APTC BULLETIN

A Practicum Education & Training Medley

A Publication of the
Association of Psychology Training Clinics
https://aptc.org

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(a) promote high standards of professional psychology training and practice in psychology training clinics;

(b) facilitate the exchange of information and resources among psychology training clinics that provide doctoral-level practicum training in professional psychology; and

(c) interface with related professional groups and organizations to further the goals of APTC, including influencing the establishment of standards and guidelines on service delivery and training of future psychologists.

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An APTC Medley

Heidi A. Zetzer, Ph.D., University of California, Santa Barbara
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Being a practicing psychologist and especially directing a training clinic requires a medley of knowledge and skills. So too, the members of APTC are a valuable medley of diverse backgrounds, training programs, and skill sets. Some of us run tiny programs and others have 100+ trainees! On a daily basis we call on our specific skills and experiences related to therapy and assessment for sure—and also on what we know about medicine, nutrition, infectious disease, social policy, the law, history and its precedents, IT, web design, accounting, interior design, politics, fundraising, event planning, and sometimes spycraft. We manage people and space and resources. We are responsible for our own goals and other people's goals—and we deliver. And often, despite sometimes being characterized as the backing vocals, it is the clinic director who carries the weight of the program and "keeps the band together." APTC members are always willing to share their resources and expertise—no need to "reinvent the wheel"—just customize one that is already rolling. That willingness to share is what makes the *APTC Bulletin* something to look forward to, a way to connect with the ideas and innovations of our creative colleagues.

This issue of the *APTC Bulletin: Practicum Education & Training* (PET) is a medley of people, places, and perspectives on teaching, training, directing, supervising and surviving as a psychology training clinic director. Like most APTC "work products," each article consists of essential and inspiring investigations, descriptions, and insights centered on directing a clinic. Several of the pieces in this medley originated as a poster or presentation at the APTC Conference in Albuquerque, New Mexico in March 2023, and we are delighted that the authors were able to craft a written version of their work for this issue of PET. Other pieces are original to this publication and offer readers a fresh look at common concerns or yield brand new ideas altogether!

This issue is a marvelous collaboration among the authors, editors, and ad hoc reviewers who recently joined the collective effort to produce a juried periodical that is informative, engaging, and a smooth read. Special appreciation goes to the ad hoc reviewers who contributed their wisdom and encouragement to the authors who contributed to this issue. The ad hoc reviewers are:

- Deanna Barthlow, Ph.D., Indiana University-Purdue University Indianapolis
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Heroes of the Realm

Scott Gustafson, Ph.D., ABPP
Florida Institute of Technology

When I was thinking through what to write about in the president's column for this issue, my first thought was to highlight some of the extraordinary things our members are doing, discussing some examples, and titling the column "Heroes of the Realm."

There are some important examples that I wanted people to know about. Many of whom you're probably aware of, like Dr. Jordan Wright, who has put in many unpleasant hours working with Pearson on our behalf to preserve the training clinic discount for assessment materials. Or Dr. Nancy Liu, who just won an award for just astonishing levels of innovation in her clinic in California, or Dr. Dani Keenan-Miller who has been serving at the APTC Secretary while fighting for an ethical and transparent analysis of the Examination for Professional Practice in Psychology (EPPP) Phase 2.

But the more I thought about it and started jotting down examples, the bigger the list became. And the more personal it became. People like Dr. Lettie Flores, who works so hard behind the scenes at APTC to give advice, direction, and a voice of gentle reason that has concrete outcomes in the way APTC remains open, giving, and welcoming. Or Dr. Bob Hatcher, our president emeritus, who keeps coming to the executive committee meetings, long after he was required, to be our institutional memory. I keep calling him "The Giver," although I'm not sure he's thrilled with the reference. Dr. Kristy McRaney at Southern Mississippi came to mind for continuously stepping up to volunteer her technical skills that this old Gen X-er never picked up along the way, or Dr. Heidi Zetzer and Dr. Colleen Byrne for picking up administrative duties that need to be done (like this very publication, or representing us at APA, respectively).

The problem was, for every name I jotted down, I felt like I was excluding someone else who deserved specific recognition. Then Dr. Afton Kapuscinski wrote about an experience that many of us have: the loss of a student. As much as my heart ached for her, I was moved to see the outpouring of support, the kindness, the thoughtfulness, the warmth, and the wisdom that community encircled her with. She held strength and compassion for Syracuse, and you held it for her. It was possibly my proudest moment as President, and I had nothing to do with it.

That's what opened my eyes. As much as any one individual does for APTC, they can't hold the soul of who we are. The real Hero of the Realm is YOU. The people who are there for each other. The people who stop for lunch in each other's cities when we visit. The quiet private reply to a public question. The respectful disagreements and the value of consensus. I have never, and expect I will never, belong to an organization that I have so much love and affection for. It's been my primary professional home for almost twenty years now, even more than the individual universities that I'm housed in.

Clinic directors are a special breed: you need to be an academic, a clinician, an administrator, a mentor, an entrepreneur, and a mentor. I think we forget how unique the skillset is for this job. There are only a few hundred of us worldwide, and I think the nature of the job self-selects for some of the most giving, thoughtful, and competent people I've ever met.

I'm so proud of us. And proud of you. Those little acts of kindness and support build a gestalt bigger than any individual action or person: they build a community. The real hero here is you, and that makes me so happy.

—Scott

APTC DIVERSITY STATEMENT

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

Directing Training Clinics: The Art of Improvisation

William Salton, Ph.D.
Yeshiva University

Prologue

When I was in high school, I listened to "arena bands": The Rolling Stones, Journey, Fleetwood Mac, etc. They were great but more importantly, they were predictable. Every song sounded just like the record, and I knew what to expect. That was a good thing for a neurotic (remember that term?) teenager like me. Then one day, my buddy Nick (it seems like *every* high schooler has a buddy named Nick) took me to a Grateful Dead concert. I had heard a few of their songs and thought they were OK, so I agreed to go. Thankfully, my neurosis enabled me to refuse the ubiquitously proffered hallucinogens, but I paid rapt attention to the music. It wasn't like their studio albums. In fact, it wasn't like anything I'd ever heard. There were eight musicians melding one song into another, looking and listening to each other, following each other's leads, and becoming "one" with each other. I heard them get lost and then found a melody that turned into cacophony that changed beats and keys and turned into harmony and turned into a drum solo or two that then became another song that turned into… "What's this all about?" I asked Nick (who was somewhere between here and the stratosphere). "Hey man, that's improvisation… you never know what is going to happen at a Dead concert. The *band* doesn't even know what's going to happen. It's like magic, yeah?" Yeah. I really didn't know what was going to happen with the Dead, with Nick, or with me. But I did know that something pretty exciting was happening on that stage. I thought, "I want to learn how to improvise and make a little magic…"

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Dean Siegel said: "So Bill, we've got this training clinic. You're going to run it. The less I have to think about it, the more I like you." I asked, "Is there a job description?" He said, "I guess it's somewhere, but the deal is—you gotta train the students and treat the patients. Why do you need a job description for that?" I thought, because I never worked in a university before, because it's been a long time since I was in grad school, because you have three doctoral programs here that fight with each other, because I don't know what a purchase order is, because, because, because… Then I said, "Sure, I'll give it a shot."

And so, my "Grateful Dead clinic director experience" began. I knew what I had to do, and I knew I had to improvise to get there. I'll confess that I was more than a little nervous (shades of my adolescent neurosis?).

How do we improvise as training clinic directors? Why not start by taking our cues from the Grateful Dead? They had two guitars and a bass, two keyboards, two drummers and up to five singers; and they had to get through the concert. I had 175 students, three mercilessly competing doctoral programs, 35 faculty members (who rarely visited the clinic but wanted to dictate its policies), about 10 rooms with VHS video recorders, an administrative assistant with a heart of gold from the "hood," and we had to treat a New York borough full of prospective patients who desperately needed our services, but had no idea that we existed. I had my "band" and I had to help them "play" so that I could create a clinical whole that was more than the sum of its parts. Along with the Dead, I channeled George Vaillant, a psychologist whom I had cited in my dissertation. In *Adaptation to Life* (1995) he detailed his own version of improvisation, which utilized "mature defense mechanisms," such as affiliation, altruism, anticipation, humor, self-assertion, self-observation, and sublimation. "I'll take all of those, along with a shot of rhythm and blues," I thought.

