

The Next Generation of Clinical Psychological Science: Moving Toward Antiracism

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Abstract

The field of clinical psychological science exists within a broader field of psychology, which is increasingly acknowledged as embedded in racist and white supremacist history. In the production of clinical psychological science, the Clinical Science Model predominates as one of the most influential scientific voices that emphasizes the value of rigorous scientific theory, training, and praxis. We highlight some of the ways in which the Clinical Science Model has neglected antiracism. By examining the idiosyncratic development of the Clinical Science Model within clinical psychological science, we outline how its failure to contend with systemic racism within the field propagates a racist subdiscipline. Our hope is that by enacting difficult self-reflection, we invite other stakeholders within our field to think more critically about how systemic racism and white supremacy pervade our structures and institutions, and to begin making more concrete changes that move the clinical psychological science field toward explicit antiracism.

Keywords: Clinical Science; Antiracism; Clinical Psychological Science; Mental Health Disparities; Psychological Clinical Science Accreditation System

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Prologue: Racial Violence in US Society

The murder of George Floyd on May 25, 2020 sparked the large-scale resurgence of a protest movement that began in 2012 after the killing of Trayvon Martin, and swelled in 2014 after the police killing of Michael Brown in Ferguson, Missouri (Kilgo et al., 2019). Apart from police killings that disproportionately threaten the lives of Black Americans and other People of Color (Edwards et al., 2019; Ross et al., 2021), racial and ethnic minoritized (i.e., those racialized as non-white) groups face disproportionate and increasing stigma, prejudice, discrimination, and violence within US society. In 2020, hate crimes perpetrated against Asian Americans rose by nearly 150% (Center for the Study of Hate & Extremism, 2020). In 2021, a string of attacks against Asian Americans in Oakland, California and New York City, and a massacre of Asian American workers—primarily women—in Atlanta, Georgia (Fausset et al., 2021) occurred. In 2022, a racist attack at a grocery store in Buffalo, New York left ten Black Americans murdered. These are only a handful of the examples illustrating the violence faced by individuals from racialized groups in the US. This violence represents one illustration of the stigmatizing societal and political backdrop racialized persons within the US face (Dearman, 2020). The demands of the protest movements center racial justice and equity through dismantling systemic racism, oppression, and anti-Blackness.

Recently, there has been greater reckoning with how systemic racism impacts psychology, and the scientific academy more broadly; one recent example includes the American Psychological Association's apology for its promotion, perpetuation, and failure to challenge racism (American Psychological Association, 2021). Our contribution in this manuscript is to

continue reckoning with how racism is tolerated, and propagated, within the *Clinical Science Model* of clinical psychology. Our intention is that uncomfortable reflection can move the field toward overt antiracism.

Clinical Psychology, Clinical Science, and Antiracism

This paper extends the conversation about racial equity in clinical psychology. Specifically, we focus on the Clinical Science Model that forms the foundation for training in at least 75 research-oriented clinical psychology doctoral and internship programs in North America. The Clinical Science Model emphasizes a “commitment to empirical research and the ideal that scientific principles should play a major role in training, practice, and establishing public policy for health and mental health concerns” (Society for a Science of Clinical Psychology, 2003). The Clinical Science Model shapes scientific research by emphasizing rigorous scientific methods to answer questions about the etiology, course, and treatment of psychopathology. It has been enormously influential in shaping the tenets of clinical psychological research, training, and funding (Academy of Psychological Clinical Science, 2022). Given its influence, and the readily apparent adverse mental health consequences of racism, one could reasonably expect that Clinical Science Model programs would be leaders in studying racism and promoting racial equity. However, as we will demonstrate, the Clinical Science Model lacks an active, explicitly antiracist approach to clinical psychological science grounded in concrete antiracist policies and training. Put simply, the Clinical Science Model cannot achieve its goals without an actively antiracist focus.

The field of clinical psychology must therefore engage in deep, undeniably uncomfortable reflection about how our institutions—however unwittingly—perpetuate and

benefit from systemic racism (Buchanan & Wiklund, 2020). Several scholars have recently outlined how the fields of clinical psychological science and psychiatry perpetuate epistemic exclusion of marginalized voices (e.g., Adams & Miller, 2021; Buchanan & Wiklund, 2020; Settles et al., 2020; Shim 2021). It is noteworthy that psychological science most broadly is steeped within an explicitly racist and white supremacist history (e.g., Bulhan, 1985; Guthrie, 2004; Harrell, 1999; Lavallée & Poole, 2010); the Clinical Science Model developed within this context. Further, scholars have outlined concrete steps that stakeholders within the field can take to actively combat systemic racism at multiple levels (e.g., Buchanan et al., 2021; Dutta, 2018; Galán et al. 2020; Neville et al., 2021; Reyes Cruz & Sonn, 2015). We refer to several of these readings throughout the current manuscript, drawing some examples and suggestions from them. We build on these previous contributions in our specific focus on the Clinical Science Model approach to research and training, to which specialized attention has not yet been paid.

To achieve racial equity in science, it is imperative that scientific disciplines not only rebuke racism, but also take an actively *antiracist* approach in all aspects of their work (Roberts & Rizzo, 2021; Rollins, 2021). Achieving racial equity requires identifying the specific needs of heterogeneous racialized communities and providing resources to meet those needs. This means that racialized populations are not only provided with the *same* resources as majority group members (*equality*), but also any other *necessary* resources to thrive. This requires the identification of unique systemic barriers to equal access, representation, and success among racialized persons; removing those barriers; and providing resources based on this *need (equity)*. While our thesis may also be applied to improving equity among other marginalized groups that do not identify with the prototypical non-Hispanic white, cisgender, male, heterosexual, non-disabled identities historically and contemporarily privileged in (clinical) psychological science,

our focus in this article is specifically on racialized populations. Re-defining clinical psychological science as an antiracist discipline through self-reflection, awareness, and action can position the Clinical Science Model as a scientific leader in the racial justice movement.

Authors' Positionality Statement

We acknowledge that our own backgrounds, identities, and experiences surely influence our perspectives on this topic. Each of us is a clinical psychological scientist, ranging from graduate students to senior career academics. We collectively have a range of intersecting identities based on race, ethnicity, sex assigned at birth, gender, disability status, lived experience, sexual orientation, first generation student status, nativity status, and others. Our shared interest stems from our collective affiliations and experiences with the Clinical Science Model in terms of our training, institutional affiliations, and associations within professional organizations. The idea for this manuscript derives from our involvement in Clinical Science-affiliated organizations, and specifically from recent discourse around systemic racism and other forms of inequalities within these professional spheres.

| Box 1: Glossary of Key Terms | |
|------------------------------|---|
| Anti-Blackness | <ul style="list-style-type: none"> (1) racism specifically directed toward Black people. (2) “Indexes the structural reality that in the larger society, blackness is inextricably tied to slaveness. While this doesn’t mean that Black people are actually still enslaved by white slave masters, it does mean that slavery marks the ontological position of Black people—that the relation between humanity and blackness is an antagonism, is irreconcilable. Anti-Blackness lays bare the problem with analogizing Black suffering to other forms of racialized suffering and argues that the differences are ontological rather than experiential.” (p. 2, Ross, 2020) |
| Antiracism | <ul style="list-style-type: none"> (1) stems from the worldview that “racial groups are equal and none needs developing” and emphasizes the importance of enacting |

