. Moreover 90.1% of the supervisees reported de facto inadequate supervision characterized by at least one deficiency and 46% reported multiple de facto inadequacies in supervision

(e.g., no supervision contract, no live or video observation of supervisee). About 36.2% of participants reported receiving self-identified harmful supervision. Finally, 39.2% reported receiving de facto harmful supervision (e.g., felt exploited or harmed by dual roles). Approximately 50.9% reported receiving harmful supervision over the course of their training.

Reports like this and others (Ellis, 2017; Ladany, Mori, & Mehr, 2013) raise questions about whether the clinical supervision being provided to trainees meets standards set by the American Psychological Association (APA; 2015) and the Association of State and Provincial Psychology Boards (ASPPB; 2015). One domain of competence that is particularly vulnerable to inadequate or harmful supervision is *Domain B: Diversity*, for which "Supervisors are encouraged to infuse diversity into all aspects of clinical practice and supervision, including attention to oppression and privilege and the impact of those on the supervisory power differential, relationship, and on the client/patient and supervisee interactions and supervision interactions" (APA, 2015, p. 36). Despite supervisors' commitment to meet this standard, supervisees with multiple intersecting identities still encounter a lack of cultural competence and microaggressions (Sue, et al., 2007) in supervision (Bryan, 2018; Burkard et al., 2006; Hernández, Carranza, & Almeida, 2010; Hernández, Taylor, & McDowell, 2009; Wong, Wong, & Ishiyama, 2013). In these situations, it is often up to a supervisee to challenge the supervisor or to endure. They typically choose the latter.

A Humanistic Approach

I propose that one way to prevent inadequate and harmful supervision that is caused by a lack of multicultural attunement is to adopt a humanistic stance that is grounded in an I-Thou rather than an I-It relationship (Buber, 1958). In I-Thou relationships, the supervisee is treated as a *whole person*. Such relationships are at the heart of the intersubjective dynamic between supervisor and supervisee (Sarnat, 2015). I-It relationships feel depersonalizing. Supervisees feel undervalued or ignored; only part of them matters and it is the part that delivers the interventions to the clients. This is not an uncommon feeling for anyone, supervisor and supervisee alike, who is working in a high-volume clinical setting in which revenue is based on numbers served. Supervisees feel like objects when their needs, their clients' needs, and their respective cultural identities and social location(s) are diminished or neglected. This occurs when their multicultural contributions to supervision and/or client welfare are unappreciated or dismissed. Such missteps can be made by even the most well-intentioned supervisors. We all have the potential to be harmful (Ammarati & Kaslow, 2017).

In a multicultural context, trainees may feel harmed by a loss of visibility and voice in supervision, which creates a rupture in the supervisory alliance. They might give the supervisor feedback on this, but it is more likely that such ruptures will lead them to withdraw from full engagement and reduce their willingness to disclose (Mehr, Ladany, & Caskie, 2015). I do not believe that supervisors do this on purpose. We become anxious about client welfare, are charged with meeting service quotas, or fear stumbling further into a multicultural misstep ourselves (Zetzer, 2016). Mutual avoidance then leads to relational paralysis and the rupture in the supervisory alliance goes unrepaired.

How can supervisors who are committed to providing culturally sensitive supervision develop their own ability to train, support, and empower supervisees while reducing the likelihood of harm? I recommend

that we develop ourselves in three areas: (1) Grow our awareness and ability to describe our own "social location," and the power, privilege, and vulnerabilities that go with it, (2) Cultivate cultural humility, and (3) Learn to apply models of cultural identity and trainee development (e.g., Integrated Developmental Model, identity development models) in order to situate ruptures in multicultural supervisory relationships in a compassionate humanistic framework. The goal is to promote empathy and understanding so that supervisors can take a step back and consider ways to rebuild the alliance and promote supervisee growth.