In the rest of this article, I will try to depict three instances of how I improvised and "wrote the tune as I played the notes," to develop one of the largest training clinics in the country. (But of course, if you're reading this, you already know what I'm talking about.)

Funding and Clinic Moves

My first training clinic was situated in a dark and humid basement in a poorly maintained academic building in the Bronx. Although we preached social justice, it seemed like this dank setting was more accommodating and respectful to the water bugs than to the patients, and I believed that our institutional disrespect was directly proportional to our no-show rate. Not surprisingly, this troubled me more than it troubled my university's administrators and the money to move or renovate the clinic was theirs to withhold and mine to raise. And since there was no course on fundraising in my graduate school, I had to improvise. I pitched the value of

my clinic to local politicians whose constituents were our patients. After two years, many meetings and many doors that closed, I raised two million dollars, and we were rockin' and rollin'.

Or not. I knew nothing of blueprints, renovations, moving companies, web-based video platforms and I am a lousy interior decorator. So, I formed a "band" that could play many instruments. A T.A. with an architect mother taught me to read blueprints. I wrote a "technology R.A." into our new budget and my clinic administrator had a great color sense. (As Sir John and Sir Paul [1967] once said, "I get by with a little help from my friends.")

The Pandemic (with a twist)

March 2020 really did "come in like a lion" and we all had to improvise very quickly. Telehealth, out of state students and supervisors, HIPAA compliant email, Business Associate's Agreements, plastic screens for assessments, legal conundrums, and protocols, protocols, protocols. We were all scathed, and some of us were traumatized. But how do you improvise when someone in your team/band starts to believe that the pandemic was caused by extraterrestrial beings? And your not-believing in the existence of aliens becomes perceived as persecutory behavior? Time for more musicians to join the band! Cue legal, cue risk management, cue human resources and cue the provost's office. "What kind of 'solos' are you all going to play to help me improvise my way through this number?" I also learned to add "paper trail" to my cadre of mature defense mechanisms. Rest assured that everyone's OK now, but this "song" came close to breaking my heart.

SCOTUS

In the fall of 2022, Yeshiva University entered a legal dispute with its Pride Alliance of LGBTQ students. As of this writing, the dispute continues, and the case is in the Supreme Court of the United States (SCOTUS). To say the least, it is "complicated" from legal, moral, ethical, and spiritual perspectives. For a year, the university has been a boiling cauldron of controversy with numerous sparks and ignitions. I also had no courses on this in grad school; Vaillant did not write about it and even my beloved Grateful Dead did not sing about it. (Where is my buddy Nick when I need him?) However, I still had a clinic to direct, and my challenge was still to create harmony amidst cacophony. After some reflection (while listening to "The Music Never Stopped" [1974], one of my favorite Dead tunes), the improvisational answer became quite clear. There is no need for improvisation here. Our mission statement says that our clinic is for "everyone" including Orthodox Jews, LGBTQ folx, Orthodox Jews who are in the LGBTQ community and LGBTQ folx who are in the Orthodox Jewish community. So, when the lawsuits began, we re-posted our joint mission of training students and treating patients and invited anyone who needed help to come to the clinic. When people came, we gave a lot of thought to patient-clinician matchups and we kept everything confidential.

Epilogue

There really is no epilogue. The improvisation continues. The mature defenses function. We know that a unique aspect of our job is that we can never guess what will happen on any given day. It could be a tough patient, a narcissistic faculty member, an ignorant administrator, a challenging legal issue or a troubled student. We thrive on these scenarios and figure them out as we go along without a manual, policy, or protocol (except during the pandemic.) We pause, we brainstorm, we segue, we consult (often with our APTC colleagues), we try to laugh and eventually, we solve problems…until the next unexpected scenario comes along. Because, as the good ole Grateful Dead wisely sang, "The Music Never Stopped."

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The Current State of APTC

Sarah M. Thompson, University of Tennessee

Danielle Keenan-Miller, University of California Los Angeles

For those working among academic colleagues who don't fully understand the work and concerns of university training clinic directors, obtaining support and suggestions from those who 'get it' can be invaluable. In that spirit, the Association of Psychology Training Clinics (APTC) Research Committee sent a survey to the APTC listserv in January 2023 to better understand the current state of health service psychology training clinics and the recent experiences of clinic directors. All APTC members were invited to participate in the survey via several emails in January and February 2023. Here, we summarize the results of the survey (Keenan-Miller & Thompson, 2023) in the hope that these data can support clinic directors in their efforts to advocate for themselves and their clinics.

Out of a total of 214 APTC members, 106 full members, three associate members, and one international affiliate completed the survey. The majority of respondents (80%) indicated that they hold faculty positions, with 66% in non-tenure-track faculty positions and 14% tenured or tenure-track. A total of 19% of respondents indicated that their position is designated as an administrative or staff position. Most report to the chair of their department (66%), the director of clinical training (DCT; 16%), or the dean (10%).

Most respondents reported involvement in administration (96%) and clinical supervision (93%), spending an average of 36% of their time on administrative tasks and 29% of their time on supervision each week. Teaching (79%) and service to the department or university (74%) are also common tasks, with respondents reporting that they spend an average of 17% of their time teaching and 7% of their time on service each week. A total of 30% of respondents are responsible for organizing external practicum placements, while 28% provide direct clinical services and 28% engage in research. Additionally, most respondents (62.1%) have some on-call responsibilities.

Salary data is understandably an area of strong interest for APTC members. Results of the survey indicated that clinic directors receive an average salary of $104,181 per year (*SD* = $25,891). Associate directors reported an average salary of $81,250 (*SD* = $5,619), while those holding the position of DCT receive an average salary of $113,446 (*SD* = $32,077) per year. Salary did not significantly differ depending on length of appointment, with an average salary for 9-month employees of $92,373 (*SD* = $29,870) and an average salary for 12-month employees of $98,907 (*SD* = $25,521).

Average annual salaries for clinic directors (not including associate directors) are $85,060 at the assistant professor level, $102,239 at the associate level, and $117,080 for full professors; these figures include both non-tenure-track and tenure-track faculty. The average annual salary for those designated as lecturers is $81,500, and those in staff positions reported an average salary of $101,738. A breakdown of associate clinic director salaries by position is not possible due to the small sample size (*n* = 3).

Approximately half of all respondents (51%) regularly receive professional development funds and 27% sometimes receive them. The average amount of professional development funds respondents receive per year is $1,735 (*SD* = $1,079).

Based on the results of the survey, clinics serve an average of 29 trainees (*SD* = 30.9) per year. Most clinics (81%) have 30 trainees or fewer, with a range across clinics of six to 200 trainees. The number of clinical supervisors in APTC clinics ranges from one to 150, with 49% of respondents indicating that their clinic utilizes the services of five or fewer supervisors and 81% reporting 10 supervisors or fewer. Approximately half (53%) of respondents rely on supervisors from outside of the program to conduct clinical supervision. Of those, 69% of community supervisors are paid. Most clinics (77%) require their supervisors to be licensed.

Supervisors oversee a maximum of zero to 15 trainees conducting therapy, with an average of 6.2 trainees (*SD* = 3.0) per supervisor. For trainees conducting psychological assessments, supervisors in APTC clinics oversee a range of zero to 16 trainees with an average of 5.9 trainees (*SD* = 3.2).

Approximately a quarter of clinics (24%) have an associate or assistant director. Most (74.5%) employ professional office staff with an average of one staff member per clinic. A total of 81.2% of clinics employ graduate students, with an average of 1.6 graduate students per clinic, while only 29.5% utilize undergraduate staff, employing an average of .4 students. Few clinics (9.5%) have postdoctoral fellows.

Clinics also vary widely in terms of the number of clients seen per year with a range of zero to 1400 clients. After removing two clinics who see more than 650 individuals per year, the median number of clients who receive services in APTC clinics is 130 clients per year. A total of 14% of clinics provide services to 50 or fewer clients per year, 29% see 51-100 clients, 29% see 101-200, and 16% see 201-300 clients per year. Respondents indicated that the typical maximum therapy caseload in their clinics ranges from zero to 25 clients, with an average of 5.6 therapy clients per trainee (*SD* = 3.7). The average maximum caseload for psychological assessment is two clients (*SD* = 1.0) with a range of zero to four clients.