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|----------------------|---|
| | <p>“policy that reduces racial inequity” (p. 24; Kendi, 2019).</p> <p>(2) the active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably (NAC International Perspective: Women and Global Solidarity)</p> <p>(3) Anti-racism is the practice of identifying, challenging, and changing the values, structures and behaviours that perpetuate systemic racism (Ontario Anti-Racism Secretariat).</p> |
| Color-evasive | <p>(1) a racial ideology that acknowledges that to avoid talking about race is a way to willfully ignore the experiences of People of Color, and makes the goal of erasure more fully discernible. In other words, to use the term ‘evade’ highlights an attempt to obliterate. (Annamma et al., 2017)</p> <p>(2) denial of racial differences by emphasizing sameness (Neville et al., 2013)</p> |
| Equity | the state, quality, or ideal of being just, impartial, and fair (The Annie E. Casey Foundation, 2020). |
| Institutional Racism | “sometimes used as a synonym for systemic or structural racism, as it captures the involvement of institutional systems and structures in race-based discrimination and oppression; it may also refer specifically to racism within a particular institution.” (Braveman et al., 2022) |
| Racial Equity | “process of eliminating racial disparities and improving outcomes for everyone. It is the intentional and continual practice of changing policies, practices, systems, and structures by prioritizing measurable change in the lives of people of color” (https://www.raceforward.org/about/what-is-racial-equity-key-concepts) |
| Racialized | <p>(1) socially viewed and treated as non-white</p> <p>(2) the act of being “raced” or seen as someone belonging to a particular race (Alberta Civil Liberties Research Centre (https://www.aclrc.com/racialization))</p> <p>(3) the very complex and contradictory process through which groups come to be designated as being part of a particular "race" and on that basis subjected to differential and/or unequal treatment. (https://www.aclrc.com/racialization)</p> <p>(4) the process of manufacturing and utilizing the notion of race in any capacity (Dalal, 2002, p. 27)</p> |
| Racism | a system in which one group of people exercises power over another on the basis of skin colour; an implicit or explicit set of beliefs, erroneous assumptions, and actions based on an ideology of the inherent superiority of one racial group over another, and evident in organizational or institutional structures and programs as well as in individual thought or |

| | |
|------------------------|---|
| | behaviour patterns (Henry & Tator, 2006, p. 352). |
| Systemic Racism | form of racism that is pervasively and deeply embedded in and throughout systems, laws, written or unwritten policies, entrenched practices, and established beliefs and attitudes that produce, condone, and perpetuate widespread unfair treatment of people of color. Reflects both ongoing and historical injustices. Emphasizes the involvement of whole systems, and often all systems—for example, political, legal, economic, health care, school, and criminal justice systems—including the structures that uphold the systems. (Braveman et al., 2022; Bonilla-Silva, 1997; Feagin & Ducey, 2018) |
| White <u>Privilege</u> | <ol style="list-style-type: none"> (1) the unquestioned and unearned set of advantages, entitlements, benefits and choices bestowed upon people solely because they are white. Generally white people who experience such privilege do so without being conscious of it (McIntosh, 1990) (2) white privileges are the unearned privileges that white individuals experience on a daily basis (often unconsciously) because they are not subjected to racism. These benefits are often “invisible” to white individuals because they feel like “a given,” like something that everyone experiences. (https://www.aclrc.com/white-privilege) |
| White Supremacy | <ol style="list-style-type: none"> (1) a historically based, institutionally perpetuated system of exploitation and oppression of continents, nations, and peoples of color by white peoples and nations of the European continent, for the purpose of maintaining and defending a system of wealth, power, and privilege (2) a form of racism centered upon the belief that white people are superior to people of other racial backgrounds and that whites should politically, economically, and socially dominate non-white persons. While often associated with violence perpetrated by the KKK and other white supremacist groups, it also describes a political ideology and systemic oppression that perpetuates and maintains the social, political, historical and/or industrial white domination. (https://www.nea.org/resource-library/white-supremacy-culture-resources) (3) a political, economic and cultural system in which whites overwhelmingly control power and material resources, conscious and unconscious ideas of white superiority and entitlement are widespread, and relations of white dominance and non-white subordination are daily reenacted across a broad array of institutions and social settings (Ansley, 1997) |
| Whiteness | a dominant cultural space with enormous political significance, with the purpose to keep others on the margin (p 21, Estable et al., 1997; Frankenberg, 1993) |

The Clinical Science Model and Antiracism

Historical Roots of the Clinical Science Model

For an elaborated historical account of the origins of the Clinical Science Model, see Bootzin (2007). In brief, the origins of the Clinical Science Model date back to the creation of the Society for a Science of Clinical Psychology. In 1966, the APA's Division of Clinical Psychology (Division 12) Executive Committee approved a new section, Section III, formally establishing *The Development of Clinical Psychology as an Experimental Behavioral Science*. In 1991, Section III members voted to formally change their name to the Society for a Science of Clinical Psychology, which is widely known in the field by its initials SSCP (Oltmanns & Krasner, 1993). How does Clinical Science differ from clinical psychology writ large, and where and why did the subfield splinter away from the larger discipline? Answers to these questions provide critical clues about the attention to antiracism in this subdiscipline's development.

The establishment of SSCP was initiated by APA members who viewed themselves as both clinical psychologists *and* behavioral scientists (Oltmanns & Krasner, 1993), initially requesting a new section that emphasized that the principles of psychological science should guide all manner of clinical work, teaching, research, and/or consulting. The Division 12 Executive Committee initially balked at this suggestion because the emphasis of science was baked into the scientist-practitioner model, which emerged from the Boulder Conference in 1947 (Committee on Training in Clinical Psychology, 1947). Although it is true the phrase "scientist-practitioner" exemplified the field of clinical psychology, the founders of SSCP were concerned that prevailing headwinds in the profession were cleaving the scientist from the practitioner;

indeed, there was a growing sense that scientific principles and findings played little role in guiding clinical practice. The founders of SSCP also shared concerns that the ascendance of professional schools and the PsyD degree would further weaken the research foundation of the profession.

During his SSCP Presidential Address at APA's 1990 Annual Convention, Richard McFall called for a plan of action and, in his seminal paper emanating from that address, outlined a future-oriented agenda for "building a science of clinical psychology" (McFall, 1991, p. 76). McFall's "Manifesto for a Science of Clinical Psychology" offered what he referred to as a simple agenda with one cardinal principle, "a scientific clinical psychology is the only legitimate and acceptable form of clinical psychology;" and two corollaries, "psychological services should not be administered to the public unless they have satisfied a set of criteria that involve scientific validation" and "the primary objective of doctoral training must be to produce the most competent clinical scientists possible." In the paper, McFall reviewed these ideas and then offered the term *clinical scientist* as a means of eliminating the dualist and hyphenated nature of the term scientist-practitioner.

The Manifesto galvanized considerable action within clinical psychology, especially in terms of training. Largely disillusioned and frustrated by the APA accreditation system, a number of faculty members in graduate programs that valued the newly developed Clinical Science Model banded together at a 1994 "Clinical Science in the 21st Century" meeting that McFall organized in Bloomington, Indiana. The meeting culminated in a vote to create the Academy of Psychological Clinical Science (APCS; Fowles, 2015). Unlike SSCP where the members are individual clinical scientists, the APCS's members are doctoral and internship programs in clinical psychology that share a clinical science training mission. The initial goal of

the APCS was to encourage and promote clinical science training among its member programs. As the APCS grew, so did the desire to move beyond APA's accreditation model (Baker et al., 2008). In 2007, the APCS became the parent organization to the Psychological Clinical Science Accreditation System (PCSAS; see Levenson, 2017), which has emerged as an independent accreditation system that now recognizes, at the time of this writing, 46 Clinical Science Ph.D. programs in the United States. Although the differences between the APA and PCSAS accreditation models are described in detail elsewhere (Levenson, 2017), we note here that the PCSAS places the emphasis of accreditation on training outcomes and the extent to which graduates have careers that emphasize the production of knowledge in the field and/or widespread dissemination of clinical science.