Social location or "location of self" (Watts-Jones, 2010, p. 405) refers to a therapist or supervisor's ability to identify their multiple intersecting cultural identities and to recognize and name the ways that these identities are connected to sources and experiences of privilege and subjugation (Hardy & Bobes, 2016). Pamela Hays' (2016) ADDRESSING model is a useful tool that supervisors can use to create a culturally inclusive supervisory relationship by first self-disclosing their social location in relation to their **A**ge and generation, **D**evelopmental and acquired **D**isabilities, **R**eligion and spiritual orientation, **E**thnicity, **S**ocioeconomic status, **S**exual Orientation, **I**ndigenous heritage, **N**ational origin, and **G**ender and the ways that these identities have contributed to their development as a professional. Such disclosures show that supervisors are capable of talking about multicultural identities and contexts and provide acknowledgement of the ways in which supervisors' intersecting identities interact with the power dynamics that are always inherent in a supervision (Hernández & McDowell, 2010).

Cultural humility is "the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client [or supervisee]" (Hook, Davis, Owen, Worthington, & Utsey, 2013, p. 354). Tervalon and Murray-Garcia (1998) described cultural humility as a commitment to lifelong learning, self-reflection, self-evaluation, and self-critique. Humility consists of interpersonal behaviors that address and redress the negative effects of the imbalance of power in supervisory relationships, invites expressions of values that differ from one's own, and provides for institutional accountability. Supervisors who neglect to attend to the structural and systemic context in which trainees provide services and in which supervisors provide oversight are ignoring powerful forces that have positive and negative effects on supervisees and clients alike.

Developmental models are theoretical frameworks that supervisors may use to deepen their understanding of supervisees as multicultural beings and as developing psychotherapists. Racial/cultural (Root, 2013; D.W. Sue & Sue, 2016), lesbian, gay, bisexual (Cass, 1979; D'Augelli, 1994; Fassinger & Arseneau, 2003), transgender (Lev, 2004; Levitt & Ippolito, 2014a, 2014b), and feminist identity development models (Erchull, Liss, & Wilson, 2009) help supervisors understand the attitudes and behaviors of their supervisees, their supervisees' clients, and the ways that identity statuses may play out in relationships. For example, a supervisee of color who is in the resistance and immersion stage of racial/cultural identity development (D.W. Sue & Sue, 2016) is more prizing of their own racial/cultural group than other groups, working with a supervisor of color who is in the integrative awareness stage, may feel frustrated by the supervisor's appreciation for members of other minoritized groups and selective appreciation for white colleagues. If the supervisor understands this, then they are able to empathize and support the development of the supervisee as a person of color and as a professional. Knowledge and application of a wide range of identity development models help supervisors

conceptualize trainee learning goals in ways that promote their development as *whole* people – developing professionals with multiple intersecting identities who are cultivating their competencies in a particular sociopolitical context, which includes time and place.

Similarly, supervisors who know and apply the IDM (Stoltenberg & McNeill, 2011) can integrate identity development with the supervisee's level of professional development to further understand what learning goals and supervisory interventions would be most beneficial to the supervisee. For example, if the same supervisee is in Level I of their development, which typifies first year doctoral students, then interventions related to training supervisees to appreciate their understanding of other cultures, might include teaching them how to conduct a culture-centered assessment (Arredondo, Gallardo-Cooper, Delgado-Romero, & Zapata, 2014) because Level 1 trainees want information on "how to" work with clients. Whereas, a supervisee who is in Level 3 of their development, with a high degree of competency and self-efficacy, may be ready and appreciative of a deeper discussion of their social location, preceded by the supervisor's self-disclosures about their own social location, and a mutual discussion of how their identities and life histories impact the supervisory and therapeutic relationships.

In sum, best practices for humanistic culturally sensitive supervision include: (1) Start a supervisory relationship by revealing how one's own multicultural intersecting identities (social location) and life history has influenced your approach to psychotherapy and supervision and how such locations may interact with the power dynamics of supervision, (2) Educate oneself on the growing literature on identity development and the impact of oppression and privilege on a developing professional's sense of identity and worth, (3) Remind oneself of the IDM and thoughtfully blending the IDM with identity development themes in order to support development of the trainee as a person as well as a professional, and (4) Cultivate and convey cultural humility in one's approach to supervision.

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APTC Supervision Committee

Stephanie Graham, Ph.D.