Rates for clinic services also vary. For therapy services, APTC clinics charge between $0-$250 per session. The median minimum session fee is $5, the median maximum fee is $50, and the median typical fee per therapy session is $15. Prices for psychological assessments range from $0-$4,000, with a median minimum fee of $200, median maximum fee of $700, and median typical fee of $400. A total of 57% of clinics included in the survey earn $50,000 or less in revenue per year, while 87% earn $100,000 or less. Six clinics earn $0 in revenue annually while three earn more than $400,000 per year.

Among clinics included in the survey, 83% of respondents reported using electronic health record systems, with 80% utilizing Titanium, 5% employing TheraNest, 4% utilizing Point N Click, and 3% using Therapy Notes. Other systems in use by APTC member clinics include privately developed systems, Box, CureMD, My Best Practice, Office Ally, Owl, Penelope (Social Solutions), Therapy Appointment, and Therasoft.

Most clinics represented in the survey (72%) engage in routine outcome monitoring. Interestingly, the most common method is completing measures via paper and pencil. Qualtrics, OQ Measures, Owl, RedCap, Mirah, Point N Click, Titanium Web Component, and My Best Practice are also employed. While slightly more than half of clinics (52%) included in the survey currently collect data for research, only 33% of clinics presented posters or presentations based on clinic data in the year prior to the survey, ranging from zero to 10 presentations, while 23% published peer-reviewed articles, ranging from one to seven publications. Overall, clinics averaged a total of 1.2 posters or presentations (*SD* = 2.1) and .5 peer-reviewed publications (*SD* = 1.1) in the past year.

Most clinics (95.5%) are currently utilizing telehealth, including Zoom (59%), Microsoft Teams (11%), and WebEx (6%). On average, telehealth is currently being used in 30% of therapy cases, 8.5% of assessment cases, and 27% of supervision. Moving forward, 72% of respondents reported they plan to continue using telehealth to provide therapy while 68% indicated they intend to utilize telesupervision in their clinics. A minority (30%) reported their clinics would continue to provide teleassessment while 15.5% indicated that their clinics would only utilize telehealth in unique circumstances moving forward. When asked what methods they employ to train students on the use of telehealth, most reporting utilizing webinars from the American Psychological Association (66%; Maheu, 2019), didactics provided by the clinic director (60%), and readings on best practices (59%). Other methods include other webinars, discussion in supervision, formal coursework, requiring trainees to read state guidelines on the use of telehealth, and role play.

Finally, respondents provided qualitative responses to open-ended questions assessing the best aspects of leading a clinic and respondents' advice for new clinic directors. The best aspects of leading a clinic were most frequently identified as: 1) working with students, 2) watching students develop into skilled professionals, 3) having a positive impact on the community, especially serving under-resourced clients, 4) providing clinical supervision, and 5) engaging in a variety of activities and roles within the position.

Respondents identified their best advice for new clinic directors as: 1) reach out to and consult with other APTC members for emotional and practical support, 2) work closely with faculty and administration in your program, department, and university: develop supportive relationships and facilitate buy-in around your efforts in the clinic, 3) take it one step at a time in this role and be patient with yourself, 4) don't reinvent the wheel: obtain resources and examples from other directors and the APTC website, and 5) advocate for your clinic's needs.

Hopefully, this information will assist APTC members in continuing to serve their trainees and local communities while also supporting their own professional development and well-being.

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Training Clinic Survival in an Age of Limited Resources:
Lessons Learned from Fellow APTC Colleagues

***Stephanie McWilliams, Ph.D. & *Sarah Taber-Thomas, Ph.D.**
* denotes co-first authorship

Stephanie McWilliams, Ph.D.

Sarah Taber-Thomas, Ph.D.

Feel like you are juggling and don't know which ball will drop first? "Yep…same," replied every clinic director far and wide. As clinic directors, we are expected to "wear many hats" and be eternally flexible and adaptable with our time, resources, and expertise. With this challenge in mind, the APTC sustainability committee sought to better understand barriers faced by clinic directors, as well as strategies used to build and sustain successful clinics. Surveys were collected from 35 training clinic directors in the fall of 2022 to identify barriers to and facilitators of sustainability in five key areas needed to run a training clinic: supervision, services (client flow), systemic sustainability (i.e., integration within the larger institution and/or community), finances, and the clinic director position as a whole. In addition to qualitative responses, directors were asked to rate the extent to which each domain was a barrier to sustainability of the clinic, with scores ranging from 1 (*to little or no extent*) to 6 (*this is the most impactful barrier the clinic faces*). This article will discuss results from the survey, with a focus on sustainability strategies in various dimensions that have been applied successfully within specific training clinics, as well as potential barriers to sustainability (see Table 1 for a summary.)

Supervision

As clinic directors, the supervision of students is one of our primary, and potentially most gratifying, tasks. Not surprisingly, supervision was also listed as one of the greatest challenges in our survey. The most common barrier described was not having enough supervisors to cover the students' caseloads, with this burden falling largely on clinic directors (e.g., "I am supervising way too many people as the director, while also teaching required courses," "Too many supervisees for just one person [myself]," "The load on the clinic director is nearly unsustainable given all the other demands of being clinic director and director of training for the Ph.D. program"). This is only made worse by difficulty recruiting and paying high quality supervisors, whether that be during the academic year or during summers. In addition, concerns regarding a lack of supervisor expertise in desired/needed areas was also discussed. The types of challenges faced appeared to vary depending on the supervision models used and specific job responsibilities of the clinic director. For example, nearly half of clinic directors (47%) reported that programs rely solely on internal supervisors, typically faculty (both tenure track and professional track) and/or the clinic director. Notably, one-third of clinics reported that the director is the only supervisor! This diversity in supervision challenges was reflected in the overall rating of supervision as a barrier to sustainability. Specifically, while supervision was rated as less of a barrier on average (M = 2.10, SD = 1.60), 35% of directors rated this as a moderate barrier or higher.

Table 1
Summary of Sustainability Challenges and Strategies Reported by Clinic Directors

Domain	Barriers/Challenges	Strategies
Supervision	• Not enough supervisors to cover students' caseloads (i.e., too many students and too many clients for one person) • Cost of external supervisors and/or summer supervisors • Reluctance of program faculty to supervise • Lack of supervisor expertise	• Capping supervision caseloads to reduce burden • Recruiting volunteer supervisors (e.g., local psychologists in private practice) • Using post docs and peer supervisors (e.g., vertical supervision model) • Incentivizing supervision (access to library resources, professional opportunities within program) • Offering course release for faculty supervising in summer • Advocating to the department for increased support
Services (Client Flow)	• Establishing referral streams • High demand for services • Shrinking student cohorts • Change in expertise or specialty services offered • Insufficient client diversity	• Marketing and outreach to campus and community partners • Maintaining website to advertise services • Use of waitlists; at times closing the waitlist • Establishing quality referral lists of other local providers • Increasing minimum requirement for student caseload • Expanding teletherapy
Systemic Integration	• Other offices/programs on campus have limited knowledge about the clinic and services available • Need for differentiation from counseling center on campus • Limited time to engage in outreach given other responsibilities • Limited access to services for community members from underserved populations	*Within the organization* • Networking, collaboration, and outreach on campus • Educate and build relationships with administration, legal, human resources officials • Speaking engagements • Service on committees across University • Close working relationship with department Chair *With the community/public* • Outreach and relationship-building with potential referral sources and other community organizations • Offering presentations to the public • Advertising about clinic services/programs • Attending community events • Social media • Serving on boards/committees within community organizations
Finances	• Expectation to cover costs of running the clinic (e.g., salaries, GA funding, training supplies, office supplies) • Low revenue generated by client fees	• Increasing assessment fees and number of assessments provided • Reducing spending/ cutting costs • Diversifying funding sources • Advocating for departmental support • Seeking external funding via grants and/or donations • Fundraising
Clinic Director Position	• Balancing the sheer number of responsibilities (e.g., administrative duties, supervision, teaching, budgeting, technology, outreach) • Supervision load is too high • Teaching load is too high • Personnel issues (incompetence, poor salaries) and insufficient staffing	• Capping supervision caseload • Use of vertical team model for supervision • Requesting reduced teaching load • Limiting departmental and college-level service obligations • Use of technology to stay organized • Learning to say "No" • Advocating for administrative support • Hiring graduate student assistants to work in the clinic

For clinics utilizing external supervisors, 37% reported that these supervisors are paid while 10% reported they are volunteers. One clinic listed multiple strategies to recruit pro-bono supervisors (e.g., connecting with nearby private practice practitioners, networking with colleagues, using professional listservs). To incentivize pro-bono work, some programs offer benefits, such as providing access to library resources and other professional opportunities within the program (e.g., guest lectures, presentations). Additional strategies used to address the broader supervision challenges included capping the supervision caseload, using peer supervision and/or postdocs to ease the supervision burden, and advocating to the department/chair for additional supervision support. A couple clinics also indicated that they have specifically worked on hiring professional track faculty who express an interest in supervision and/or who might be dedicated to that supervision (i.e., teaching faculty and private practice psychologists).