Clinical Science Philosophy and Racial Justice

Addressing racism or societal inequity has not been at the forefront of the Clinical Science Model. The Clinical Science Model—at least implicitly—has operated from an arguably color-evasive philosophy that remains antithetical to antiracism and social justice. For instance, in McFall's landmark Manifesto he asserted that an appropriately functioning scientific focus of clinical psychology would render the need for such special interest groups like APA Division 12's Section VI (Racial/Ethnic and Cultural Issues) unnecessary (p. 78; McFall, 1991). This explicit assertion is absent in subsequent descriptions of the Clinical Science Model (e.g., McFall et al., 2014). Nonetheless, the Clinical Science Model overwhelmingly propagates from this color-evasive (Annamma et al., 2017) perspective. For example, in a special issue of *Clinical Psychological Science* on "Reenvisioning Clinical Science", though one might hope to see forward-thinking leadership in regard to racial equity, there was no mention of racism, diversity, or any consideration of how topics remotely related to diversity, equity, inclusion, and/or (racial)

justice impact clinical science research and practice in any of the articles comprising that special issue (Atkins, 2014; Kazdin, 2014; Levenson, 2014; Onken et al., 2014; Shoham et al., 2014; Weisz et al., 2014). As it currently stands, the Clinical Science Model perpetuates (un)spoken norms that complex psychological experiences can be understood through assumedly objective scientific approaches that eventually distill “truth”.

More specifically, psychological science operates from a positivist/post-positivist philosophy of science (Eagly & Riger, 2014), and clinical psychological science is no different (Hughes, 2018). Positivist philosophy assumes that a single, discoverable “truth” exists and well-designed scientific research is poised to objectively unearth that “truth”. Post-positivist philosophy introduces the idea that the scientific endeavor itself impacts the search for that truth, where “truth” can only ever be imperfectly understood. This stands in contrast to contemporary constructivist philosophy of science, which argues against the idea of a mind-independent reality or absolute “truth,” instead suggesting reality is malleable, socially constructed, and pluralistic (Hughes, 2018).

The reduction of complex phenomena to elemental units exemplifies the analytic-reductionist colonial bias (Bulhan, 1985) that still plagues psychology to date. When one asserts that an appropriately rigorous science negates the need for special interest groups, one fails to contend with the fact that the “business as usual” of clinical psychological science ignores history and social contexts, reifies racism and inequity, and results in the continued epistemic exclusion of researchers and research bases devoted to the experiences of racialized—and other minoritized—populations. That is, through its focus on the advancement of rigorous science as a cardinal virtue above all others and its positivist/post-positivist guiding philosophy, the Clinical Science Model sets itself up to be color-evasive in regard to racial equity at every stage, from the

conceptualization of the research enterprise, to the formulation of research questions and methods, to the interpretation of results. It is therefore possible for clinical psychological science to propagate racism and structural inequity. We argue that the Clinical Science Model has done exactly that.

Color Evasion in the Clinical Science Model

Throughout the history of the Clinical Science Model, little explicit attention has been given to minimizing racial and ethnic inequities in psychopathology and treatment outcomes; developing and testing culturally responsive treatments; or exploring the impact of systemic racism on psychopathology, the training pipeline, or the institutions that shape clinical science research and mental health care. On one hand, it is odd and perhaps even stilted to criticize a discipline-wide movement for not doing something it did not, on its surface, set out to do in the first place. In this respect, the Clinical Science Model has been relatively agnostic about the best means of studying or promoting racial justice. The same can be said of many other critical topic areas in the field—none of the seminal works or professional societies associated with the Clinical Science Model dictates *how* clinical scientists should study psychological treatments. Instead, the Clinical Science Model provides an epistemological umbrella under which knowledge could grow and develop.

On the other hand, might there be some aspects of the Clinical Science Model that have hindered its focus on racial justice? After all, clinical psychology's closest disciplinary neighbor, counseling psychology, has developed as a field with a deep commitment to antiracism and social justice in its endeavor to reduce mental health-related suffering. These topics, often organized as part of the multicultural counseling and psychotherapy movement (American

Psychological Association, n.d.; Lau et al., 2008), are as central to counseling psychology as empiricism is to the Clinical Science Model. And perhaps this is a part of the problem. One of the earliest activities aligned with the Clinical Science Model, the quest for empirically supported treatments (Chambless et al., 1996; Chambless & Hollon, 1998), over-valued the hypothetico-deductive (see Fiedler, 2018) method and positivist/post-positivist understanding (Settles et al., 2020) in which “objectivity” is valued to the exclusion of context, positionality, and many other scientific and valid ways of learning about the world (Elliott, 1998).

Additionally, this approach aligns with the white supremacist propagation of psychological science, which assumes truths can be obtained from exclusively studying white samples and populations; must simply be *extended* to racialized groups, rather than developed with key considerations of the experiences of racialized groups from the ground up; and differences reflect deviations from the [white] norm.

The problem, however, is that the work of the early empirically-supported treatment (EST) movement prized a certain kind of empiricism: the experiment demonstrating causal efficacy under controlled research conditions. Additionally, the positivist/post-positivist outlook on science assumes a singular universal “truth” that can be understood in relation to mental health, and that this highly controlled scientific approach is poised to unearth that truth which can be adequately generalized to the [white] human condition. Much of the work in the multicultural counseling and psychotherapy movement, however, does not emerge from this tradition and is often idiographic and qualitative, including social contextualization within its standard operations. Indeed, in describing the Clinical Science approach, McFall and colleagues (2015) state “that empirical evidence from controlled research must be the gold standard for evaluating all claims about the value and relevance of any particular factor” (p. 8), and advocate

that failing to do so will stymie “progress toward ‘truth’” (p. 8). In general, “control” in psychological research often equates to decontextualization, which ignores social and structural determinants of health (e.g., racism) in favor of situating dysfunction and intervention at the level of the individual. Further, the Clinical Science Model fails to consider the context in which research aligned with the model has developed, how sociocontextual factors impact which research is deemed “objective” and “rigorous”, and how such factors further impact *who* is present at the scientific table.

The Clinical Science Model’s overreliance on decontextualization as an assumption of universality exemplifies the trait-comparison colonial bias (Bulhan, 1985); clinical psychological research remains decontextualized in ways that advantage specific groups (i.e., white populations for our purpose) to the detriment of others (i.e., racialized populations). We are just now beginning to see tides of change coming to clinical science. For example, the National Institutes of Health (NIH) Science of Behavior Change movement (Nielsen et al., 2018; Onken et al., 2014) has made a very clear case that successful intervention development work is often based on case or qualitative studies and community-based participatory research methods, none of which relies exclusively on positivist/post-positivist philosophy and methods. Scholars who operate within an intersectional and racialized lens are more likely to approach science from a constructivist philosophy, assuming multiple realities that depend on sociocultural context (Settles et al., 2020).