While APTC clearly supports our work as clinical supervisors, there was excitement at the conferences in Maui and Charleston to have a small working group focused on clinical supervision; hence, the revived Supervision Committee was formed. And, a handful of eager APTCers were ready to dive in! We met and developed two broad goals to help guide the work of the committee: 1) provide support to members on supervision and training- related issues and 2) grow the online resources on clinical supervision.

Given these broad goals, we have started two projects for 2019-2020. First, we have solicited syllabi for courses or course content that meets the APA's Standards of Accreditation (SoA) Profession Wide Competency requirement related to Supervision. We now have these materials (e.g., syllabi, reading lists, etc.) available on the APTC webpage (under "Training Resources" then "Syllabi for Clinical Training Courses") and are planning a content review and summary to be available in Spring 2020. We hope this is helpful to members who teach this content in their programs and to help folks who are developing these courses for the first time. If you'd like to contribute your syllabus or other materials, please email them to Stephanie Graham (srgraham2@wisc.edu).

A second project for the Supervision Committee was to offer virtual consultation group meetings for APTC members to discuss supervision-related topics. While the APTC listserv is very active, email is not always sufficient (or efficient) in discussing issues related to student trainees, their clinical work, and the myriad of other nuances associated with clinical supervision. We held our first group meeting in November and had 11 members attend! We hope to offer these at least once per semester and will send out the Spring 2020 date soon.

Finally, we welcome interested members to join our committee! If you are interested or would like to talk more about the work of the committee, please feel free to reach out to any of us!

With appreciation and on behalf of the Supervision Committee,

Stephanie Graham (Chair)

Committee Members:

Dani Keenan-Miller
Lisa Smith
Kristy Kelly
Nancy Liu
Bill Salton
Mary Beth Heller
Jennifer Mabry

Neuropsychological Assessment of Dementia in Latinx Populations

Philip Sayegh, Ph.D., MPH

Associate Director, UCLA Psychology Clinic

Research on dementia assessment in Latinxs is becoming increasingly important as the older adult population continues to burgeon. In our recent book chapter entitled "Dementia Assessment in Latino Americans," published in 2019 in the most recent (3rd) edition of Ethnicity and the Dementias, Cynthia M. Funes and Paola Suarez of the UCLA Geriatric Psychiatry Department and Cultural Neuropsychology Initiative and I provide an overview of the research on this topic. Specifically, we focus on assessment of neuropsychological status, functional abilities (i.e., activities of daily living [ADLs], such as feeding and grooming, and instrumental ADLs [IADLs], such as medication management and cooking), and behavioral and neuropsychiatric symptoms associated with dementia (e.g., apathy, delusions, and disinhibition) in Latinx Americans in an effort to provide recommendations for best practices and research. Below, I summarize our key findings and recommendations for best practices pertaining specifically to neuropsychological assessment in Latinx Americans.

The traditional approach to the neuropsychological assessment of Latinx Americans has involved determining if a client's English-language skills are adequately proficient to be tested in English, whether informally during the course of the intake interview or using standardized measures such as The Woodcock-Muñoz Language Survey III (WMLS III) and Bilingual Verbal Abilities Test (BVAT), or if they should be tested in their primary language (e.g., Spanish). Given the dearth of bilingual providers who are qualified and culturally competent to conduct neuropsychological assessment among Spanish-speaking Latinxs, interpreters are often used, which offers the chance to render needed care to this group yet also comes with several limitations (e.g., possible third-party observer effects, unintended biasing of results, and interpreters' limited familiarity with assessment procedures and clinical terminology). Therefore, we encourage clinicians to first seek local, qualified bilingual providers (see https://hnps.org/find-a-spanish-speaking-neuropsychologist/ for a list of Spanish-speaking neuropsychologists). If not feasible, they should seek professionally trained interpreters who are socio-linguistically competent and possess the appropriate certification, and seek training in the use of interpreters themselves. In reports, the use of an interpreter and translations utilized should be documented, and a note that results should be interpreted cautiously should be included. The use of non-professional interpreters, especially family members, is strongly discouraged for numerous reasons (e.g., confidentiality concerns and possible secondary motivations to aid or hinder test performance).