Services (Client Flow)

A second key area of sustainability is client flow. On average, directors rated insufficient client flow as a minimal barrier to clinic sustainability (M = 1.90, SD = 1.10), with many directors noting the opposite problem: a high demand for services resulting in long waitlists. There were a wide range of successful strategies described to establish client flow, including advertising to undergraduate instructors, marketing and outreach to referral sources (e.g., school districts, primary care offices), and advertising on a clinic website. Directors' responses suggest that stability in client flow, rather than sufficient referrals, is one of the most impactful challenges. This is exacerbated by a variable (and often unpredictable, as noted in APTC meetings) number of student clinicians available to see clients across semesters. Incoming cohorts appear to be shrinking, while client needs have grown. Some clinics depend on funding from client encounters for financial sustainability, which can be a real problem when numbers fluctuate greatly. Changes to therapeutic offerings due to a change in expertise or specialties can also make the balance of referrals tough as clinics become known for specific, specialty services.

Directors also noted insufficient diversity in the clients served as another challenge to sustainable client flow, particularly in terms of providing adequate training for students. The primary solution offered was to increase teletherapy offerings to access more diverse populations throughout the state. With the ever-growing need for mental health services in communities across the country, high demand and long waitlists were frequently listed as both a challenge and a benefit for clinics. Ensuring wait times are not excessive can be difficult; however, with more potential clients calling in, students can diversify their portfolio. Some respondents noted the importance of having reliable referral options for clients who do not fit clinic expertise or capabilities, or will have to wait too long on a waitlist. Some clinics have also increased minimum caseloads to handle higher volume. And on the upside, little to no marketing is required when a predictable and regulated flow of clients is being added to the waitlist.

Systemic Sustainability (Integration with Institution)

Another key area of sustainability surveyed was integration within the larger department, program, and university, which is essential for smooth clinic operations and for maintaining the institution's interest in providing financial support. Items used to assess integration were adapted from the Program Sustainability Assessment Tool (PSAT; Luke et al., 2014), and ranged from 1 (*to no extent*) to 6 (*to the highest extent possible*). On average, clinic directors reported moderate levels of leadership support within the larger organization (M = 4.27, SD = 1.14), with 73% rating the item "The program has leadership support from within the larger organization" as moderate or higher. In contrast, support from outside the organization was rated lower, including little external leadership support (M = 2.50, SD = 1.55) and some public support (M = 3.63, SD = 1.40). Directors also reported that, on average, clinics moderately demonstrate their value to the public (M = 3.83, SD = 1.31) and are moderately well-known (M = 3.73, SD = 1.34). Less common is the explicit use of strategies to promote systemic integration, such as partnering with community leaders (M = 2.90, SD = 1.40) and adoption of communication strategies to secure and maintain public support (M = 2.93, SD = 1.46). Overall, lack of integration within the larger institution was not identified as a notable barrier to clinic sustainability (M = 2.43, SD = 1.25), with 50% of directors rating this as "to no or little extent."

Nonetheless, nearly half of directors (44%) reported that they engage in networking, communication and outreach on campus to other offices, programs and clinics. The next most reported common strategy to promote systemic integration was to educate and build relationships with university administration, including department chairs, the Bursar's office, the provost, and human resources. Approximately 20% of clinic directors reported that they did not see a need for integration, either because the clinic was embedded within other services on campus (e.g., a wellness center), or due to concerns about eliciting increased scrutiny/monitoring. Strategies to promote integration within the larger community most often included outreach, such as building relationships with potential referral sources, offering free presentations to the public, marketing and advertising about the clinic's services, and attending community events (e.g., health fair). Two clinic directors reported use of media, such as news stories and social media accounts to promote clinic services. Notably, several directors reported that while this was something they hoped to do, they either did not have enough time or already had a strong reputation in the community such that this type of outreach and engagement was no longer needed.

Finances

Financial sustainability is top of mind for most directors, particularly when clinics are expected to be self-sustaining and/or revenue-generating. Thankfully, this appeared to be the exception rather than the rule, as many directors reported that they receive a range of financial support from the department and/or larger institution. Overall, finances were rated as a moderate barrier to sustainability (M = 3.40, SD = 1.30). Common costs incurred to run the clinic included salaries of other staff, graduate assistant funding, training supplies, office supplies and undergraduate assistants. When asked about sources of funding, on average clinic directors reported two or more funding sources (e.g., client fees, department funds, university funds, grants, donations). This suggests that diversifying income sources is key to increasing a clinic's bottom line and overall outcomes. The most common strategies to promote fiscal sustainability included increasing assessment fees and the number of assessments provided, reducing spending, grant-writing, and requesting departmental support. One of the more unique strategies reported was fundraising efforts of a variety of sorts, including seeking donations from local politicians.

Clinic Director Position

Finally, on the whole, directors reported feeling overwhelmed by the quantity of things on their task lists on a regular basis. Capping numbers of supervision caseloads, partnering with other supervisors, utilizing a vertical team model (with mid-level or student supervisors-in-training), limiting departmental and college-level service obligations, and using tech to stay organized were all listed as potential solutions. In addition, consistent with themes that emerged at the 2023 APTC Conference, learning to delegate responsibilities where appropriate, learning to advocate for oneself, and learning to say "No," were noted as well. Directors also offered solutions such as arguing for a reasonable (read smaller) teaching load in order to manage clinic responsibilities, deciding how to manage poorly performing students or personnel, and making clear the need for administrative support (often achieved through a graduate assistant position). In sum, by utilizing such strategies, or finding a combination of strategies that work in your specific clinic, the goal of increasing productivity and positive outcomes while decreasing "busy work" and burnout just may be achievable.

Thank you to APTC directors for sharing your tips, tricks, expertise, and problem-solving skills to this endeavor!

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TELEHEALTH AND TELESUPERVISION WITHIN PSYCHOLOGY TRAINING CLINICS:
Overcoming Challenges and Creating Positive Change

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In response to the COVID-19 pandemic, practitioners of psychology, and directors of university-based psychology training clinics specifically, were forced to abruptly pivot to telehealth services and telesupervision. Moving forward, it will be important to be guided by the literature as the field determines what role telehealth services and telesupervision play in service provision and training. While the field continues to evolve, there is support for the feasibility and positive outcomes of telehealth service provision. For example, group psychotherapy provided via telehealth produces comparable outcomes to group therapy conducted in person (Gentry et al., 2019). Individual psychotherapy conducted via telehealth is associated with positive user satisfaction and achieved similar outcomes to face-to-face psychotherapy (Backhaus et al., 2012). Patients report "comparable treatment satisfaction as well as similar ratings of therapeutic alliance" as compared with face-to-face therapy (Jenkins-Guarnieri et al., 2015, p. 652). And especially important for the APTC readers, positive therapy outcomes for clients attending services in a psychology training clinic specifically have been noted (Rowen et al., 2022).

Supervision is just as important to consider, especially for training clinics. Ensuring quality, ethical, and accessible supervision is at the core of training budding psychologists (American Psychological Association [APA], 2014). At this time, less is known about how telesupervision compares to in-person supervision of psychologists in training. Overall, trainees report that this modality reduces barriers to accessing supervision and increases access to competent supervisors from the trainees' perspective, and there are no significant differences in supervisee satisfaction or ratings of supervisory working alliance from the perspective of the trainees (Tarlow et al., 2020). Over 90% of trainees reported that telesupervision met or exceeded their expectations, and generally trainees believe that telepsychology can be a positive component of training (Bernhard & Camins, 2021; Thompson et al., 2022). Overall, current psychology literature suggests that telehealth service provision is "here to stay" and is comparable to face-to-face supervision. The literature further suggests that telesupervision, when conducted thoughtfully, is a useful and beneficial method to incorporate into psychology training programs (Perle & Zheng, 2023; Phillips, et al., 2021).