The Clinical Science Model’s failure to adopt an antiracist research agenda is multi-determined, and our analysis focusing mainly on the EST movement here is an incomplete explanation of the problem. We propose that the Clinical Science Model’s allegiance to the positivist/post-positivist philosophy and associated methods serves as a bottleneck to advancing

the topics related to social and structural determinants of mental health, including social justice issues and the study of health disparities. Settles and colleagues (2020) explain how the adoption of intersectionality and other constructivist epistemologies challenges and changes psychological science's norms and assumptions, and how these approaches are used often for the specific purpose of social justice and antiracism. They also outline (p. 804; Settles et al., 2020) how the underlying positivist/post-positivist outlook propagates the epistemic exclusion of constructivist epistemologies, which can be applied to the Clinical Science Model. Indeed, adopting an intersectional framework aids understanding how the color-evasive philosophy of the Clinical Science Model fosters systemic racism within the very sub-discipline.

Summary: The Clinical Science Model and Antiracism

The Clinical Science Model reflects a positivistic/post-positivistic philosophical position, which generally ignores race/ethnicity, overlooks systemic and contextual factors, and centers pathology squarely within the individual. A philosophical orientation that begins from the ingrained assumption that pathology exists in the person rather than the environment will not be well-equipped to characterize or consider the role of systemic factors—of which issues of race and racism are central considerations—and remains inadequately supported. Further, failure to contend with and comprehend the impact of contextual factors in research stems from a similar philosophical outlook (i.e., one that fails to appreciate context within the structures that contribute to one's philosophy).

In the next section, we review the scope of inequity within the scientific enterprise itself for racialized scientists and populations. We then illustrate how the status quo of the Clinical Science Model—using PCSAS for our illustration—upholds systemic racism within the field.

Systemic Racism in Clinical Psychological Science

Systemic racism pervades the various institutions that are integral to clinical psychological science (e.g., universities, funding agencies, health care systems; Cénat, 2020; Ginther et al., 2011; McGee, 2020). We highlight below some of the myriad ways in which racialized individuals and their scientific contributions are marginalized at multiple levels within the scientific process. Racialized researchers face several obstacles that arguably stem from—or are at least influenced by—the lack of emphasis on antiracism within the scientific process. It is noteworthy that some of the literature cited in this section is not specific to the Clinical Science Model, or even psychology broadly. We make connections between this more general literature and the participation of racialized scientists in the clinical scientific endeavor.

Institutional Challenges Faced by Racialized Researchers

Institutional Representation

Faculty. Despite comprising 23.5% of the US population (United States Census Bureau, n.d.), racialized individuals represent only 11.2% of faculty in research-intensive clinical psychology programs (White et al., 2020). In 2018, non-Hispanic white psychologists comprised 81.5% of all faculty in APA-accredited Clinical Psychology programs while Black psychologists comprised 4.2% of all faculty (American Psychological Association, 2019). Taken together, these statistics indicate that every demographic group, *with the exception of non-Hispanic white men*, are poorly represented among clinical psychology faculty (Gruber et al., 2021). While faculty representation is only a single factor, diverse faculty within the academy, clinical psychology programs, as well as within the Clinical Science domain would not only be an issue of justice. Increasing representation could also contribute to the wellbeing of trainees and

provide additional power and instantiation of diverse methodological approaches—assuming this also includes scientists who operate from the margins rather than the center.

Graduate students. Data from the APA on the demographic makeup of doctoral programs in clinical psychology programs in 2020 and 2021 demonstrated that 59% of students were non-Hispanic white students in both years, while only 8% of students were Black/African American students (*Graduate Demographics Data Tool*, n.d.). Previous literature on admissions trends from 1995 – 2015 suggest more racialized students are accepted into counseling than clinical psychology programs (37% vs. 22%; Norcross et al., 2020). Black, Hispanic, and Native Hawaiian/Pacific Islander students experience lower admittance to APA-accredited graduate psychology programs and substantially higher rates of attrition when they are admitted to these programs; the representation within psychology among Black and Hispanic persons reflects under-representation relative to the U.S. population at large (Callahan et al., 2018). Unlike clinical and counseling psychology doctoral programs, however, Black students comprise 35.8% of the student population among social work doctoral programs (Council on Social Work Education, 2020).

Funding and Support

Racialized scientists also receive less financial support than their non-Hispanic white counterparts. Black scientists receive grant awards at lower rates than their non-Hispanic white peers (Ginther et al., 2011, 2016). A recent analysis of NIH funding statistics suggests this discrepancy is mostly attributable to decisions made by grant reviewers (Hoppe et al., 2019). Grant proposals from Black scientists are discussed at significantly lower rates than those from non-Hispanic white scientists, receive lower impact scores from reviewers, and are funded at

lower rates. Examination of the thematic content of NIH grant award proposals further demonstrates that grant reviewers prefer certain topics related to basic mechanistic processes and disfavor topics often proposed by Black scientists, including disease prevention, intervention, and disparity research (Hoppe et al., 2019)—topics more likely to be aligned with racial justice. In addition, Black scientists are also more likely to be hired at institutions with the lowest record of NIH institutional funding, representing an additional barrier to receiving subsequent funding. Black scientists at these institutions would likely have less access to senior colleagues and mentors with experience with the grant award process and histories of grant funding, and substantially fewer resources to remain competitive with short turnaround times for grant submission. This is especially important at earlier career stages, as the more grant awards one receives, the more likely one is to receive subsequent grant awards (Bol et al., 2018; Merton, 1968).

Workload and Service Burden

An extension of the disparity in representation and funding support, and perhaps a direct result of these factors, is the disproportionate service burden placed on racialized faculty (Edwards & Ross, 2018; Kelly et al., 2017). Black faculty are more likely to serve on department and institutional committees related to minority issues (Allen et al., 2000), and faculty of color are more involved in undergraduate teaching and mentoring than their non-Hispanic white colleagues (Umbach, 2006). Service responsibilities may function as a way for racialized faculty to promote social justice in the academy (Baez, 2000). Black professors may feel a sense of obligation to take on more mentoring due to historical racial inequities in the academic space (Reddick, 2011). Domingo and colleagues (2020) found women of color faculty in STEM reported inequitable service demands without reward, devaluing of service demands, and lack of

clarity about the promotion process as key institutional barriers, and that gendered racism amplified the impact of these barriers (Domingo et al., 2020). Indeed, Padilla (1994) wrote about the “cultural taxation” that comes along with being a racial/ethnic minority scholar in academic spaces that involves increased service work often not formally recognized. Transparency in tenure and promotion guidelines as well as teaching and service workloads across departments can help alleviate these concerns for racialized faculty (Liu et al., 2019).

Taken together, racialized scientists are less well-represented within the field, and racialized students are accepted and graduate at lower rates. Racialized scientists receive less support than their non-Hispanic white colleagues; racialized scientific interests are denigrated with reduced funding from awarding bodies; and racialized scientists are burdened with more under-acknowledged service than their non-Hispanic white counterparts.

Challenges Related to Publication that Impact Racialized Researchers

Journal Prestige and Impact

Research on racialized participants and populations is severely underrepresented within the psychology literature base. Only 5% of empirical articles in other psychological disciplines (e.g., cognitive, social, and developmental psychology) highlight race/ethnicity (Roberts et al., 2020), and clinical psychology research is no different. Content analyses of the most prestigious journals within clinical psychology repeatedly show a concerning dearth of empirical research specific to racialized populations. A recent review of publication metrics in the *Journal of Clinical Psychology* demonstrated that only 4.3% of articles ($n = 66$ of $N = 1,520$) focused on racialized populations (Perez Aquino, 2019). When specifically considering focus on Black populations, the statistic becomes reduced further to a mere 1.1% of articles published over an

18-year period (1990 - 2017). Other studies examining publication trends of cross-cultural and ethnic diversity research within psychology (e.g., Adams & Miller, 2021; Hartmann et al., 2013; Nagendra et al., 2020) show little change in the diversification of psychological science.