Although the amount of research aimed at developing normative data for English-language neuropsychological tests among Latinx individuals has increased, we continue to struggle to understand how linguistic and cultural diversity may affect test performance, as manifested in persistent ethnic-group differences in performance on various tests. Fortunately, there are now at least 555 tests that have been translated into Spanish (e.g., MMSE-2, MoCA, WAIS-IV, Batería IV Woodcock-Muñoz, MMPI-2-RF, and SCL-90-R), in addition to Spanish-language neuropsychological batteries developed specifically with Latinxs both in the US and abroad. Nonetheless, it remains to be determined the extent to which such measures are appropriately suited for Spanish speakers from diverse backgrounds (e.g., nationality, acculturation, bilingualism, and SES).

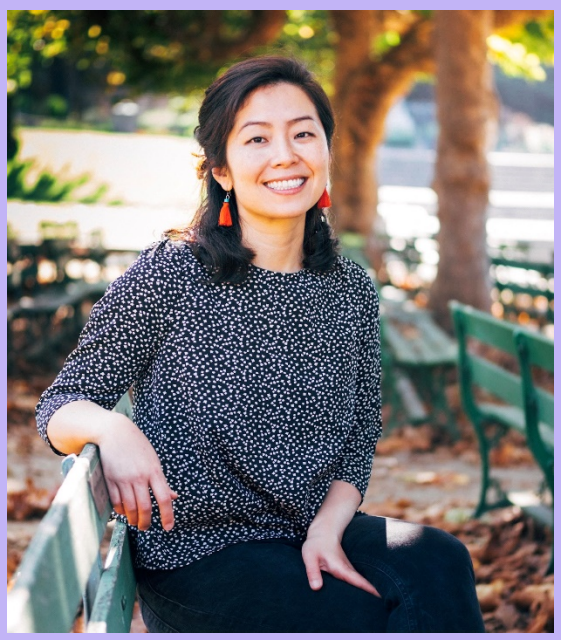
Based on clinical experiences from UCLA's Cultural Neuropsychology Initiative and a review of the literature, we strongly recommend that clinicians strive to test bilingual patients in their two languages when possible to help increase test specificity and sensitivity. This approach can lead to more accurate clinical diagnoses and tailored recommendations. We also encourage clinicians to seek formal and informal training, supervised clinical experiences, didactics, and workshops in working with Latinxs (see https://hnps.org for resources), consult the literature for guidance on how to formally assess language proficiency, and assess clients' quality of education as well as levels of education and literacy to help improve the validity of assessment results and provide the best care possible.

PERSPECTIVES

Acknowledging New Contributions and Long-Standing Support

Karen J. White, Ph.D.

Interview with Nancy Liu, Ph.D. - Newly Elected, Early Career Member-at-Large



Seattle 2016 was her first APTC conference. Just a few weeks into the position, Dr. Nancy Liu, the clinic director at University of California-Berkeley, felt welcomed and included by the APTC crowd. And she also learned that we tend to be prepared. Remember the great umbrellas we received as conference swag in Seattle? It's still one of her favorite umbrellas! Maybe she was impressed by more than the still-functional umbrellas because Nancy is APTC's newly elected, Early Career Member-at-Large.

Nancy has a long-standing interest in homelessness and severe mental illness (SMI). Dr. Liu trained at the University of Nebraska-Lincoln under Dr. William D. Spaulding where she developed a strong appreciation for treatment for SMI—she saw that treatment can work *if and when* effective services are available and clinicians have been trained to provide them. In her current role as clinic director, she continues that interest. She cited a number of factors that support such work. At UC-Berkeley, clinical science faculty study schizophrenia, bipolar disorder, and mental health stigma, among other topics, and often supervise some of her clinic's toughest cases. Her clinic also has close partnerships with the local academic medical center, the University of California – San Francisco (UCSF), which facilitates connections with prescribers to allow the stability needed for therapy. Several of her clinic's supervisors are part of the UCSF comprehensive DBT team which allows students to learn from skilled DBT clinicians and treat high-risk clients in their graduate training clinic. Dr. Liu also practices clinically in a half-day integrated OB-Psychiatry clinic at UCSF that serves pregnant women who often have SMI, addiction, and complex trauma. Dr. Liu clearly is committed to reaching out to those who probably would not otherwise receive mental health services.