APTC Clinic Directors believe that there are strong reasons to include training in the use of telehealth and telesupervision that is well aligned with the APA Ethics Code (Keenan-Miller & Thompson, 2023). The principles of the APA Ethics Code appeal to the highest aspirations of ethical psychologists. The principles of beneficence, nonmaleficence, and justice are especially relevant to the continued use of telehealth and telesupervision. Practically, this means that clinic directors should attempt to minimize harm to trainees and clients by advocating for continuation of practicum training in, and the supervised delivery of, telehealth and telesupervision (Knapp et al., 2017; Tarlow et al., 2020). With regard to the latter, dispensing with or strictly limiting virtual modalities during training could be unjust, as it creates unfair financial and time burdens on trainees, clients, and supervisors (Rowen et al., 2022). Indeed, there is a danger that some supervisors, particularly supervising psychologists who volunteer their time, will opt out of providing this critical service to training clinics. Losing these critical supervisors (and their years of wisdom and experience) is potentially disastrous to those programs that have long built their practica around the willingness of supervisors to volunteer and to quite literally put their time and money towards the supervision of doctoral trainees who will be the next generation of psychologists.

The ethical standards that cover competence, human relations, and education and training are the most relevant to telehealth and telesupervision. The ethics standards on competence state that students must receive adequate training in telehealth before providing clinical services. Fortunately, there are many such resources, some created by APA. Supervisors can receive similar training in telesupervision, gaining competence through advanced certifications such as The Trust's Telepsychology Competency Credential (The Trust, 2022). Human relations standards

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mandate that psychologists avoid unfair discrimination, minimize harm, and avoid exploitation. It can be argued that rescinding telehealth for clients and/or telesupervision for trainees who have limited or no other access to in-person services, or who are disabled (physically or by mental illness) or disadvantaged (lacking money and/or transportation) is discriminatory, harmful, and exploitative.

Studies examining both interest in and access to telehealth mental health services have demonstrated that accessibility varies based on a number of factors including location, resources, and need. While there are some limitations in terms of access to care for mental health services delivered via telehealth, younger potential clients, especially in rural areas, as well as older potential clients more generally, expressed interest in receiving mental health services via telehealth, and would utilize those services if they had adequate internet connectivity (Weinzimmer et al., 2021). Changes that were temporarily allowed in 2020 resulted in telephonic mental health treatment availability for 95.5% of Medicare subscribers who are over 70 years of age (Lepkowsky, 2020). These trends indicate that psychology trainees will be graduating into a field that has created space for hybrid care, which includes telehealth services.

In order to more clearly understand how APTC clinics are currently utilizing telehealth and telesupervision, the APTC Telehealth Work Group conducted a survey in May 2023 which received 74 responses (out of 200) from clinic directors. The survey results indicate that 95% of the clinics that responded are using telehealth and/or teleassessment to some degree. A similarly large percentage of clinics (93.7%) reported providing training to student clinicians before telehealth or tele-assessment services are delivered. The APA Best Practices webinar was the most commonly used training, along with APA readings (APA, 2013). Other resources that were utilized included training through health insurance companies, didactic exercises, clinic specific web courses, additional empirical readings, and security training.

As far as the frequency of telehealth utilization, "some" was the most common response, meaning a combination of in-person and telehealth encounters are occurring in most clinics. Services offered via telehealth include individual therapy (37%), group therapy (43%), family/couples therapy (28%), and assessment (19%). These percentages reveal a balance of in-person and virtual services already occurring in our training clinics. A similar trend is present for supervision, where 60% is being conducted in-person, and 35% is being conducted via telesupervision, with the remainder occurring over the phone.

In general, the vast majority of clinic directors reported improvements in accessibility to services (over 90% of surveyed directors), continuity of care to clients (87%), no show rates of clients (73%), students' abilities to meet training requirements (63%), student mental health (53%), and student-patient communication (35%). Regarding telesupervision, a similar trend of overall improvement was reported, with specific improvements reported in accessibility to supervision (87% of directors), student mental health with telesupervision as an option (85%), continuity of care (66%), student-mentor communication (32%), students' abilities to meet training requirements (53%), and no-show rates of students (41.5%). Other noted benefits of telehealth included convenience (for both students and supervisors), reduced commuting stress/demands, and reduced childcare needs. Some clinics reported offering lower cost services due to the accessibility and convenience of telehealth. Increased competency was noted by many directors as a training benefit. Finally, reduced family stress, the ability to reach underserved and more diverse populations, and an overall reduction in stress was emphasized with access to telehealth and the ability to conduct supervision remotely.

A few challenges with telehealth were noted, including concerns regarding the appropriate (or potentially inappropriate) use for certain cases (i.e., child clients with attention-deficit/hyperactivity disorder [ADHD]). Navigating the jurisdictional laws and staying apprised of changes throughout the emergence and evolution of telehealth and

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telesupervision was also identified as a challenge. Ensuring the environment can be distraction-free and minimizing technical difficulties were also listed as concerns.

As clinic directors in APA and Psychological Clinical Science Accreditation System (PCSAS) accredited programs, we are dedicated to providing training that prepares students for work as license-eligible psychologists in our communities; indeed, ethics standards on education and training require that we take "reasonable steps" to do so. Keeping telehealth and telesupervision as a routine part of didactic and practicum training is essential for training the next generation of psychologists. As directors, we have a unique perspective with a hand in each of these areas, making us uniquely qualified to decide what is the best approach for our students and clients, and our clinics as a whole. We take the responsibility to prepare and train our students very seriously, and with telehealth and telesupervision, we are able to increase both the depth and breadth of that training. Telehealth and telesupervision as resources are something that students and clinics will continue to rely on, and ensuring the proper training of our students so that they can proceed competently and ethically is our top priority.

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Trans-Affirming Care in Psychology

A Clinician Training Model

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Transgender and gender diverse (TGD) people, those whose gender identity does not match their assigned sex at birth (Giblon & Bauer, 2017), often experience significant stigma, discrimination, and minority stress (Cicero & Wesp, 2017). Many mental health consequences have been associated with these life experiences, including increased rates of depressive symptoms and risk for suicide (Giblon & Bauer, 2017). These struggles are coupled with a lack of trans- or gender-affirming mental health care (Fredriksen-Goldsen et al., 2014), and many TGD people report discrimination by healthcare professionals as a major deterrent to accessing health resources (Grant et al., 2011).

It is well established that gender-affirming care results in TGD people having fewer mental health concerns (Call et al., 2021). While trans-affirming training models have been explored in social work and nursing (Lim et al., 2015), the field of clinical psychology has been slower to fully integrate trans-affirming care into standard clinical training and practice (American Psychological Association [APA], 2015, 2021). Historically, mental health clinicians have received little specific education or training pertaining to the delivery of trans-affirming care to TGD clients (APA, 2015).

To address this training gap and respond to a student-expressed need for increased exposure to treating gender diverse clients, the University of Calgary Psychology Clinic (Alberta, Canada), in partnership with Skipping Stone Foundation (a local community organization serving TGD individuals), co-created a trans-affirming care educational workshop for clinical psychology trainees, staff, and supervisors.

A clinician training model for how to be affirming of gender identities

Our clinician training model was designed using a Students as Partners in Teaching and Learning (Mercer-Mapstone et al., 2017) pedagogical approach which has many benefits, including increased student engagement, greater understanding of the experience of learners, and better relationships with faculty instructors (Mercer-Mapstone et al., 2017). Current authors Caroline Luszawski and Michaela Patton are both graduate students who have been involved in the design and implementation of the workshop since its inception. Our workshop model was designed using a blended learning format with online and in-person material. Partnering with the Skipping Stone Foundation allowed participants to learn from those with lived experience.

Our partners at Skipping Stone Foundation created and narrated a series of four online modules, which included: What is Gender, Introduction to Core Concepts, Needs and the Barriers to Access, and Implementing Our Values Through Action. The modules were designed for beginner learners such that no prior knowledge was needed to participate and learn in the workshop. The online modules were provided to learners two weeks in advance of the in-person session to allow for self-paced learning. The modules served as a foundation for the discussion and case study presented at the in-person session.

