WEBINAR VIDEO TRANSCRIPT

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Community Connections Fellow-led Webinar

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INA RAMOS: Good afternoon or good morning, everyone. My name is Ina Ramos, and I'd like to welcome you to the Minority Fellowship Program, Community Connections Fellow Led Webinar. This webinar is brought to you by the SAMHSA Minority Fellowship Program Coordinating Center.

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the US Department of Health and Human Services. During today's webinar, you will learn about the community engagement work of two current and two alumni fellows, explore the impact of MFP fellow community engagement efforts, and hear about some lessons learned from those community engagement efforts.

I'd now like to introduce today's first speaker. Ms. Shahrzad Yekta is a 2015-2016 American Association of Marriage and Family Therapy master's alumna. Shahrzad, the floor is yours.

SHAHRZAD YEKTA: Good morning and good afternoon to everybody. Thank you for joining, and I'm happy to be back presenting to all of you today. I am going to-- my presentation today is not going to be so much about research. I myself, I like to enjoy and learn from other people's research and apply it. So you're going to learn a little bit about what I've done in the past year and the community efforts that I've done by myself. We can go to the next slide.

So I'll give you a little background story to myself. I was working at a community clinic, a full-service community clinic doing behavioral health consultation, and when the pandemic started, I was laid off. So I had to kind of regroup, and being a part of the community and being able to offer services was always something that I enjoyed doing. So I wanted to get a little bit creative on how to reach out, and certain populations that I knew are going to need a little bit more of an outreach than others.

So I got I started putting a list together for myself of organizations that I thought could benefit from mental health services. And as we all know, everything that happened within the past year kind of changed the layout and the way we do reach-out for mental health services especially, and the need for it, definitely, that went up a lot.

So I started finding new organizations through-- food pantries, I found, was one of the places, good places to connect with because a lot of people now had food insecurities. They would go to those places, so you could reach them through those places. Living resource centers, I'm in the state of Texas where I am-- we have 211, which is part of the United Way. And that's the place where a lot of people go to get all kinds of living resources.

To a couple of nonprofits as well that we're affiliated with different minority groups based on religion, race, and other stuff. And also schools. Schools are also-- although a lot of them were not in session, somewhere in the middle of the pandemic, schools also are suffering. A lot of kids and their families were suffering from many different things as I'm sure you all know.

And then also small medical practices. And in particular, the ones that were catering to-- basically minority doctors that had a lot of patients from other minority groups. So I reached out to some of them as well to be able to offer the services and how I wanted to present my idea of how I wanted to collaborate with them.

So some of the things that I started doing in particular with the community centers that were catering to specific minority groups was I started doing presentations, workshops, and offer them educational pamphlets that they could offer to their community. So I presented on a weekly basis on different topics in mental health. What I found was in the beginning, of course, there was-- we had a crisis or we have a crisis. And so there was a lot less people.

But then as the word got out through Facebook or through different social media, and the organization itself that a lot of advocating for themselves and saying that they're offering this valuable service for free, basically, to the community, I saw that a lot more people started to join. And it was a great way for me to connect to the community and also hear feedback on what are some of the needs of these specific groups of people?

So I was doing a lot of service for the BIPOC community, and there's different ones. There's so many. I just-- I started reaching out to the ones that I knew about, and in particular, ones that had just opened up. Like I knew a few that had just opened up nonprofit organizations and they were just starting, so they were perfect care for me as well.

I offered them workshops on different mental health topics. There is a lot of anxiety, depression. Especially with anxiety, there was a big need for that, so I offered presentations and workshops on that. And also given them different educational material and pamphlets that they could print out to even either put at their organization whenever people reached out over there. To maybe pick up food if they were offering a food pantry over there. So-- or either send it through their email list that they had access to kind of distribute between them.

And also there was-- to collaborate with school counselors. School counselors are-- their role is-- their role is-- it involves-- depending on the school and the district and where you are, their role involves many different things, and sometimes it's harder for them. They are required to do a lot more than actual counseling, offering counseling to the students. So they always-- what I've found in my experience, that they welcome the help from the outside.

If you're able to go and offer them a hand in either presenting during school fairs or parent night or some sort of student organizations or different ways, they would be the best person within the school to connect with to see how you could be of help with them. Basically collaborating with them to be able to offer help, because what you'll find is that if you decide to work with, let's say, adolescents, parents are always going to be involved and you cannot ignore the family. Cannot treat or work with an adolescent without working with their family.

So school counselors, a lot of limitations as it comes to working with the family. So that's where you could come in and work with them to be able to offer some sort of help. So my main focus was basically doing a lot of Zoom presentations and workshops, because at the time I was not seeing anyone in-person. So everything was through Zoom and we had a great turnout because people were-- parents were at home and they could basically just join and listen in or watch as we were presenting, and there was a lot of great feedback that these organizations got, and also I got myself.

So everybody wins in this situation. The organizations welcome this because they would love to-- this mental health services, no matter where you go, there's always a shortage. If you go to the biggest clinic, there's probably-- their littlest amount of budget is contributing-- is going to be for their mental health services. One of the first things that was cut off from the clinic that I was working on was the mental health department.

So being able to offer this service is a win-win for everyone. For the community, of course, for the organization that you're working with, and it can also be a win for yourself because it brings a lot of potential clients and other opportunities for you. If you are someone who likes to either practice your public speaking skills, likes to present more, or likes to go into creating more of these opportunities online, it's a great place for you to start and practice your skills-- your speaking skills, your mental health skills, especially if you're new into the field.

Now I feel like it's a great way for you to start. And it brings potential clients to you depending on who you're connecting with. And it's a lot of word of mouth, and organizations a lot of time work together. So it's a win-win for both sides. And it's a very, very, very valuable source of-- resource for the community, and especially for a community that otherwise does not have access or will not reach out for help.