When asked about issues important for APTC to address, Dr. Liu highlighted how the training clinic plays a critical role in setting the tone for the future of our profession. It's here that students first learn what it means to "do clinical work" and wherever they go, they will likely propagate that model (for better or for worse!) The training clinic provides a foundational socialization into the field. It's also here where students learn limits—their own, our own, or even to how the integrate research and practice with real clients. By the same token, Nancy commented on how well APTC integrates new members to help them find a place to connect on issues that are relevant to them and their clinic. She expressed appreciation for APTC's focus on mentoring and supportive and wise community for its newest members.

As a "newer" clinic director, Nancy shared that the first couple of APTC conferences felt like being a "visitor to a family gathering" in which everyone appears to feel connected and known - - intimidating at first, but also inviting at the same time. Dr. Liu was impressed by the warmth and kindness and felt drawn in by the group's willingness to openly discuss difficult training issues and ethical dilemmas. It was really kind of a "shot in the arm" to interview Nancy Liu. She closed our discussion by positing that clinic directors seem to possess a self-awareness of their strengths and weaknesses. APTC members seem to represent the best of what our profession offers: genuine warmth and compassion, commitment to teaching, a strong interest in research, high ethical standards, and creativity and innovations. She believes APTC members do some of the best work that the field offers.

Interview with Karen Saules, Ph.D. – APTC Secretary

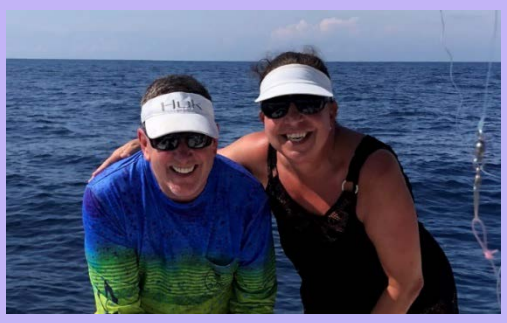
We decided to interview Dr. Karen Saules (Eastern Michigan University, Ypsilanti) because she has been part of the "backbone" of APTC for a long time…even back when we were ADPTC. In interviewing Nancy Liu (above), she noted that the first APTC member she had contact with was probably Karen Saules. Yea, probably so; and here's why. In interviewing Karen Saules, I learned more than a few things. Here's the probably incomplete list of activities and duties that Karen has completed, managed, handled, put up with, cringed at, and/or gladly been a part of: managed the archive of the listserv, managed the website, kept track of members (their membership dues, conference fees, login problems) …and Karen added, "and I repeat myself a lot on the listserv" about all of the above.

In describing her involvement in the inner workings of APTC, she highlighted her enjoyment of the fact that she is probably the one person who has encountered all of us at the beginning of our connection to APTC, and she keeps track of us for years. Karen served as Resources, Listserve, and Website Coordinator from 2001-present. She was Member-at-Large from 2002-2004 and 2010-2012. She has also been on various committees, most notably Diversity from 2006-2012. At some point along the way (Karen thinks when Erica Wise was president of APTC), Erica said something like "Karen, if you're going to do all this stuff in service of the organization, you might as well actually be our Secretary." Good idea. Since 2012, she has been our Secretary.

To perhaps overuse Thomas Paine's quote, it's interesting how the tasks and "the times have found" Karen Saules. When asked, when did you start in your job? Karen replied, "We opened the clinic on 9/11". She explained that, in reality, the clinic wasn't really open for business, but word on the street was that a Psychology Clinic had moved into the building. So, on that fateful day, folks seemed to wander in…they just showed up and asked if they could come in to talk to someone. Karen Saules has a way of showing up when there's work to be done.

What's on the horizon for Dr. Saules? Very significant developments in resources and connections for the EMU Psychology Clinic. Karen noted that the "current place is kind of a wreck, but for good reason." EMU is nearing completion of a new health center, which will provide primary health care services to community members as well as the EMU community. The EMU Psychology Clinic will be more strategically co-located within the new health center, along with primary care, urgent care, and the student counseling center (CAPS). Karen hopes that this will allow for more integrated care to be provided on campus and will facilitate continued connections with the community. Karen already oversees a number of satellite clinics such as a collaboration with EMU's Eagle Nutrition Center, where Dr. Saules can pursue her interest in eating disorders, and the Children's Institute, where psychology trainees work with kids on-site at a daycare/pre-school center. Karen explained that each "arm" of the clinic has a faculty supervisor whose research and clinical interest is expressed by the satellite clinic. With the new integrated approach to medical and mental health care on campus, the EMU doctoral psychology training program will be able to address interests in health psychology with greater focus, even though Eastern Michigan University does not have a medical school.