Our two-hour in-person session consisted of a presentation led by a clinician from Skipping Stone, a small group case study discussion, a panel

discussion with clinicians, and an informal question-and-answer (Q&A) session. The in-person session was designed to build upon the base knowledge participants gained from completing the online modules and to provide an opportunity for group learning and discussion. When surveyed, all participants reported that the blended online/in-person approach was appropriate for this training workshop.

Participants included undergraduate (n = 3) and graduate students (n = 11), postdoctoral fellows/research scientists (n = 1), university staff (n = 3) and faculty (n = 1), and clinicians acting as clinical supervisors in the community (n = 7). The majority of participants had not yet had training in providing trans-affirming care (54%) or reported having little past training (42%). Participants were surveyed before starting the online modules and after completing the in-person session regarding comfort and confidence in providing trans-affirming services, and their willingness to serve TGD individuals in their lines of work.

Using paired sample t-tests, we found that after completing the workshop, participants were significantly more comfortable (M = 5.73, SD = 1.00) in providing trans affirming clinical care compared to before the workshop (M = 5.12, SD = 1.24), $t(25) = -2.31$, $p = .029$). Participant willingness to serve the TGD community in their line of work did not differ significantly after completing the workshop t (25) = 0.37, p = .713. This finding is likely because participants indicated in their pre-workshop surveys that they were already either very willing (73%) or moderately willing (23%) to serve TGD folks in their line of work.

Qualitatively, participants reported that having presenters with lived experience, the group discussion, the panel Q&A and practicing skills in a small group case study were all helpful for their learning. Participants reported that having more information on work with adult clients (as opposed to a child/adolescent focus) and more opportunities for interaction would have further benefited their learning. Most participants found that having a community and lived experience perspective in the training benefitted their learning (92%) and the majority (88%) would recommend this workshop to a colleague. Similarly, 84% of participants reported that they would be interested in attending another workshop like this in the future. Overall, these results highlight the self-reported efficacy of the workshop, as well as support for the design and implementation of the workshop, and highlight an interest in additional learning opportunities.

Future Directions

To our surprise, there is little information on the best methods to teach clinical psychologists trans-affirming care. Based on the qualitative feedback gathered from workshop learners, we plan to provide more opportunities in future workshops for experiential learning through smaller group discussions and offer either more online modules or breakout sessions to cover specialized topics (e.g., writing medical letters, working with TGD clients with a history of sexual abuse). Through the iterative process of delivering this annual workshop, we continue to learn, re-learn, and grow in the area of trans-affirming care. In line with our commitment to providing the best possible care to all clients, we will continue to evaluate the short- and long-term benefits of this training workshop with the hope that one day we can provide the formula for an evidence-based method to effectively train and educate the next generation of psychologists.

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Optimizing Assessment Supervision: Debuting the *Case Monitoring Form*

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In psychology, supervision involves the constructive, meticulous oversight of trainees' activities by a trained, knowledgeable professional (APA, n.d). Supervision is critical to students' training because it allows them to gain the experience and achieve the competencies required for future training settings (e.g., practica, internship) and to work with special populations. Without supervision (specifically, *high quality* supervision), trainees are vulnerable to committing errors that are risky (e.g., forgoing a needed suicide assessment on a client), dangerous (e.g., failing to report an incident of child abuse), and difficult to correct (e.g., improper assessment administration that results in invalid scores). Clearly, supervision is a time-intensive process because it needs to be. Trainees require monitoring, feedback, and scaffolding, throughout every step of training experience because they are developing skills that have the capacity to impact individuals' lives in a powerful way. The impact that trainees' make on the lives of their clients is attributable, in part, to the quality of the supervision that they receive.

Supervision of assessment differs significantly from supervision of therapy and counseling because it is time-constrained, rigid, and high-stakes (Wright, 2020). Unlike therapy and counseling, assessment can be unforgiving to errors (even small errors, such as forgetting to obtain a ceiling on a subtest) because it could compromise the reliability and validity of the client's assessment results, which could impact whether they qualify for testing accommodations or disability benefits. In light of this, the onus falls on supervisors to ensure that they can adequately train, support, and supervise their students throughout the assessment process. Unfortunately, a limitation to providing students' with the supervision they need is supervisor time and availability (Silva et al., 2016). For example, faculty supervisors are not just responsible for supervising students, but also for teaching courses, fulfilling departmental and university service duties, and engaging in scholarship and research. Through no fault of their own, faculty supervisors may find themselves in a quandary because they must "establish a timely and

Figure 1

Case Monitoring Form Part 1

Case Monitoring Form *(example)*
Date: Fall 2021

Legend	
✓	Completed
~	In progress
X	Incomplete
	Updates/additions

Examinee: Neptune	**Grade**: College Freshman	**Age**: 18	**Gender**: Neutral	**Ethnicity**: White

Referral Concern
Learning how to cope with feelings of anxiety, depression, and dissociation. Exploring own gender identity and trying to figure out next steps in life.

1) Clinical and Diagnostic Interviews
- Clinical Interviews
  - MBAC Adult Clinical Interview (✓)
- Diagnostic Interviews
  - DIVA (✓)
  - DIAMOND-depression (✓)
  - DIAMOND-anxiety (✓)

2) Intellect/Cognitive Functioning
(2a) WAIS-IV ✓
- (subtests 1-10)

(2b) WJ-IV-COG clusters ✓
Short-term Working Memory
- Verbal Attention
- Numbers Reversed

Cognitive Processing Speed
- Letter-Pattern Matching
- Pair Cancellation

Auditory Processing
- Phonological Processing
- Nonword Repetition

Long-Term Retrieval
- Story Recall
- Visual-Auditory Learning

3) Executive Functioning and Learning
- RCFT (~)
- DKEFS: (~)

1. Trail Making Test
2. Verbal Fluency Test
3. Design Fluency Test
4. Color-Word Interference Test
5. Sorting Test
6. Tower Test

4) Memory and Learning
- CVLT-3 (California Verbal Learning Test)

Note: Administer in conjunction with DKEFS. Administer CVLT-3 first then any nonverbal component from the DKEFS

5) Self-Report Forms
- PAI (~)
- BRIEF-A
- Vineland-3

6) Performance-Based
- TAT (~)

Day to Day In-Person Assessment Battery
Note: Complete tests in their numbered order

Day 1 (3/9)	Day 2 (3/16)	Day 3 (extra day)
1. Finish Interview (✓) 2. DIAMOND (✓)	3. WAIS-IV 4. WJ-IV-COG 5. RCFT ○ Note: give her BRIEF-A and PAI during *30 min delay* ○ If time remains, engage in friendly conversation with her. Ask follow-up questions.	6. CVLT-3 ○ Note: administer Trail Making Test and Design Fluency Test from DKEFS during *20-minute delay* 7. DKEFS 8. TAT

Report forms scored/interpreted (~)
• BASC-3 SRP-A (✓)
• WJ (✓)
  • Verify with supervisor (~)
• WAIS-IV (✓)
  • Verify with supervisor (~)
• PAI (x)
• TAT (x)
	Date submitted report for feedback –
	1st round of edits
	2nd round of edits

Report writing in progress (x) Clinical Impressions (*in progress*) Recommendations (*in progress*)	Uploaded case notes into PnC • 3/29 (✓) • 4/5 (✓) • 4/19 (✓) • 4/24 (✓)
Feedback Completed (x)	Presented case during practicum • 3/1 (✓) • 3/8 (✓) • 3/15 (✓) • 3/22 (✓) • 3/29 (✓)