So when you go through these organizations that are offering other basic needs like food, cash, and other things, other kinds of help-- and they-- because they already have a connection with those clients, and when they present this other service which is the mental health service, it's usually received a lot better than if you were to reach out to the community directly.

So it's a very valuable service and an educational material basically at no cost to them, which is great. And like I said, it's a great skills practice for you as a new person in the field, or just in general. I mean, I was-- I knew when I did this, but I knew that the direction I wanted to go, reaching out to the community was something that I wanted to do, that I reached out to the population that I was really interested in working with, and it was-- it turned out great for me. Thank you so much, everyone.

INA RAMOS: Thank you, Shahrzad. Now I'd like to introduce Jeff Capps who is a class of 2020 Council on Social Work Education Youth Master's Alumnus. So Jeff, we'll go ahead and turn things over to you.

JEFF CAPPS: Hi, everyone. Thanks so much for that introduction, Ina, and for having me. And thanks to Dr. Winn at CSWE MFP for his guidance. So I'll be presenting my community outreach project that I completed during my fellowship in 2020. OK, so I'll start by giving some context for this project, which was an open student-led group for Asian and Pacific Islander students.

API students make up about a third of UCLA student body and face barriers to mental health services. And so in my second year of my social welfare program, I attended a presentation on campus about API mental health, and one of the panelists worked at CAPS, our Mental Health Center on campus.

So I introduced myself to this clinician and said I was interested in developing a program for API students like myself. And that's when I learned that CAPS had in the past decade attempted to host a handful of API groups without much turnout. And so I think at the time I recognized my position as both a budding, quote-unquote, "professional in clinical social work," and also as a student, just like any other student on campus.

To give you more context here, I mixed Asian and white, and having grown up in a Taiwanese Buddhist community and knowing the target status that Buddhism holds in this country, I found it strange learning in grad school about the proliferation of mindfulness and behavioral health care. The number of white clinicians who borrowed from Buddhism as they develop new psychotherapies, and this idea that people can make a living by delivering mindfulness-based therapy, or selling self-help books on mindfulness for $29.99, or working at a University like UCLA and making a living studying mindfulness, or teaching mindfulness in the military or at tech companies.

So this is where the name for the Project Mindful came from. That strangeness that I felt and that I still feel today as a psychotherapist working in community mental health. I have two photos here. So at the top I'm pictured with Steve Hayes, founder of a mindfulness-based cognitive behavioral therapy. And at the bottom I'm seen standing in the Buddhist temple that I grew up attending.

So my classmate and co-developer, Nancy Tang, and I began writing curriculum in January 2020 while also starting a cross-departmental marketing effort around March of 2020. We planned for an eight-week schedule in the spring quarter starting in April 2020, and to maximize access, we adopted a two-tiered approach.

So in the first tier we have the actual group, which would meet on Tuesdays for about 75 minutes. And in the second tier, we had an online folder with mental health resources, including ones for crises, literature about mental health issues, and handouts related to topics we discussed each week. This way, people could still access resources without having to attend the group if they really didn't want to.

Group sessions were a mix of psychotherapy-- or I'm sorry, psychoeducation exercises and open discussion about these topics. As far as marketing went, it was left up to our discretion. We contacted different departments and student groups, and we have the UCLA Office of Student Organizations Leadership and Engagement selectively share our flyer with different students. So here's our flyer on the right side here.

We made a point of not mentioning campus affiliation due to possible stigma that may go along with the Mental Health Center. We also emphasize that the group was by and for API students, and we gathered ideas for topics from sign-ups for the group-- group registrations. And we wrote curriculum week by week based on those ideas.

And so I mentioned that we planned on starting this group in April 2020, and while in March, the unexpected occurred right before the spring quarter when the pandemic forced us online. As the pandemic continued for the next few months, anti-API acts across the country made us think deeper

about what we were doing. And so we made real-time adjustments for current issues like the pandemic and xenophobia, and we also have to redo our marketing about I think one week before we started the program.

I will say that pivoting online had upsides, like students were able to log on with the click of a button instead of trekking to the northeast corner of campus at 5:00 PM. And it's possible, too, that, in this case, having like two screens between us instead of being in-person, that might have increased accessibility as well.

So here are the results of our Mindful Project. On the right you see a breakdown of session topics, which included issues like diagnoses, intersectionality, anxiety, suicide, addiction, trauma, and grief. We also added a ninth session due to requests to discuss Black Lives Matter shortly after the death of George Floyd.

In terms of project reach, we had 30 registrants from 17 departments across campus who accessed our Resources folder and we had 11 group participants. This included some STEM majors like computer science, genetics, statistics. As far as participant feedback, we tried to collect data with the participant survey, but unfortunately no one completed it. Maybe that's part of the nature of an open group, we're sort of like a drop-in setup. And our efforts-- maybe that was a part of our efforts to make participation in this program as noncommittal as possible in order to maximize access.

However, we did get anecdotal data with positive feedback each session. So some that come to mind included one participant from UCLA fraternity expressed appreciation for our mindfulness activity, and he planned on running a mental health event in the Greek community in the near future. Another participant who attended all of our sessions said that they would do it all over again if they could. I think that's positive feedback. And then also, three participants like the group enough that after our ninth session, we actually continued to meet informally on a monthly basis three times last summer as the pandemic was continuing.

Now my co-developer, Nancy, and I are working on a guide based on the Mindful Project that can hopefully be used by different groups to develop their own peer-based programs. OK, so here are some implications of our work. The importance of culturally-responsive programming is a given. Being sensitive to the interests of others and adjusting programming as needed. And thinking about, in this case, what it means to be API in the context of mental health issues and the mental health system that we have in our country. And how might API perspectives challenge what we take for granted?