Clinical Psychological Science and Race-Related Research. In preparation for this article, we systematically reviewed articles published in *Clinical Psychological Science* to determine the percentage of articles that substantively address race/ethnicity considerations. Articles were considered to substantively address race/ethnicity if either (a) the research topic was substantively focused on race, ethnicity, or racism, and/or squarely focused on a minoritized racial/ethnic group(s), or (b) 50% or more of participants were from minoritized racial/ethnic groups and the article provided a clear rationale or discussion concerning race or ethnicity considerations. Decisions were made by reviewing abstracts and, if unclear from the abstract, reviewing the full text. To maximize reliability, more than 25% of articles were double-coded; discrepancies and “maybe” decisions were resolved among the six reviewers. Among double-coded articles, reviewers initially agreed 93.6% of the time. Among articles with discrepant coding, all had one “maybe” vote (none were yes vs. no disagreements) and all were resolved through discussion among reviewers.

Of the 543 regular articles (excluding editorials, commentaries, corrigenda, etc.) screened from the first issue (2013) through the end of 2020, only 23 (4.2%) were identified as substantively addressing race/ethnicity based on our criteria. Three of these articles were from a special section on “Diversity Science.” Fourteen (60.9%) were situated in the United States: five focused on Black/African Americans, two on Asian Americans, two on Hispanic Americans, one on American Indian/Alaska Native Peoples, and four on multiple racial/ethnic groups. Among the nine articles from outside of the U.S., six focused on trauma among refugee populations. We

note that although the 23 articles frequently focused on mental health inequities, racial/ethnic differences, and cultural factors, only four of these articles mentioned racism explicitly.

Although we do not expect or recommend for all articles about racialized populations to be framed in terms of racism, one could reasonably infer that the near absence of such in *Clinical Psychological Science* has reflected a color-evasive lens within the Clinical Science Model.

Reasons for Epistemic Exclusion of Racialized Research in Prestigious Publication Outlets

Iwasama and Smith (1996) outline several contributing factors to the publication disparities highlighted above. Analogous to the finding that grant award reviewers show bias against topics commonly proposed by Black and other racialized scientists, journals specifically focused on minoritized groups are often perceived as more receptive to topics that involve racialized populations. However, despite following the same scientific procedures as more “mainstream” journals, scholarship within such outlets is often denigrated and viewed as less rigorous or more “niche” (Settles et al., 2020). In addition, the scientific aversion to publication of studies with specific reference to Black and racialized populations places racialized scientists, who are more likely to study these topic areas, at a disadvantage. For example, scientific impact is used in the decision-making process for grant awards as well as institutional advancement. Racialized scholars’ research would be deemed less impactful by virtue of their publications in specialty journals. Their publications would receive fewer citations and therefore demonstrate lower impact on the scientific field.

Taken together, this finding suggests that at least one, and likely most, prestigious journals do not incorporate an antiracist focus, instead adopting an approach that ignores racism and continues to perpetuate white supremacy within their actions. Indeed, as Adams and Miller (2021) point out, only 7.25% of board members across the most prestigious clinical psychology

journals possess a primary or secondary focus on health disparities of minoritized populations. Further, in the face of racially homogenous editorial boards, racialized scholars are more likely to believe their work will not be valued at or published in those journals, and subsequently would refrain from submitting to such (Auelua-Toomey & Roberts, 2022).

Indeed, a recent debacle at the journal *Perspectives on Psychological Science* illustrates the racism and gatekeeping that scholars whose foci are antiracism and racialized populations. It is a prime example of the hostility that scholars face when publishing scholarship on antiracism. In that case, the editor solicited critiques from four senior, white men on one article related to inequities in psychological research (Roberts et al., 2020). The events are outlined, at this time, in a preprint from Roberts (2022). In brief, the editor decided to publish peer reviews of Robert et al.'s 2020 manuscript as formal commentaries without sending them for peer review. Additionally, Roberts' own response to these commentaries was subjected to review and the publication appeared contingent upon the approval of one of the main commentators. Though the editor, Klaus Fiedler, was pressured to resign from the position by the Association for Psychological Science (*APS Board of Directors Accepts Resignation of Perspectives on Psychological Science Editor-in-Chief*, n.d.; *APS Statement in Response to Concerns About Editorial Practices at Perspectives on Psychological Science*, n.d.), it is unclear if this would have been the outcome without the public disapproval that occurred once Roberts made his preprint public. One can reasonably speculate that similar experiences frequently occur but are never made public. Indeed, we are confident based on our own experiences and conversations with other racialized scholars that such experiences continue to occur, and far too often. In fact, we received a particularly racist review of an earlier version of this manuscript that was rejected

for publication in this journal—a decision that was reversed upon our appeal and after the racist review was removed.

It is noteworthy how the descriptors used to denigrate research on racialized populations (e.g., “not rigorous”) correspond with the specific focus of the Clinical Science Model (i.e., the gold-standard for research incorporates control and rigor). We do not suggest the Clinical Science Model is completely to blame for continued devaluation of scholarship on racialized populations, but we do suggest the Clinical Science Model must contend with its decontextualized approach to clinical science and consequent contributions to systemic racism and how the wider psychological scientific structures on which it depends embrace such racism.

Challenges to Alleviating Racialized Suffering and Psychopathology

One superordinate goal of our field is the reduction of suffering among humans. We have reviewed how racialized scientists and their research contributions are actively excluded within the scientific domain. In addition, it is important to consider how such epistemic exclusion impacts our field’s ability to effectively reduce suffering *for all persons and populations*.

Because racially and ethnically minoritized people remain underrepresented in randomized clinical trials, for example, it is difficult to determine the efficacy of various treatments for racialized individuals and populations (Santiago & Miranda, 2014). For example, in a recent analysis of research related to schizophrenia in four major journals, only 59% reported race or ethnicity in the participant characteristics (Nagendra et al., 2020). Moreover, only 9% of studies analyzed racial or ethnic identity as the primary topic. This is especially problematic given the evidence of racial bias in the diagnosis of schizophrenia (Gara et al., 2012) and racial disparities in the prevalence of psychotic disorders (Bresnahan et al., 2007; Schwartz

& Blankenship, 2014). In essence, despite known disparities and bias in one mental health domain—psychotic disorders—as a function of race/ethnicity, clinical psychological research has still remained resistant to incorporating race/ethnicity within this remit.

Black and Hispanic Americans are also significantly less likely to receive mental health services compared to non-Hispanic white Americans (Alegría et al., 2002; Cook et al., 2007; Jimenez et al., 2013). When they do receive services, they often have worse treatment outcomes compared to their non-Hispanic white counterparts (Eack & Newhill, 2012). Although there is some evidence suggesting many empirically supported treatments work for racially and ethnically minoritized people (Miranda et al., 2005), racialized individuals continue to have negative experiences in mental health treatment or do not seek services due to cultural insensitivity, lack of providers who look like them, and stigma (Kawaii-Bogue et al., 2017). This has led to efforts for cultural adaptations that address patient preferences and increase flexibility to improve efficacy for racialized populations (Alegría et al., 2016). Indeed, when culturally responsive interventions are developed and utilized, they demonstrate efficacy within racialized populations (e.g., Watson-Singleton et al., 2019). Analogously, intervention development for sexual minority populations that explicitly contend with minority stress processes—like stigma rooted in heteronormativity (i.e., important contextual and structural determinants of sexual minority health at the population level)—show efficacy for these populations (e.g., Pachankis et al., 2015, 2019), further justifying the importance of culturally responsive approaches to the research and alleviation of suffering across historically excluded populations like racial/ethnic minorities.