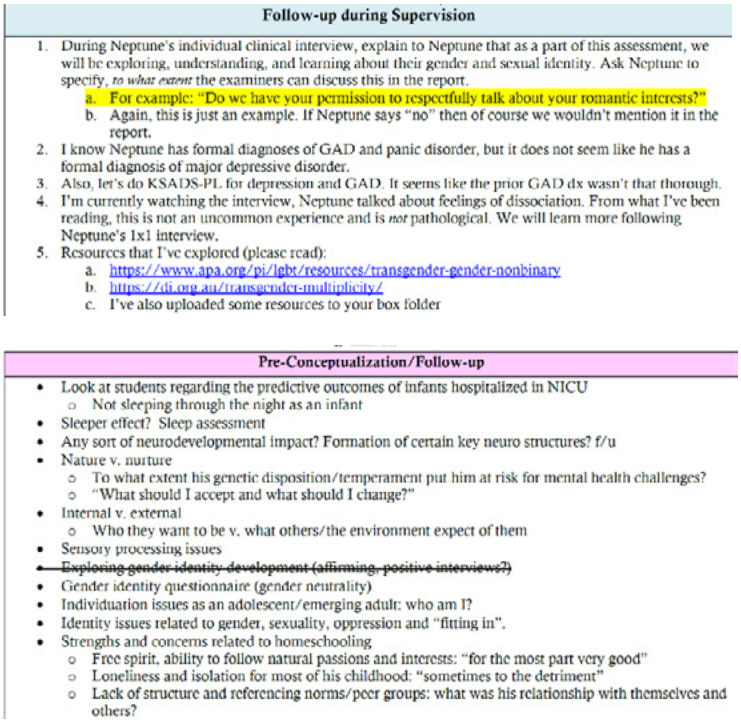
Note. The first two pages of the case monitoring form illustrate the different assessment components based on the referral concern. There is a record of the completed and incomplete assessment components.

specific process for providing feedback to students and supervisees" (APA, 2016, p. 10). Also, in terms of evaluation of trainee performance, supervisors must observe the students' activities in real time or watch recordings of their activities (APA, 2018).

Using the *Case Monitoring Form* can help mitigate the challenges that result from faculty supervisors' busy schedules without compromising the quality of trainees' supervision experience. The *Case Monitoring Form* is a document that allows the supervisor to keep track of all the multifaceted components of each assessment case. It is a collaborative, "living" document in the sense that supervisors and trainees make changes, add comments, ask questions, and more to the document. The trainees keep track of their progress by reporting the dates of assessment administration, past and future clinical interviews, assessment procedures, and more. This form is updated regularly and greatly reduces the number of email exchanges because it "lives" in a secure cloud-based program (see Figures 1 and 2 for examples). Also, supervisors document their working conceptualization of the case following review of recordings. Using this form optimizes everyone's time by ensuring effective, efficient, and thorough coverage of the multiple components involved in the assessment process. This helps the trainees develop excellent administrative skills and helps supervisors keep track of the multiple cases that are being supervised.

Figure 2

Case Monitoring Form Part 2



Follow-up during Supervision

1. During Neptune's individual clinical interview, explain to Neptune that as a part of this assessment, we will be exploring, understanding, and learning about their gender and sexual identity. Ask Neptune to specify, *to what extent* the examiners can discuss this in the report.
   a. For example: "Do we have your permission to respectfully talk about your romantic interests?"
   b. Again, this is just an example. If Neptune says "no" then of course we wouldn't mention it in the report.
2. I know Neptune has formal diagnoses of GAD and panic disorder, but it does not seem like he has a formal diagnosis of major depressive disorder.
3. Also, let's do KSADS-PL for depression and GAD. It seems like the prior GAD dx wasn't that thorough.
4. I'm currently watching the interview, Neptune talked about feelings of dissociation. From what I've been reading, this is not an uncommon experience and is *not* pathological. We will learn more following Neptune's 1x1 interview.
5. Resources that I've explored (please read):
   a. https://www.apa.org/pi/lgbt/resources/transgender-gender-nonbinary
   b. https://di.org.au/transgender-multiplicity/
   c. I've also uploaded some resources to your box folder

Pre-Conceptualization/Follow-up

- Look at students regarding the predictive outcomes of infants hospitalized in NICU
  - Not sleeping through the night as an infant
- Sleeper effect? Sleep assessment
- Any sort of neurodevelopmental impact? Formation of certain key neuro structures? f/u
- Nature v. nurture
  - To what extent his genetic disposition/temperament put him at risk for mental health challenges?
  - "What should I accept and what should I change?"
- Internal v. external
  - Who they want to be v. what others/the environment expect of them
- Sensory processing issues
- ~~Exploring gender identity development (affirming, positive interview?)~~
- Gender identity questionnaire (gender neutrality)
- Individuation issues as an adolescent/emerging adult: who am I?
- Identity issues related to gender, sexuality, oppression and "fitting in".
- Strengths and concerns related to homeschooling
  - Free spirit, ability to follow natural passions and interests: "for the most part very good"
  - Loneliness and isolation for most of his childhood: "sometimes to the detriment"
  - Lack of structure and referencing norms/peer groups: what was his relationship with themselves and others?

Note. Neptune is a pseudonym. The last two pages of the case monitoring form are reserved for supervisor's and graduate student clinicians' notes. After watching recordings and participating in supervision, it is helpful to record working impressions of the case.

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The Benefits of Housing Intensive Outpatient Programs in Psychology Training Clinics through the Lens of Drexel University's Mother Baby Connections Program

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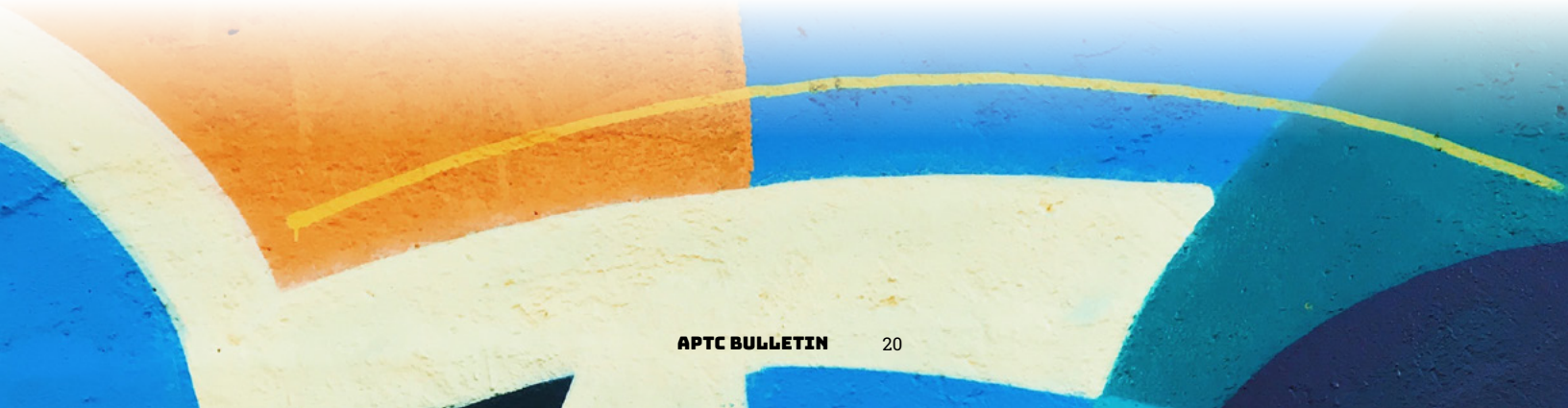
Intensive outpatient programs (IOPs) provide a comprehensive, structured mental health treatment option for individuals experiencing significant psychological distress and symptomology who need a higher level of care and support than traditional outpatient therapy and a lower level of care than residential and inpatient services. In addition, IOPs offer a venue for mission-aligned training, research, and community service, and provide experience with interdisciplinary teamwork, supervision, and collaboration. In this article, we demonstrate that housing a specialty IOP in a psychology training clinic (PTC) is feasible and beneficial to both students and the patients they treat. We identify benefits of an IOP through examples from Drexel University's Mother Baby Connections (MBC) program.

MBC is an interdisciplinary perinatal mental health IOP offered through the Drexel University Psychological Services Center, the university's PTC. The program, aimed at addressing the significant public health issue of perinatal mental health concerns and meeting the need for intensive perinatal day treatment programs in the greater Philadelphia region, launched in 2015 (Geller et al., 2018). The program has a three-fold mission to: 1) provide perinatal mental health clinical training, 2) offer evidence-based clinical services for women in the community experiencing distress during pregnancy or the postpartum period, and 3) conduct perinatal mental health research. To our knowledge, MBC is the only IOP, as well as the only mother-baby day-treatment program in the United States, that is situated within a university training clinic (APTC listserv survey, personal communication, December 17, 2020).