There's also the issue of protocols. How I think a content-based or protocol-based approach to program development and dissemination can seem rigid a lot of the time and almost implies like a hierarchy or top-down approach to knowledge and wisdom. And personally, I think we could have done a better job of countering that cliche in our own program, but I do recommend more process-based approach. Encouraging people to develop their own curriculum, start from the bottom-up, especially when we know that psychoeducation is really bidirectional.

Part of the benefit of being flexible I think is the opportunity to ask every step of the way, what's missing here? That's the importance of questioning everything, I think. There's also the power of a peer-based model, which is the chance for people to see eye-to-eye and decide for themselves what they think, to

not feel as though there's only one right way of approaching anything, considering that everything is a social construct. And so no topic was off the table for us.

And I sincerely believe that peer models are the strongest force against stigma. I think this peer-based approach gives an idea for what could be piloted moving forward among affinity groups and other kinds of groups doing similar kind of work. I also want to emphasize reflexivity. Examining our unquestioned or unconscious beliefs about ourselves and others and just the world and reality in general.

For instance, how do we think about evidence-based practice versus community-defined evidence and practices based on that? What counter-narratives are we neglecting in the realm of mental and behavioral health? So those are just some implications of the project. That's it. Thanks so much for having me present this project.

INA RAMOS: Thank you so much, Jeff. So we will now hear from Ms. Debbie Manigat, a current Doctoral Fellow with the American Association of Marriage and Family Therapy.

DEBBIE MANIGAT: Greetings, everyone, and thank you for having me. This is my second year as an AAMFT Fellow, and I'm honored to be here to represent the 2020-2021 MFP Doctoral Fellowship under the leadership of Dr. Diana Harris McCoy, Mr. Jermaine Lorre, Grace [INAUDIBLE].

My project is titled, Disaggregating Data by Race and Infant Mortality and the Rise of Family Therapy in Infant Mental Health. Today we honor the story of our ancestors. Today we speak their names-- Lucy, Anarcha, and Betsey. They are our medical and mental health pioneers. In 1844, Lucy, Anarcha, and Betsey were leased to J. Marion Sims for his research. For five years they were separated from their children, forced to undergo over 30 surgeries with no medication management, no social-emotional mental health care, and then returned to enslavement on plantations in America.

This project reflects upon their narrative and encourages a reproductive renaissance in mental health service. Our part on this journey begins by understanding the gap in knowledge. When it comes to dealing with reproductive and maternal mental health, many graduates, now practicing professionals, are actually quite unprepared.

Professionals who work in high-risk communities see innumerable and stark ways the intergenerational transmission of adversity is triggered. These realities often lead providers feeling numb and helpless as they observe the impact of fractured family life. Women who manifest significant depression, anxiety, or PTSD during pregnancy are often referred by prenatal care providers to mental health professionals, many of whom do not have special training in the prenatal period.

Additionally, racial equity and cultural responsiveness is another gap of knowledge in IMH training for therapists. Being aware of cultural bias, implicit bias or microaggressions is essential regarding how this can affect the provider-client relationship and the family system overall. Despite this and the large number of women affected by perinatal mood and anxiety disorders, infant mortality, miscarriage, parenting issues, most graduate programs do not explore these topics in-depth or at all. Consequently, to address the particular concerns of birth, trained therapists are desperately needed.

So what is Infant Mental Health? Here on the slide are the pioneers of IMH. Infant mental health is the developing capacity of a child from birth through age five to experience, regulate, and express emotions,

form close relationships, explore the environment and learn, all in the context of family, community, and cultural expectations for young children.

The IMH lens and basic beliefs are so exciting to me because they mirror core aspects from the foundation of family therapy, such as systemic thinking, reflective supervision, recognizing the parent-child relationship, and a focus on understanding intergenerational trauma. Most notably, Dr. Nadine Burke Harris states, early childhood experiences gets under our skin, changing people in ways that can endure in their bodies for decades. It can alter the way DNA is read and how cells replicate. And it can dramatically increase the risks for heart disease, stroke, cancer, diabetes, even Alzheimer's.

Her work as a pediatrician is critical to the IMH field as she further investigated the importance of recognizing toxic stress in early childhood and its impact on mental health and biological health of children as well as parents' unresolved trauma. In her book, The Deepest Well, she notes that for many families she observed, toxic stress was more consistently transmitted from parent to child than any genetic disease.

Now take a moment to imagine the amount of ACES that Lucy, Anarcha, and Betsey's children endured. And that's the purpose of this project, to bring us all together in trauma-informed care and a readiness to serve families in healing intergenerational trauma. Family therapists are needed here to work collaboratively with OB-GYNs, pediatricians, and even each of these organizations pictured here to help in prenatal and postnatal care.

While birthing medical professionals play a critical role assessing the physical needs, family therapists is an opportunity for us to come together in this process for understanding what is going on in the family system? In Satir family therapy, she says is essential to provide mental health support. And as my project builds in this area to teach therapists how to integrate these concepts, such as maternal depression, infant mortality, substance abuse while pregnant, developmental delays, and the critical attachment period between the parent and infant, we get to see that together.

Experts agree that therapy can be an effective way to help monitor a woman's mental health, note shifts in her mood and anxiety, and ensure that she gets additional support as needed both during and after pregnancy. IMH perspectives in family therapy are a wellspring of change to support the social and emotional development of the birthing experience. Supportive information and resources for prenatal care can be found in IMH research programs, training, and professional development.

My project explores a narrative systemic review of articles organized by birth experiences to end of life and how IMH specialists play a role, as well as a quantitative analysis disaggregating the data of infant mortality rates in South Florida. My research question is, what are the differences in the infant mortality rate in Palm Beach, Broward, and Miami-Dade County, if any, based on race between 2007 and 2017?