Summary: Systemic Racism in Clinical Psychological Science

Racialized scientists and research related to the experiences of racialized populations are overlooked as niche or derivative. Racialized scientists remain simultaneously undersupported and overburdened. Racialized scientists are accepted into clinical psychology programs at lower rates and receive less funding once working in the field. Racialized scientists' research outputs are often relegated to outlets the field deems lower tier, despite their research being no less rigorous than other work published in "prestigious" outlets. Racialized scientists are employed at less well-funded institutions and remain underrepresented among faculty across institutions. The use of any of these metrics in decisions about scientific rigor, then, disadvantages racialized scholars and research devoted to understanding racialized individuals' mental health needs. Because clinical science persists overwhelmingly of, by, and for non-Hispanic white consumers, contributors, and gatekeepers, it is unsurprising that the net effect is the disproportionate impediment to clinical science conducted by, for, and about racialized populations: *systemic racism*.

How the Clinical Science Model Upholds Racial Injustice

Up to this point, we have discussed the color-evasive underpinnings of the Clinical Science Model. In addition, we have briefly reviewed some of the disparities that face racialized scholars as well as the scholarship devoted to understanding and alleviating mental health challenges facing racialized populations. In this section, we return to the Clinical Science Model. Using the PCSAS, we illustrate *how* the status quo of the Clinical Science Model propagates racism. We chose PCSAS for pedagogical reasons, as it is a concrete reflection of the value system of the Clinical Science Model. For this reason, it can provide important illustration of how the business as usual of the Clinical Science Model operates from a color-evasive

standpoint, thereby reifying inequities within the field. Our discussion is based on analysis of public-facing information largely from the PCSAS website.¹

The PCSAS Accreditation Standards are designed to ensure high-quality scientific training at the doctoral level. The standards are written to ensure both flexibility and rigor in the training of psychological clinical scientists. The PCSAS Accreditation Standards address diversity in two major ways:

1. flexibility of training approaches and importance of holding diversity as a value within the training system [General Accreditation Standards 1 and 6], and

2. as one example of an indicator that might be used for the accreditation process [Exemplars of Evaluation Criteria 6: Curriculum and Related Program Responsibilities].

We discuss each of these standards in turn.

1. Diversity as a Value in the Training System

In Accreditation Standard 1, the term “diversity” is used in an abstract sense. Standard 1 expresses the PCSAS belief that a *diversity of approaches* to training are both welcomed and expected. Indeed, the Clinical Science Model does not explicitly prescribe *how* clinical science should go about propagating, but decisions must be based on the best available evidence (p. 7; McFall et al., 2015). Additionally, the Clinical Science Model welcomes diversity of approaches—“the CS model does not rule out consideration of any factors a priori” (p. 8; McFall et al., 2015)—but specifies that evidence from controlled research must be the deciding factor. On its surface, this welcoming of diversity in scientific approaches is a notable strength of the PCSAS, and Clinical Science Model, approach to training. As several scholars have stated (e.g.,

Buchan & Wklund, 2020; Settles et al., 2020), psychology as a discipline is in desperate need of diversity in its approaches to the science and doing so both evens the playing field for scholars who operate from the margins through their use of methods and approaches that do not always conform with the strict, decontextualized approaches of the mainstream.

However, while the value of diversity in approaches might be espoused, if the day-to-day actions and the metrics of success that institutions—like the Clinical Science Model, the APCS, and/or PCSAS—identify are prejudicial, then the resulting system reifies racism. Instead of actually fostering diversity of scientific approaches, reliance on metrics that disfavor racialized scholars as well as those who operate from the scientific margins results in homogenization of specific types of and approaches to clinical science research and practice, those approaches being from the mainstream.

2. Diversity in the Accreditation Process

Standard 6 of the PCSAS Evaluation Criteria specifically mentions the PCSAS value system of attending to diversity in terms of marginalized populations. Standard 6 holds that the PCSAS expects “that programs hold diversity, equality, and inclusion as essential values,” explicitly stating that programs must attend to myriad dimensions of human diversity. Race and ethnicity are included within the subsequent list of diversity-related constructs. When it comes to Evaluation Criteria—which represent “the types of information considered by the Review Committee in its evaluation of a program’s performance”—Exemplar Evaluation Criterion 6 states that the PCSAS will adjudicate programs based on the extent to which their training demonstrates sensitivity to contextual factors in both research and clinical training (Psychological Clinical Science Accreditation System, 2011).

The fact that the PCSAS explicitly addresses the importance of diversity, equity, and inclusion and contextually sensitive training in clinical psychology training programs is noteworthy. However, it remains unclear how the PCSAS contends with this information in the accreditation process. The PCSAS operates from a desire to provide training institutions with the utmost flexibility in fulfilling their training mandates in Clinical Science. As such, the PCSAS does not mandate specific training requirements in its accreditation process, unlike that of the APA where specific mandates can be burdensome and perceived as unhelpful to meet training goals. By doing so, programs would offer flexibility aligned with McFall and colleagues' description of the values of the Clinical Science Model: "... [the CS Model] offers flexibility, encouraging individual programs to experiment, to develop the best educational program[s] possible ..." (p. 7; McFall et al., 2015). However, unchartered flexibility reifies inequities when a color-evasive philosophy dominates practice, as is the case within Clinical Science philosophy.

The PCSAS's website explicitly states that the accreditation process places "the greatest weight on each program's record of success." However, many of the specific metrics on which the PCSAS appears to place the most weight disadvantage programs that would attract and support racialized scholars and/or engage in clinical research devoted to cross-cultural diversity, the experiences of racialized groups, and antiracism explicitly. We highlight some examples below.

The PCSAS evaluation process examines how program selection procedures ensure the highest quality of students using such metrics as undergraduate GPA, GRE scores, previous research experience, and publication metrics (Exemplars of Evaluation Criteria: Criterion 2(a)(ix)(1)). What is absent, however, is how the PCSAS contends with the well-documented history of racism in each of these metrics (e.g. Callahan et al., 2018) alongside the lack of

empirical evidence supporting their use. We have reviewed some of these issues above in this manuscript. One illustrative example is that Graduate Record Examinations (GRE) scores are lower among Black, Latino, and Native American applicants compared with white and Asian applicants and using the GRE poorly aligns with empirical evidence regarding graduate school success (The National Center for Fair and Open Testing, 2007). The GRE fails to predict dropout from graduate programs, even at the polar extremes of scores (Miller et al., 2019; Becker, 2019). Specific to the GRE, the lack of rigorous evidence supporting its use in the graduate admissions process in addition to evidence that the metric specifically unfairly disfavors racialized persons is antithetical to even the Clinical Science Model's purported philosophy.

Yet, according to the PCSAS's standards, the GRE of students admitted to PCSAS-accredited programs provides information about their caliber as scientists, for which no evidence exists. McFall and colleagues (2015) explicitly assert that factors without research evidence should not be considered when making clinical decisions (p. 8). We would argue that such a standard applies for decisions about graduate admissions and evaluating programmatic rigor. When it comes to the GRE, we are unaware of much evidence supporting its use other than as an incremental predictor of graduate GPA (Michel et al., 2019). Furthermore, it is a metric that disadvantages racialized populations (Bleske-Rechek & Browne, 2014) and seems hypocritical to use in Clinical Science-aligned programs. The metrics deemed evidence of scholarly rigor within the PCSAS accreditation system are at odds with the Clinical Science philosophy.