Dr. Saules has some wishes for the future of APTC. She pointed to the need for us all to plan for sustainability by greater involvement and leadership from our many new members. The organization has a crew of very long-standing members who have held office, instituted by-laws, have made a mark on the field (e.g., articulation of clinical competencies), and have strengthened connections to other organizations (e.g., CUDCP, APA, APPIC, CCTC). Those contributions and connections put APTC on the map. And Karen Saules helped chart the course, but she welcomes new energy into the various roles she has fulfilled.

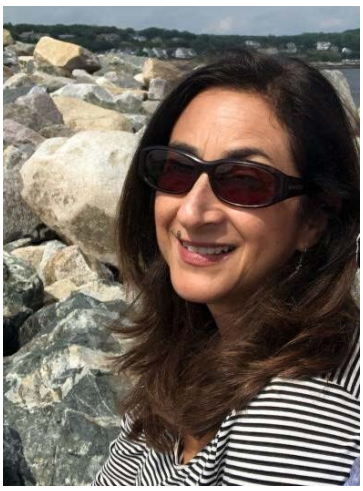


Karen & husband fishing for marlin.

HAPPENING NOW

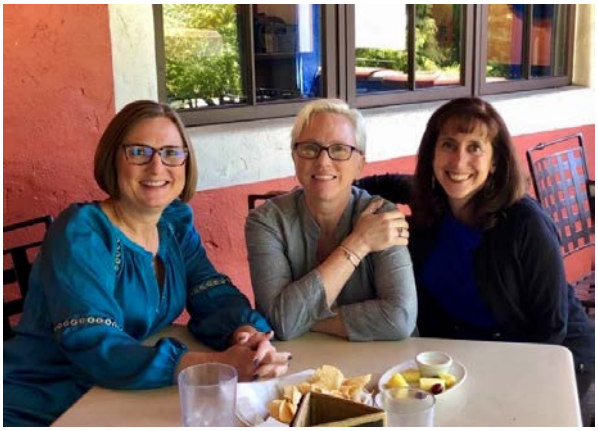
Diversity Committee

In the spirit of APTC's commitment to supporting and furthering social justice and cultural awareness and competency, the Diversity Committee, under the direction of Randy Cox, Ph.D. and Saneya H. Tawfik, Ph.D., is planning a Survey. We are interested in collecting data on social justice practices/initiatives, as well as resources provided to underserved clients and student clinicians. We are also interested in how diversity competencies are developed in clinics, and training challenges, which could impact the nature and quality of services provided to students and diverse clientele. It is hoped that results from this survey will help improve an understanding of how approaches to individual differences, cultural awareness, competency, and humility in training clinics are evolving and being advanced. Stay tuned for the upcoming survey!

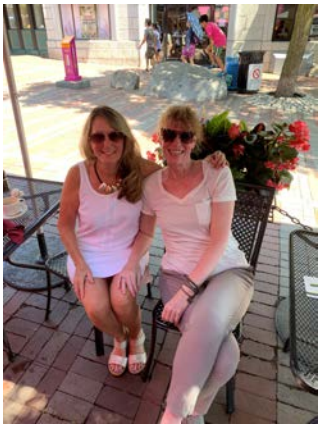


Randy Cox and Saneya H. Tawfik (Co-Chairs)