Nationally, African Americans have 2.3 times the infant mortality rate as non-Hispanic whites, and African-American infants are 3.8 times as likely to die from complications related to low birth weight as compared to non-Hispanic white infants. African Americans had over twice the sudden infant death syndrome mortality rate as a non-Hispanic white in 2017, and African-American mothers were 2.3 times more likely than non-Hispanic white mothers to receive late or no prenatal care.

Disaggregating data by race may help uncover hidden racial inequalities and that reveals that this work is about saving lives. Recognizing the national disparities, I looked at my state of licensure. Between 2007 and 2017, the infant mortality rate in Florida actually declined 14%. And in Palm Beach County, it was the lowest in 20 years, even lower than the state and the nation at 6.0.

So what's behind the numbers? Let's take a look. Here at my results. Palm Beach County had one of the highest Black infant mortality rates. The rate fluctuates, but is notably lower in 2017. The Palm Beach County white infant mortality rate fluctuates with an overall downward trend. The Miami-Dade County Black infant mortality rate is relatively high and remains constant, while the white mortality rate is decreasing slowly.

Overall, my findings indicate that Miami-Dade and Palm Beach County Black infant mortality rate is statistically significant, but Broward County was not statistically significant during this time period. The white infant mortality rate in Miami, Broward, and Palm Beach County was also statistically significant.

This data is important because it informs an area of research where mental health professionals can be present for grief care, depression counseling, and even post-family planning or preconception care when the family is ready. Pregnancy-related deaths are not just about infants. Nearly 700 women die in the US each year as a result of pregnancy or its complications. Understanding how death affects the family unit is foundational in order to provide quality holistic therapeutic services.

Professional development on how to better support families during those particular types of transition is essential, and we can support families in a strength-based way when they may be experiencing a variety of end-of-life issues. This includes racially equitable and culturally responsive care. It needs to be addressed as Black women have disproportionately high rates of maternal mortality and morbidity.

The intersections of culture and family planning and therapy requires a safe space for all voices. Where does our field intersect with IMH? To build a sense of cultural responsiveness, intersectionality is the bridge to accountability. People face celebrations and challenges in their family system that allow them to determine their ways of being, where they can set boundaries or build relationships skills.

As such, for each stage, it is necessary that therapists build new skills when working with the family as well, recognizing that growth is not linear and experiences cannot be pathologized. I recommend the practice of family therapy to be included in hospital and maternity care units, pediatrician officers, OB-GYN practices, early childhood centers, and other spaces intersecting with infant and maternal mental health.

Family therapists play a key role in helping families in crisis, and they can serve as, they determine what are their goals? This includes awareness on implicit bias, racial disparities, and patterns that take into consideration adverse childhood experiences, including racism, substance abuse, intergenerational trauma, protective factors, and resiliency.

In conclusion, we end where we began. To consider the trajectory of Lucy, Anarcha and, Betsey, their children and the historic trauma that was passed through generations. Racism, hatred, poverty, segregation, housing disparities, sexual assault, environmental trauma, child abuse, and government-sanctioned violence demonstrates part of the lost stories and lies due to racial trauma in America. All clinicians need to be aware of this narrative, intentionally strive to better understand and collaborate in

service to protect the sacredness and the care of human pain, mental health, soul care, and the healing of their bodies.

We have to explore deeper and get the total narrative. To eliminate racial inequities in birth outcomes, health care professionals, policymakers, and social and economic institutions need to understand acknowledge, address, and prevent racism. Recognition of each of these perspectives in IMH requires a paradigm shift for most early childhood professionals like family therapists, and it requires significant training in order to fully understand and integrate these perspectives into clinical work.

I hope that as our field advances with this information from this project, that all therapists will be cognizant of racial health disparities in birth experience, seek trainings on the intersection of IMH and social-emotional development, and then lead culturally trauma-informed clinical care and take action on racial equity. Thank you.

INA RAMOS: Thank you so much, Debbie, for your presentation. So our final presenter for today is Mr. Curtis Warren, a current Master's Addiction Counseling Fellow with the National Board for Certified Counselors. Curtis, the floor is yours.

CURTIS WARREN: Yes, good morning. I just want to thank Debbie and all of the presenters that have went before me. And I think my work is really the next step as far as intervention. So my study really examined the impact of intergenerational trauma, mental health, and substance use disorders amongst African-American men. And I primarily looked at African-American men in the city of Baltimore.

And it was through a study group and having good mentors that allowed me to explore how intergenerational trauma leads to substance use disorders and some of the risks and preventive factors that exist, and really some of the interventions. So it was through mentoring that I was able to start my project, Brothers Helping Brothers.

And Brothers Helping Brothers was with the help of my mentor, Mr. Dennis Winkler, who is a licensed professional counselor in Baltimore. I did my internship with him, and I basically used 20 of his African-American male clients. Now my research started out to look at men ages 18 to 45. But as I began to do interviewing, have one-on-ones in both group sessions, I began to realize that the men that were coming then were over 45 years of age.

So then I had to really expand my target to up to 75 years of age. Began to study first and foremost how adverse childhood experiences impacted their substance use disorders. Digging down into intergenerational trauma, I got creative. I use genograms that really help illustrate to the men of some of the trauma that was passed on and given them a pictorial illustration of how looking at the maternal and the paternal contributions, being able to trace some of the mental health as well as substance use disorders that didn't just manifest in them. That were passed down from the most-- the maternal as well as the paternal lines.

And this research, really, when men were showing up, I was looking at the men as fully-grown adults. And once I began to realize, as I began to do in individual and group counseling-- and this is a Russian nesting doll, I began to have to do inner childhood work. Because I realized that these Black men that were showing up is not this person, but we really had to regress it down to the trauma that they experienced growing up.