At the faculty level, the PCSAS merits quality and impact of publications, research grant support, and peer recognition, influence, and awards [Exemplars of Evaluation Criteria: Criterion 2(e)(ii), (iii), (iv), (v)]. Finally, the PCSAS admittedly places greatest favor on the extent to which programs produce "graduates who have gone on to lead productive careers, and make

high-quality contributions.” By adopting a color-evasive philosophy, the Clinical Science Model allows itself ignorance by failing to acknowledge the myriad systemic factors that stymie science from, by, and for racialized populations. Racialized faculty are, on average, employed at institutions with lower history of external grant support and more commonly study topics related to minority mental health. As a result, they receive fewer grant awards and are less well-funded. Similarly, because racialized scientists often research topics related to socially contextualized processes within the mental health domain, their publications are relegated to outlets with lower notoriety and would demonstrate lower “impact” within the field when compared with their non-Hispanic white counterparts. Thus, by favoring such metrics of success, the Clinical Science Model ignores the context of racism within the clinical psychological field. It erroneously attributes productivity and “high-quality” with scientific rigor and status. However, these proxies privilege mainstream scientific productions, and marginalize those often produced from racialized scholars and devoted to racialized populations. If the quality of one’s scientific contributions rests upon metrics that consistently disadvantage racialized students, applicants, and researchers, as well as cross-cultural and racial/ethnic minority-centered research, then these standards propagate systemic racism.

The reliance on metrics that historically exclude and disadvantage racialized participation further burdens clinical scientists and programs who enact explicitly antiracist science. For instance, based on the literature we have reviewed and an examination of the PCSAS standards, it would seem fair to assume that a program with relative focus on the mental health of Black individuals would likely be one that (1) receives lower levels of grant funding, (2) publishes studies frequently relegated to “specialty” journals with concomitant lower impact regardless of scientific rigor, and (3) produces graduates who are victims to such a cycle. Currently, it is

unclear how the PCSAS contends with these racialized metrics in adjudicating the rigor of clinical science outputs. One relatively simple suggestion would be prioritizing not just the prestige of the outlets in which graduates and graduate students publish, but also shifting to explicitly prioritizing the production of knowledge that incorporates intersectional approaches and socially contextualized science, as well as leads to measurable changes in communities of greatest need.

Summary: How the Clinical Science Model Upholds Racial Injustice

The PCSAS accreditation standards are aspirational in their commitment to diversity in clinical science. However, the standards fail to actionably illustrate how this might be achieved. Thus, one can safely assume the PCSAS Standards assume an even playing field for racialized students and researchers. They represent a commitment to inclusivity that, at least at this time, remains divorced from the contextualized realities of the actions used in the Clinical Science Model business as usual. Additionally, the standards are compromised by reliance on metrics that actively contradict fundamentals of the Clinical Science Model (e.g., overreliance on the GRE in spite of research evidence not supporting such). What is needed now, we argue, is an earnest recognition and acceptance of how the Clinical Science Model inadvertently upholds systemic racism and white supremacy, followed by an actionable shift to antiracist commitment. In the final section of this manuscript, we begin to envision what an antiracist Clinical Science Model might look like.

The Future of Clinical Science: Moving Toward Antiracism

What would an antiracist clinical science look like? We end this manuscript with a brief discussion of some of the changes that must be made to embed antiracism within the Clinical

Science Model going forward. These recommendations are not exhaustive or necessarily novel, though we aim to situate such in the context of the Clinical Science Model specifically. Our goal is that this article sparks necessarily uncomfortable discussions that lead to actionable change from stakeholders within the Clinical Science Model approach to clinical psychological science.

Reactive: Alleviating Existing Disparities

Recruitment, retention, and promotion of individuals from diverse racial/ethnic groups, at minimum, must be reflective of the wider society. Such parity will not organically result from accepting more racialized students into the profession. It must also involve providing the necessary support and resources based on *equity* to sustain continued participation and success among racialized scientists within the field. Gatekeepers at funding agencies must ensure parity in resource allocation. Prestige of research products should be judged based on true scientific rigor that encompass epistemologically-diverse methods and societal impact, rather than current proxies like journal notoriety and impact factors. Simultaneously, gatekeepers within academic publishing (e.g., journal editors-in-chief) must be diversified, place value on antiracist approaches within scientific products (e.g., explicit justification of racial/ethnic diversity of samples as can be found recently at *Clinical Psychological Science*; Association for Psychological Science, 2020), and include diverse scientists with expertise in epistemologically-diverse methods within their editorial boards and at the decision-making levels within academia.

Within a truly antiracist clinical science, transparency and accountability would become standard in tenure and promotions considerations. Priority would be given to ensuring empirically supported treatments demonstrate appropriate efficacy across racial/ethnic groups, not solely by testing them *on* diverse populations, but from the embracing of constructivist philosophies to build them *for* diverse populations. Clinical science would more thoroughly

incorporate diverse methodologies—like community based participatory, qualitative research designs—and explicitly value an understanding of the role of systemic factors such as racism in contributing to mental health challenges. For instance, incorporation of intersectionality and other constructivist theories would become the norm within mainstream clinical science to adequately situate findings within structures of power and privilege. Two notable publications we cite throughout this manuscript outline how the epistemic exclusion, and dilution, of intersectionality theory tenets within mainstream psychological science upholds systemic racism within the field (Buchanan & Wiklund, 2020; Settles et al., 2020); these provide needed understanding for gatekeepers at various levels within clinical psychological science.

Additionally, two recent publications outline several concrete steps that can be taken for moving toward antiracism (Buchanan et al., 2021; Galán et al., 2020). Buchanan et al. (2021) describe several ways in which racism and white supremacy propagate within psychological science. They recommend concrete steps for increasing antiracism in the conducting, reporting, reviewing, and dissemination of psychological science. For example, they encourage diversification of samples, from inclusion of the full spectrum of racialized participants (e.g., not only racial/ethnic minority participants from lower socioeconomic backgrounds) to promoting diverse scientific approaches (e.g., centering patterns of structural oppression and inequity in backgrounds and discussions of scientific manuscripts, and their implications for equality and social justice). Galán and colleagues (2020) outline concrete steps that can be taken to promote an antiracist clinical science. In Section V of their manuscript, the authors outline several steps related to recruitment, retention, and success of scientists that would be necessary for achieving an envisioned antiracist clinical science. Among recommendations for graduate admissions, they suggest removal of barriers that disfavor participation of racialized persons (e.g., GRE entry

requirements) and modification of the use of other biased metrics, like recommendation letters and past publications, that disproportionately affect racialized applicants.

Proactive: Thinking Ahead with Antiracism

Actions to reduce existing inequities are invaluable. However, those inequities stem from an underlying philosophy that upholds systemic racism. So, while several articles have highlighted steps that can be taken to reduce existing disparities, we also think it is important to consider how current actions—taken from a color-evasive philosophical approach—foster racism, however unwittingly. For instance, the APCS’s creation of the PCSAS stemmed from disillusion with the APA accreditation system. One of the criticisms routinely expressed involves the difficulties of meeting specific course-load demands. By increasing flexibility in the accreditation process, the PCSAS empowers Clinical Science Model programs to tailor their training to increase scientific rigor. By freeing programs of the bean-counting often associated with APA accreditation, the PCSAS reduces student and faculty burden; PCSAS programs can offer courses that will strengthen the rigor of their students’ scientific training.