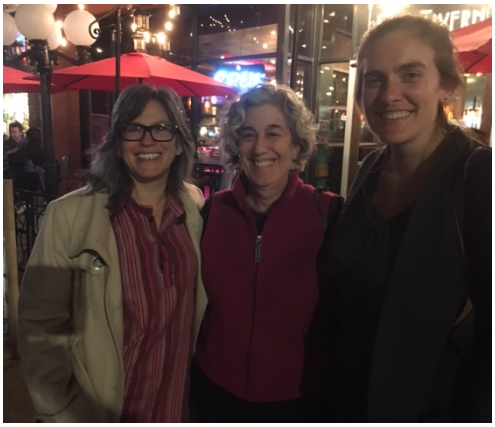
DIRECTORS STAYING IN TOUCH



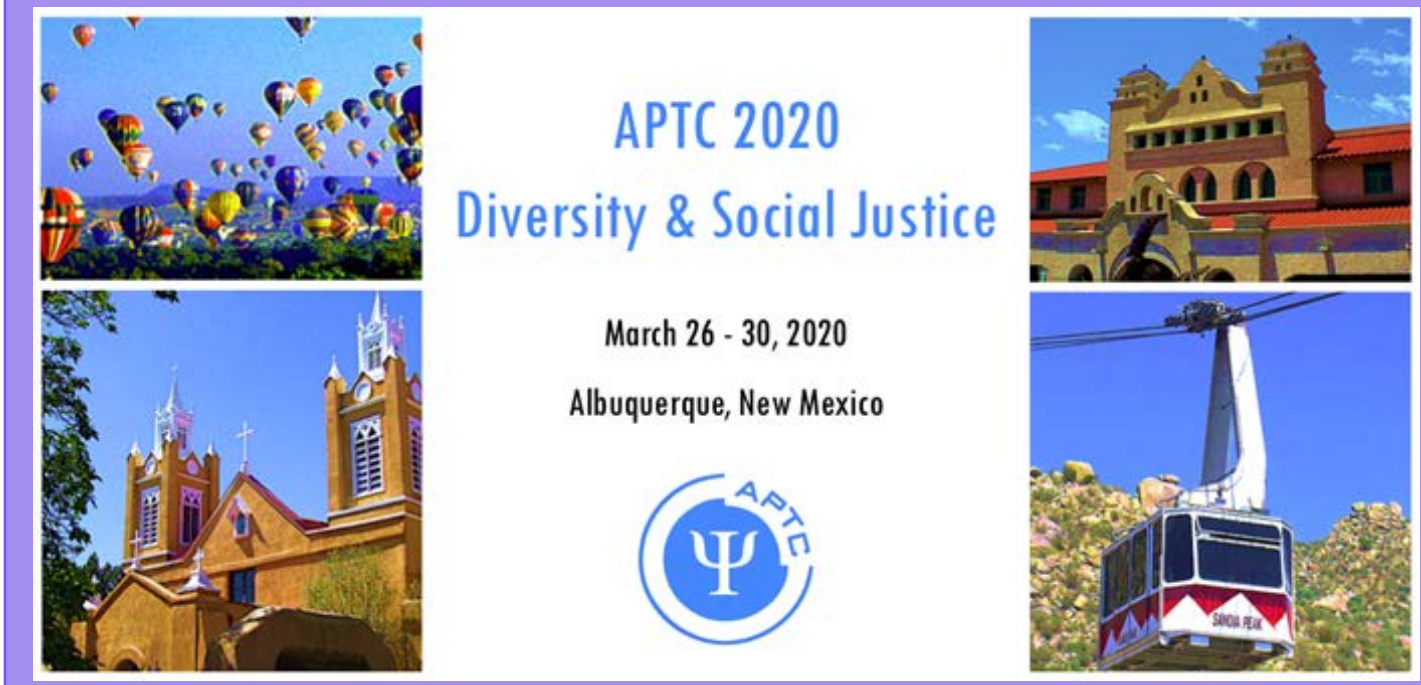
L to R: Mary Beth Heller - Virginia Commonwealth University; Colleen Byrne - University of Maryland; Robyn Mehlenbeck - George Mason University



L to R: Karen Fondacaro - University of Vermont; Lisa Smith - Boston University



L to R: Lettie Flores - University of Tennessee, Knoxville; Erica Wise - UNC-Chapel Hill; Sarah Thompson - University of Tennessee, Knoxville



Dear APTC Directors!!

We are excited about our next APTC Conference (Thursday March 26th through Saturday March 28th, 2020) at The Hotel Albuquerque at Old Town, in Albuquerque, New Mexico (https://www.hotelabq.com). Please join us!