And one of the things that we were able to do outside of the individual and group counseling, we had a book club where we explored My Grandmother's Hands. And Resmaa Menakem really talks about intergenerational trauma, . But also racialized trauma and its impact. And it was through my mentors-- and I think one of them, Dr. Jackson, Antimoore Jackson down in Arkansas, really was influential in getting me to challenge some of the traditional clinical interventions and clinical considerations.

And I began to study a African-based theoretical model called Into. And Into is a psychotherapy and it's a clinical model that deals with trauma and it deals with therapy from a holistic but an Afrocentric or Africentric-based theoretical framework. And it is through the mentorship of therapist like Mr. Winkler and Mr. Antimoore Jackson that allow me to not only see myself, but allow me to connect with other Black men, to make me more comfortable understanding that what I'm saying to my clients is not just a localized problem, but Black men are experiencing the same type of intergenerational trauma all over the country.

When I first started my study, I started it with clients of a particular therapist, Mr. Winkler, but I realized that that was not really enough. I really wanted to capture the co-occurring drug and alcohol and mental-- a mental health and substance use disorders, so I decided to go to a residential treatment program.

In all of the groups I did group counseling there, and all of the groups were open-based. So at any time, men just showed up. And one of the things that we really-- the first thing I would do, I would do all the traditional assessments. We studied for depression and alcoholism and substance use.

But when I begin to introduce ACEs, the Adverse Childhood Experience, and begin to talk to them about the trauma that they experienced. And then when I first went out with the ACEs, it was only a 10 questionnaire-- a 10-question questionnaire. And I never really initially dealt with the resiliency and some of the preventive factors that some of these guys were able to use for a sense of resiliency.

As I began to interview more clients, it first just started out as a comparison between the clients that came through, regular traditional therapy, comparing them with the clients that I was experiencing in the drug treatment program. And I begin to look at both the young and the old and the levels of resiliency in both young adult African-American men and coupling that with the research of adult American men.

And I found that some of the younger men were able to be more resilient and had closer ties to the community, closer access to wraparound service that allowed them, when they were a crisis, to develop a plan and people that they identify in the community and services that when they were in crisis, they were able to attach to a larger group or a larger support system.

But I realized through the research, as Black men got older, some of the ties, especially when you begin to deal with men that are dealing with substance use disorders, some of them burned bridges, and the old support system that would allow them to be resilient and move forward and deal effectively with how to reclaim their authentic self, those support systems over time were so fragile and the bonds and the connections that they begin to break.

So it was so important in the study to have some type of research to understand how the continuity and how important it was for Black men to have support systems within their community, and first and foremost, a support system coming from the home and close friends and associates.

While ACEs was significantly associated with the severity of depression, we understand that the resiliency allowed a lot of men to be able to come full circle, and having that support really boost their resiliency and their effort with challenging experiencing crisis, experiencing substance use disorder. Their level of resiliency allowed them to maintain a healthy lifestyle, and their road to recovery even after a relapse allowed them to go out and become more important and productive citizens. So thank you for allowing me to share.

INA RAMOS: Thank you so much, Curtis. So what we're going to do with this time is we're just going to have a nice discussion with our presenters today. We have a few questions for the panelists. OK. But I'll go ahead and start with the first question. What influenced you to select your field of study and to engage in the work that you presented today? And feel free to jump in, each of you.

CURTIS WARREN: Well, I think I'll go first. So I'm an Iraqi veteran. When I came back from Iraq, I went to the VA, which is the largest government organization next to the Department of Defense. I said I'm having symptoms of post-traumatic stress. I appealed to them for Black male therapist.

And I'm in Baltimore City. They were unable to provide me-- and Baltimore is not a small city, and nor is the VA a small organization. So in my region alone, DC, Maryland, and Virginia, there was not one Black male therapist that they can refer me to really help me with some of the, what I felt at the time to be very unique situations.

I come now to learn that the things I was going through was not germane or unique to me, and I felt that the system failed me. So I thought it was important that I begin to find a support system, and when I did not find them, I begin to create them.

INA RAMOS: Thank you, Curtis. Did anyone else have something they wanted to add or share about your experiences, what brought you to this field of study and to engage in your work?

DEBBIE MANIGAT: Sure, I can share. Thank you again for having us, and thank you to all the guests for being with us on this journey. Again, my name is Debbie Manigat. For my undergraduate, I went to Howard University and actually studied communications. In between the time period when I graduated, I actually-- I call it a divine journey of career versus my calling.

And I had learned from a family member who was struggling with depression and suicidal ideation, which really catapulted into this field, because at that time, I really didn't know beyond just being supportive of what the clinical concerns were and how to really walk with them in the place that they were.

But it would not go away as I started to do research in terms of this passion that was building around family therapy. And so that drove me to go get my masters at Palm Beach Atlantic University, which is a clinical and Christian program. So within the African-American community, faith is also a very important part, and I want to make sure I have that lens as well. And once I've finished my master's, I went on for

my doctorate at Nova Southeastern University and had the opportunity to really focus on infant mental health and mindfulness.

So I was loving Curtis and Jeff's presentation because it's the best of both worlds, and I believe they shared a lot of insight into techniques or tools that can be helpful as we all continue our various journey. So I was brought here from personal reasons, and as the passion continued to grow, it became, what I say, is my calling.

INA RAMOS: Thank you, Debbie.

JEFF CAPPS: I can go ahead and share. Yeah, I don't know if this sounds like a good answer at all, but in grade school, I remember acting sort of like a confidant for friends and family. And I think, I don't know, early exposure to issues like depression and dementia made me interested in this kind of work.

And so I ended up taking a roundabout path toward working in mental health, but my first job in this field was at an API mental health clinic here in Los Angeles County. And I later worked in-- found a carceral system, child protective services, and went back to school for my master's, so I could practice psychotherapy. And I was really driven by a stigma to do this work. But yeah, such privilege to hear about all the other projects today.