However, if the scientific philosophy of the Clinical Science Model is one of color-evasion and if the metrics of the PCSAS merit a specific *kind* of research (i.e., that which gets published in high-impact outlets and is most conducive to grant funding, both of which currently advantage decontextualized research), then a reasonable question to ask is how realistic would it be to expect PCSAS-accredited programs to voluntarily commit to antiracist training? Since its inception—exemplified in McFall’s statements within the Manifesto—the Clinical Science Model has ignored racism, perhaps assuming that ignoring it will resolve it, or worse, that racism is irrelevant to our understanding of mental health. Despite strong claims that rigorous science would negate the necessity for special interest groups, the Clinical Science Model’s views of

rigor have overwhelmingly excluded and devalued scholarship that would emanate from/be supported by such groups. Clinical Science Model proponents—like members of SSCP, the Academy, and PCSAS—must enact future-oriented thinking about how practices today propagate racism tomorrow. Without an antiracist approach, the Clinical Science Model is incapable of recognizing how its color-evasive philosophy stymies its own progress to understanding clinical truth(s) and is antithetical to its mission.

The PCSAS must develop flexible guidelines that center the importance of antiracism within training programs and instantiate program reviews that clearly focus on evaluating programs' commitments to such. As they stand, such guidelines are vague and not actionable. While special interest groups are important, we are not suggesting the Clinical Science Model officially divorce itself from contextualized and racialized research, now leaving it exclusively to independent interest groups. Instead, Clinical Science Model stakeholders must examine their philosophy to understand where color-evasion (perhaps inadvertently) fosters racism within their activities. Of note, we do not mean to vilify APCS- or PCSAS-affiliated programs. These are issues with which Clinical Science gatekeepers must contend.

Clinical Science proponents must also consider how their development might create even more disparities within the clinical psychological science field. As an example, with increasing frustration related to APA's accreditation policies, programs are increasingly seeking PCSAS-only accreditation. Anecdotally, when discourse around this topic occurs, many Clinical Science Model proponents point out that the top programs are foregoing APA re-accreditation in favor of PCSAS. Indeed, these programs often state they have seen little changes in things like applicant numbers, suggesting little detrimental consequences of foregoing APA accreditation altogether. Are there potential consequences related to our discussion on antiracism? We have already

discussed how Clinical Science rigor reifies racism. Indeed, top programs would be those with the loftiest metrics of rigor (high-impact publications, students with high GRE, GPA, previous research experience, faculty/students who publish in high-impact outlets, receive numerous awards, and are recipients of grant funding).

For whom could PCSAS-only accreditation be a drawback? What might be the impact for diversity of graduate applicants? If the focus is squarely on the production of empirical papers and grants, applicants with less access to labs, advisors, post-bacc jobs, and other opportunities will likely be disadvantaged; we expect this will disproportionately affect racialized applicants, those interested in research on racialized populations, and those for whom clinical practice is particularly important (see Galán et al., 2020 for more explicit discussion of how these metrics uphold racism and the need for fair admissions metrics). We do not have these answers, but the first step for the Clinical Science Model, and its proponents, is to engage in a thorough review of its philosophy and resultant policies to understand where racism might be baked into the process.

Conclusion: Moving Toward an Antiracist Clinical Science

Our goal for the current manuscript was to present an exploration of the ways in which the historical development and proliferation of structures aligned with the Clinical Science Model inadvertently uphold systemic racism. We hope this article serves as both a reminder that (1) assuming racial injustice will sort itself out does not ensure racial equity, (2) understanding the idiosyncratic ways in which the Clinical Science Model—or *any* professional organization for that matter—has developed can provide clues to how science can advance racist paradigms, and (3) uncomfortable self-interrogation can be useful for moving our field toward antiracism by strategic changes to our scientific structures and practices.

We end this manuscript with the following quotation from Buchanan, Perez, Prinstein, and Thurston (2021) which encapsulates the rationale for this article:

“Without acknowledging the power disparities undergirding scientific research and publishing, proposed solutions will be ineffective in ending white supremacy in psychological science.”

Footnotes

¹ *Commentary on public facing versus private information and the Clinical Science*

Movement. We assume that the metrics on which Clinical Science program graduates will be judged are such things as numbers of publications and grant funding. It is entirely possible that there are many other ways in which different outcomes are used in PCSAS program evaluations. However, we have scoured the PCSAS website in preparation for this article. If understanding the metrics of success as defined by the PCSAS can only be defined by having intimate insider knowledge, especially as they pertain to underrepresented, racialized groups, then the PCSAS is set up in a manner to immediately present a hurdle to scientists and programs who operate from the scientific fringes in terms of the populations they service and the types of scholarship that they produce. Indeed, although the PCSAS has a blog with one entry in July 2020 specifically devoted to Diversity Issues in Clinical Science (*Diversity Issues in Clinical Science*, n.d.), there is no link to that blog on the organization's website. We were only able to find it through a search engine using the search terms "PCSAS diversity blog" largely because of our direct knowledge of the existence of that blog due because we know authors of pieces in that blog. The website for the APCS admittedly contains one page entitled Enhancing Diversity, Equity, Inclusion, and Justice which hosts links for two documents: one with resources for building an inclusive research lab, clinic, or team and one for decolonizing psychology class syllabi.

The PCSAS website, then, reflects the similar color-evasive ideology that we believe has plagued the Clinical Science movement since inception. The information presented reflects the norms of the status quo. Individuals interested in and devoted to racialized groups are tasked with having to read between the lines of the public-facing information and assuming that individuals involved with the PCSAS are competent in the domain of antiracism. We admittedly

assume that programs whose particular foci are underrepresented groups and diverse methodologies would be forced to consider whether or not their scholarship aligns with that outlined in the PCSAS accreditation standards. That the history of the Clinical Science model, the most recent publications specifically from that group, and the public facing resources are largely devoid of this information, we believe, is evidence of the place of antiracism within such a philosophy.

We acknowledge, however, that the SSCP has undertaken multiple activities to improve attention to issues related to antiracism and diversity. These deserve notable mention and appear to be largely the fruit of the SSCP Diversity Committee. Firstly, the SSCP has created a Diversity Syllabus (SSCP Diversity Committee, 2021) consisting of a repository of books and peer-reviewed scholarly articles for the intent of providing an overview of various aspects of diversity. Secondly, the SSCP President has been actively reaching out to increase the representation of minority-serving institutions within the society. Indeed, we are hopeful that representation from such institutions and scholars will be included in the upcoming APCS Clinical Science Training Summit scheduled to take place in May 2023 in St. Louis. Thirdly, the SSCP has increased the number of diversity-related awards, especially those with a monetary value attached to them. Additionally, the SSCP has increased visibility of scholars from underrepresented backgrounds and who focus on epistemically excluded populations through its social media presence (@SSCP_Tweets on Twitter), blog, virtual clinical lunch series, and newsletter—all of which are easily accessible through their website (www.sscpweb.org).

Author Contributions

C.R.S., J.M., D.C.W., D.M.N., T.E., L.S.H., G.I.S., J.B.F., L.R.K., T.J.C., J.H.A., S.A.S., J.L.H., and Y.M. developed the manuscript concept and design. C.R.S., J.M., D.C.W., and D.M.N. were responsible for the majority of the writing of the current manuscript, with assistance from all other authors. D.C.W., T.E., L.S.H., N.Y.H., K.H., and G.I.S. were responsible for conducting the review of *Clinical Psychological Science* articles presented in the manuscript. E.W.N. provided critical review, feedback, and assistance with revisions in preparing the manuscript. T.J.C. compiled the glossary of key terms in preparing the manuscript.

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