INA RAMOS: Thank, Jeff.

SHAHRZAD YEKTA: I could share a little bit, too. I'm not going to-- I think I'm at a point where it's more important for me to find the reasons why I am still in the field and what keeps me in the field and what kind of got me into it. And the best answer that I found for myself is just that I love-- although it's-- most of the times it's very painful, but over time on the good side of it, we are lucky to hear stories of resiliency and stories of healing.

So the stories of people that I get to hear on a daily basis is really what kind of inspires me to be able to do the job that I do, and that's the part of the job that I enjoy the most, to be able to hear these stories. As hard as they may be, as heartbreaking as they may be, if they take a turn, I think everyone who is in this field would agree that there are those moments where some things shift and you start to feel-- clients start to feel glimpses of hope, and in those moments, usually there is such a big breakthrough and such a big relief also on our end as the providers for them. So those stories really is what keep me in this field.

INA RAMOS: Thank you. And that's a wonderful segue into the next question about, what are some of the most rewarding parts of your work, and then some of the most challenging parts of your work? And I think Shahrzad, you've answered kind of what is rewarding for you, what keeps you here. What are some of the things that maybe are challenges for you, as you said? What keeps you here versus what makes you maybe think about--

SHAHRZAD YEKTA: I have to say, the stories are kind of a double-edged sword, because as inspiring as they can be, we have to face the fact and the truth that our jobs are very draining in a lot of ways for our own mental health. So being able to have, especially at a time like right now, where most of us are also dealing with our own things, and most people are-- to be able to-- to be in the role of a provider and

someone who is going to help other people, at least for myself, it's required a little bit of an extra work on my end to be able to make sure that I don't burn out from the job that I'm doing.

So it's-- I find that difficult. I find having that balance, at least right now, in the past year I found that to be especially-- just because being able to be there for other people and making sure that you're OK yourself is a constant-- it's something that you have to constantly do. And check in with yourself to make sure that you're doing OK and you're operating from a good place to be able to help others.

So it's inspiring, it can be challenging, it's a part of our job. Like any other job that has its challenges, that's, I think, it's a challenge for us, and we have to make sure that we constantly attend to ourselves and our own needs as well. And check in with ourselves to make sure that we are-- we're basically tuned up to work with others.

INA RAMOS: Thank you so much. Anyone else like to respond to that question? The most rewarding part or the most challenging part.

DEBBIE MANIGAT: Sure, I'll be brief. So I would say, for me, the most challenging part-- I work presently at a children's services council, which is a special taxing district. We were created by the voters of Palm Beach County. And in this work, our focus was early childhood education and environmental health.

And in my department, I oversee our touch points training and infant mental health initiative. So we bring in subject matter experts from all over the US to come and train about around 3,000 providers each year. And along this journey, there was a shift in terms of language. Everyone began talking about racial equity.

And or me, it was a culture shock because I felt like, well, isn't that what we were doing? Like, isn't this the work that we were doing? And recognizing that some of my colleagues and their just different experiences, backgrounds, and upbringings didn't necessarily feel that we were leading in that way.

And so to me, it's an opportunity, which of course, is why we are all here. So that is also the reward that we get the SAMHSA support, that we AAMFT as well as the NBCC support to make sure that these issues do not fall to the background in our secondary to our training and to our professional development.

But that it truly is integrated into who we are as clinicians, and that we seek out the necessary professional development to not only grow ourselves, but become better supervisors to others, and we can talk very clearly about cultural humility and cultural responsiveness. So it shouldn't be seen as an other or a specialty training, but it's just in who we are, especially thinking about the diverse clients that we serve.

So I'm glad that we will have all of your voices and all of your research in the field as we continue to move forward showing just how important racial equity is and that it's not just a term, but it truly is who we are.

INA RAMOS: Thank you. I wanted to read a comment someone sent in response to Curtis, what you shared earlier with your VA experience. And the comment reads, as a VA mental health provider-- I'm sorry. As a VA mental health professional, your request for a mental health provider that looks like you is not unique to the VA health care system. It is prevalent throughout the system as a result of many

barriers, including delays to hiring competent providers, challenges of working within a government organization, and lower reimbursement rates over private sector-- private practice. And so they wanted me to share that with you, Curtis.

CURTIS WARREN: Yeah.

INA RAMOS: OK.

CURTIS WARREN: Thanks for that. I think it's a real thing. I think is something that they need to correct. But again, thanks to some of these minority fellowships. It will actually open the door for some marginalized and undervalued and really underrepresented populations that really infuse the field with some competence, because I think that network-- I don't think without the fellowship, that I would be as competent. And I think that's some of the challenges, that's some of the hard work.

One of the challenges is being grounded and remaining grounded. So self-care and the proper self-care. Being connected to professional organizations that challenge you with new interventions. So when I started out, I was just taught ACE. ACEs studies. So now I'm doing more of personality assessments with Black men.

I just included the NEO, which is a five-factor model that really helps. So what the NEO does is bridges the gap. So the information that I get from this assessment covers what I couldn't have extracted in eight to 10 sessions. So I think one of the challenges is the self-care.

I think the reward is, what I do with Brothers Helping Brothers and I do with my individual as well as my group sessions, I look at-- I only deal with men primarily. I don't exclude women, but it's just that's my focus and emphasis. So the light bulb effect, the intervention. To seeing people that have not reclaimed their authentic self. To understand for me as men, to be able to come into an environment and men that were-- who only experienced the emotions that I'm happy or I'm sad or angry are now able to experience a full range of emotions, and more importantly, how to give voice and how to be seen.

So to allow men to not show up as being toxic, but the reward is allowing Black-- empowering Black men, enfranchising Black men, allowing them to be seen, to be present, to be actively engaged in their healing process and the reciprocity. Now to be involved in the healing process of their families and others. It only takes one stable force in the relationship to stabilize a healthy relationship.

INA RAMOS: Thank you. And Curtis, we have a follow-up question about, what is the NEO? You mentioned the NEO a few times. Can you talk a little bit more about that?

CURTIS WARREN: Yeah. So the NEO is a five-factor model. It is a personality assessment. And it has five factors that it really looks at-- narcissism, anxiety, hostility, anger, depression, self-consciousness. And it goes through a whole litany. So it has five factor, and it has 36 factors that evaluate individuals. It's a 240 questionnaire, and maybe I'll drop my information in the chat.

So Loyola University, a brilliant professor by the name of Dr. Piedmont who is proficient in assessments introduced me to the concept-- I taught a class with him. And it was very beneficial. And if anybody wants more information on that assessment, or on that personality. It deals primarily with personalities.

But the reports, that the information is gleaned from the reports are just phenomenal. And it takes you really to that next level of assessments. And I think the assessment is cheap, it's like $15 if you are a provider if you've been trained in the assessment tool.

INA RAMOS: Thank you. Jeff, did you want to talk about any rewards or challenges? And if not, we can go to the next question. OK.

JEFF CAPPS: Yeah, I can go ahead and share. I mean, just some that come to mind. I would say that in the context of the project and of my work now as a therapist, in terms of project, all the challenges that were happening in early 2020 with the pandemic and then the rise of anti-Asian acts. And then even now, I mean, none of those have really changed all that much.

But I would say now, the biggest issue I feel like I face every day I work is systems. So all the issues that come at us downstream, it makes it really hard working at a micro level in some ways. So I would say those are big challenges. The biggest rewards, I would say both in the project and my work now are the chance to hear and listen to other perspectives. I think that's just the beauty of the work, is being able to connect people and being able to help each other feel seen and heard, and really look at what counter-narratives we're overlooking.

INA RAMOS: Thank you. And one of the words that I've heard a few times in you all speaking is self-care and how important that is. And so could you share some of the things that you personally do to ensure that you're providing care for yourself? Or are you providing care for yourself?

DEBBIE MANIGAT: Right. I think it went silent for a little bit. I can kick us off and get us started. So being in the pandemic, wow, I think it has shown everyone what trauma is. Going through a not just national but an international pandemic and recognizing that it affected everyone and then had layers to it.

So then you had the political discourse, you had the civil unrest, the racial concerns that everyone could see on YouTube, in the news. And I think that really showed how much we truly are all connected when it comes to recognizing our emotions, the pain that we feel, the sadness that we can feel when serious issues are presented.

And for me during this pandemic, taking time to really schedule with friends opportunities to chat. Sometimes we do like Zoom happy hours to just reconnect and release, because in the pandemic, at least for myself, I worked from home the entire pandemic and we are still home. And our workplace is working on a transition plan back, but for now, it's still about staying safe, staying healthy, and if I do go out, making sure I have masks and finding places where I can enjoy without worrying about hurting someone else or even endangering myself.

So being in South Florida, we are a little more blessed because we have the beach. So the beach was a safe haven to just enjoy the salt water, the sunshine, the waves. So that, for me, was my self-care.

INA RAMOS: Thank you, Debbie. Anyone else want to share?

CURTIS WARREN: Yeah, I'll jump in here. Many years ago I was introduced to Reiki. So I do a lot of mindfulness meditation coupled with Reiki, an energy healing. Primarily on my family and on myself. I

don't really sit it out in the community. But unlike Debbie, I have been seeing clients in-person and doing group-- masked, of course-- throughout the whole pandemic.

And I, like many, as a vet, the one thing that the VA really did do is they allowed me to be vaccinated pretty early. And it's not because I had high risk, it was only because people were not getting the vaccine, so they put me on a waiting list. And I stayed there for one day, and as soon as the vet didn't show up, I was able to get my vaccine.

So I have been doing in-person, so self-care has been optimal. I'd only go through a process of cleansing myself after I see each client, and of course, after I see a group. And I use that energy-- I know it's non-traditional. I kind of clean my space as often as possible, trying to get all the little heebie-jeebies out of my space. Thank you for allowing me to share.

SHAHRZAD YEKTA: I always love tips about how you cleanse this space and yourself. For whatever it may be.

INA RAMOS: Yes, so do you have tips, Curtis, for how to cleanse your energy?

CURTIS WARREN: Wow. So go on a weekends-- and so for me, there is a whole ritual in Reiki in which you're able to clear-- it's almost like smudging. You just don't have incense or a sludge or anything of that nature. But you're really just wiping down your body. It's just a motion to allow the negative energy to disperse and go in the opposite direction of your person.

So it's just a little ritual, and I just go and there's little symbols that I do to kind of clear the space and allow me. So it's really a symbolic gesture, but I believe that it works.

INA RAMOS: Awesome. Thank you so much for sharing that. So we had a question in the chat that asks, how do you engage in research as a master's student? And Debbie was kind enough to respond. I wanted to share the response and the question. The response was, I think you find a professor to connect with. Also determine if you want to do quantitative or qualitative research. Read articles that interest you and reach out to the authors.

Also, take time to reflect on where your passion is regarding clinical work and share your voice in magazines, websites, and journals. Thank you so much for sharing that, very, very insightful. And kind of another question-- similar question to the group, what advice would you give to current or future fellows who really want to effectively engage their community? What are some tips that you would offer them?

SHAHRZAD YEKTA: I think for me the best thing that I did for myself-- and I know that this can be kind of-- people look at it differently depending on your background and how you view the world, but I didn't say no to any opportunities that came my way, and I actually seek to initiate a lot of opportunities for myself depending on where I was.

The thing with a lot of-- if you end up, for example, at a nonprofit, nonprofits always have limitations, will always have limitations, especially for mental health services. But being able to kind of see if there is a need or if there is a niche somewhere where you can kind of offer a different kind of service, especially if you are interested in working with minorities or a group where maybe that kind of service not offered,

don't be afraid to talk to the bosses or to people who with power who can make it happen and kind of present the project.

The worst thing that can happen is they'll say no, and that's really not the worst thing. But I really opened myself up to a lot of different opportunities, paid and unpaid. I think that's where a lot of people kind of draw the line maybe and differentiate, but I wanted experience. I wanted to work with all kinds of people to kind of see where I will fit in. And that was the best thing for me in the beginning, because then I knew-- I didn't know when I started what was the group that I wanted to work with and what kind of-- what age population that I want to work with.

So that really helped me kind of narrow it down and see where I like to work and also where I'm good at and where can I be most valuable. So that would be my-- that's what I did for myself. I didn't say no to any opportunity. And I also tried to create a lot of opportunities for myself.

INA RAMOS: Nice. Thank you, thank you for sharing that. Anyone else want to share?

DEBBIE MANIGAT: OK. The gentlemen are being very nice, letting ladies go first. So I will continue. I love the question. That's an area where I would say it is my expertise, really helping other therapists grow in their career and what they hope to do in terms of not just clinically, but if they want to go into teaching, if they want to even have their own talk show one day, I think it's very critical to understand the importance of relationships.

It's not just something we learned in family therapy or social work, but it really is what we do in interacting with each other. Not burning bridges. Recognizing that you never know where you may see this person in the future, whether they were your peer in your master's program or in your doctoral program.

So making sure that you cultivate those relationships, that you connect on different projects and think about, hey, a few years ago you worked on this. You're not really doing it now, but it may be helpful to someone else that you meet. Also being able to even call those past work opportunities to mind.

And then the second one that I think is huge is branding yourself. In our field, it has shifted so much to where everyone is talking about their mental health and well-being, whether it is Naomi in tennis or now Simone in the gymnastics field. Thinking through how do we amplify our voices is about really branding yourself as a therapist and letting people know, these are your skill sets. This is where you're an expert, and this is how you serve in the community.

For me, I brand myself as Coach Debbie in the community. And I speak at numerous organizations and nonprofits, from medical societies to NAMI, even Divine Nine Greek organizations. I really make it my goal to shift the stigma of mental health. So I even partner with churches to make sure that our faith-based community understands that they can definitely have their faith as a part of their journey, and a professional counselor is also available to help and support in issues where just as if you had a physical concern, you would see a doctor, or a mental health concern, you see a doctor.

So I know that you all understand what I'm saying. So I hope that you're envisioning, how do you brand yourself to stand out as a therapist so you become the go to person in the community that's really helping people in their journeys to heal and change their lives.

INA RAMOS: Thank you, Debbie. Jeff or Curtis?

CURTIS WARREN: I concur. Any opportunity that I get to connect the network with professionals in the field, I always look at it as an interview. And I'm always trying to figure out how I can partner in some way. Like Debbie, I am a coach. So I have a mentor. He actually was on the line, I think he dropped. But Dr. Jackson down in Arkansas, he always tells me that traditional talk therapy is good, but how can you brand yourself and how can you have multiple fields of income?

So I think it's just the branding, and knowing that there's opportunities. Knowing that there's not one way. So it's like this, that, and. If I'm kind of in that whole and, exploring the opportunities outside of traditional talk therapy. Just having to practice hanging your shingle and your shield and just say, hey, I'm taking clients.

I think that with the advent of technology, whether it's clubhouse or other public forum, whether YouTube, being able to identify yourself as a brand and really being able to market yourself. And I think that is not for everybody, but know your lane. As far as professional networks, if you want to go on to a PhD, you shouldn't have to pay for it. There's a lot of money, professors, and research out there to help facilitate that at any master's level. People are always looking for fellows and looking for people to work with, to engage to mentor and to have that continuity.

So I think that there's a lot of opportunities. Think outside the box. Look at your professional network around you. And just realize that you're not an island. So it's not about whatever city you're in. We have modern technology. Get on the internet, research, engage, look at journals, make contact with people that are doing things that you're doing. I'm Black. My focus is men, Black men. So I'll network with other people that are doing what I'm doing in other cities throughout the country, and now throughout the world through mediums like Clubhouse. And thanks, folks, Debbie for sharing that.

INA RAMOS: Thank you, Curtis. Jeff, did you want to kind of wrap it up for us sharing your views?

JEFF CAPPS: Yeah, sure. Yeah, I just graduated last year. Take what I say with a grain of salt, I guess. But I would say part of the beauty of this work and this field is that there's so many different directions to go in. And so I don't know, I would just encourage everybody to just follow their passion, what their interested in. Really take time to reflect on why is it that you came into this work, why are you continuing this work, where do you want to go with this work five, 10 years from now? And let that inform what you do right now.

I guess the main advice I have usually is question everything. I feel like it's great to look at what we take for granted and just dig into it and see what perspectives might be missing. Maybe see what's missing within your communities or maybe what they're wanting, and then see if there's somehow a match with what you can bring to the table.

And like stepping into your voice, not being afraid to say or do what seems to be needed. So I don't know. That's not very organized, but I hope perhaps helps.

INA RAMOS: It was perfect, Jeff. Thank you. So we want to thank our four presenting fellows, Shahrzad, Jeff, Debbie, and Curtis, for your amazing presentations today. This has been wonderful. And we want to

thank the participants for joining us today, and we hope that you have been inspired by the information that was presented today.

In closing, we would like your feedback on this webinar. Before disconnecting, please feel like the link found in your Zoom group chat to complete a brief survey. And this is going to conclude-- this is our final webinar for the webinar series in 2021, and we look forward to bringing you more engaging content in 2022. So thank you so much. Enjoy the rest of your day.