Clinical services at MBC are directed toward women in the Philadelphia region who are experiencing significant mental health concerns, primarily perinatal mood and anxiety disorders, and/or demonstrating impaired maternal-infant interaction styles. Patients are typically self-referred or referred by a healthcare provider. Although no specific diagnostic threshold is required to enter the program, approximately 88% have scored above the threshold on standardized, validated symptom screening measures (e.g., Edinburgh Postnatal Depression Scale; Cox et al., 1987; Generalized Anxiety Disorder-7; Spitzer et al., 2006). Current evidence-based services offered by supervised student clinicians include individual evidence-based psychotherapy, mother-baby interaction therapy (Horowitz et al., 2019), cognitive behavioral and acceptance-based group therapy (Mom-Me; Grunberg et al., 2022), group-format psychoeducation focused on overall wellness, and infant massage instruction (International Loving Touch Foundation, Inc., 2023). As needed, psychiatric medication evaluation and management services are offered through a structured collaboration with licensed providers at Thomas Jefferson University. Up to six women are served simultaneously, for an average of 13 weeks, depending on symptom severity (Geller et al., 2018). Since the onset of the COVID-19 pandemic, individual and group programming have been offered via telehealth. In addition to weekly individual and/or group supervision, MBC team members review patient progress during weekly interdisciplinary care coordination meetings.



Diverse Training Opportunities

Given patient symptom severity and the range of clinical services typically provided, IOPs offer trainees unique opportunities for service provision, learning, and competency development. Capitalizing on access to interprofessional faculty collaborators from across the university (e.g., psychiatric nurse practitioners, clinical nurse specialists, and clinical psychologists), clinical psychology doctoral students, predoctoral interns, and postdoctoral fellows, as well as graduate students from other disciplines (e.g., nursing, couples and family therapy), and trained undergraduate students, gain rich and varied training opportunities under the supervision of licensed interdisciplinary professionals.

In an IOP, one clinical case offers training experiences across modalities and to multiple students. For example, the therapeutic care team for most MBC patients includes at least four supervised student clinicians (e.g., individual therapist, mother-baby interaction therapist, group facilitators for two distinct treatment groups). Additional trainees provide other services such as patient navigation and infant caregiving, as described below.

Students have ample opportunity to build assessment skills and gain experience in routine outcome monitoring within an IOP. Moreover, the administration of measures specific to the IOP population enhances assessment training. At MBC, trainees not only conduct comprehensive psychodiagnostic evaluations and structured and unstructured clinical interviews at intake, but also administer several validated assessment measures specific to the perinatal population (e.g., Edinburgh Postnatal Depression Scale; Cox et al., 1987; Barkin Index of Maternal Functioning; Barkin et al., 2010; Dyadic Adjustment Scale; Spanier, 1976) on a monthly basis to monitor symptoms and inform treatment planning. Treatment progress is further monitored through the direct observation of interpersonal interactions with other patients during groups and mother-infant dyad behaviors (Geller et al., 2018).

Research Opportunities

IOPs situated in PTCs can offer trainees opportunities to engage in research activities and efforts. MBC's overarching research aim is to reduce the effects of serious perinatal mental illness and promote optimal mother–infant interaction to improve maternal functioning and infant developmental outcomes (Geller et al., 2018). Currently, clinical psychology doctoral students and trained undergraduate students assist with activities such as grant proposals, preparing IRB submissions, and data collection, management, and analysis. Trainees may also serve as supervised study interventionists or clinical assessors on clinical trials or other research projects carried out in the training clinic. At MBC, this work has given trainees the opportunity to present research posters and symposia at national perinatal mental health conferences and publish in peer-reviewed journals.

Additional Opportunities

Students who participate in IOPs at PTCs can also gain experience in program operations, coordination, and patient navigation. At MBC, a trainee serves in a program coordinator role to help ensure the cohesiveness of program activities and coordination of care both within the university and with other external providers and agencies (Geller et al., 2018). Trained undergraduate students assist with program operations, such as scheduling, attendance tracking, taking meeting minutes, and administering surveys. To enhance treatment access and engagement for perinatal women with substantial barriers to treatment access, MBC utilizes a designated patient navigator to coordinate care (DiSanza et al., 2020). This role is typically filled by a graduate student or an advanced undergraduate student. The patient navigator communicates with patients between appointment days to follow up about care, make referrals, address questions, and problem-solve barriers to attendance (DiSanza et al., 2018). The patient navigator is trained to utilize motivational interviewing techniques to

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explore ambivalence, enhance readiness for treatment, and promote retention in MBC programming (Geller et al., 2018).

IOPs also afford students the potential for population-specific specialized training. For example, graduate trainees and faculty supervisors at MBC received training and certification in infant massage instruction providing an additional evidence-based approach to address postpartum depressive symptoms, parent-infant bonding, and infant development (Elgohail & Geller, 2021). Undergraduate and graduate students also have had opportunities to be trained in infant care and child development through infant caregiving, a service provided by MBC to help reduce barriers to care, allow mothers with anxiety to separate from their infants in a safe setting, and enhance mothers' engagement in in-person treatment sessions.

Graduated Training Experiences

Another advantage of housing IOPs in PTCs is that they provide opportunities for graduated training experiences based on student experience and skill level. Trainees in their first year of clinical training may start by shadowing group facilitators and then progress to co-facilitating a group. As students progress in their graduate training and gain more clinical experience, they move on to carrying a caseload of individual patients and facilitating group therapy. More advanced trainees have opportunities to see more challenging and complex clinical cases, such as patients who present with increased symptom severity and more complex psychosocial stressors (e.g., homelessness). Additionally, as training clinics value and prioritize competency building at all levels, advanced graduate students have the opportunity to gain experience in evidence-based supervision as peer supervisors for more junior students. Advanced trainees at MBC have also co-facilitated group supervision meetings alongside the primary clinical supervisor and led presentations during didactics.

Interdisciplinary Teamwork and Collaboration

Many IOPs are interdisciplinary in nature and include team members from disciplines such as clinical psychology, social work, nursing, creative arts therapy, couples and family therapy, and psychiatry. Therefore, IOPs housed in PTCs offer students experience in interdisciplinary teamwork and collaboration—competencies that are highly transferable and valuable for future clinical psychologists working in a broad range of settings such as academic medical centers, hospitals, inpatient psychiatric units, and Veterans Affairs Health Care centers. The opportunity to engage in treatment planning and execution with fellow professionals across disciplines, with the shared goal of meeting each individual patient's needs, is a highly valuable training experience. Students at MBC are supervised and directed by licensed professionals from various disciplines, including a licensed clinical psychologist, psychiatric nurse practitioner, and psychiatric-mental health clinical nurse specialist. MBC team members participate in weekly interdisciplinary care coordination meetings to discuss patient progress, treatment and discharge planning, and program logistics. Much of our interdisciplinary teamwork, collaboration, and consultation occur during these care coordination meetings.

Recommendations

We offer the following considerations for developing IOPs in PTCs. First, it is essential that the IOP is mission-aligned with the PTC and university. It is also critical to have supporters and champions of the program (e.g., department head, dean) who are enthusiastic, receptive to a less traditional PTC team format, and willing to engage in out-of-the box thinking. Throughout development and implementation phases, ongoing legal consultation with university council can help ensure IOP-specific programming is in compliance with university policies and procedures.

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Next, when formulating specialty IOPs, utilize faculty expertise and research interests within your department. A specialty clinical team that already exists within a PTC could be expanded to form an IOP. Given the interdisciplinary nature of IOPs, we recommend collaborating and partnering with relevant faculty members, programs, and departments across your university. For infrastructure, the breadth of services an IOP can offer and the number of patients that can be served should be thoughtfully considered in light of what the PTC can accommodate.

Ensure that there are adequate, dedicated spaces for individual therapy, groups, and breaks that can accommodate population-specific needs. For example, MBC required spaces for infant caregiving, lactation, and stroller storage. Consider offering telehealth services or hybrid programming to enhance attendance and reduce barriers to care. Finally, payment can be similar to other PTC services (e.g., sliding scale), but given multiple sessions/days of IOPs, payments can be bundled. MBC clients pay a single weekly fee for all services. Funding also may be available through foundations, donors, and training grants.

Conclusions

Operating an IOP within a university training clinic is an innovation that is feasible and cost-effective. This model provides much-needed mental health services to the community and allows a host of beneficial clinical training and research opportunities to trainees. The diverse programming and training opportunities at MBC may serve as a model for others interested in developing IOPs situated in a PTC.

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CLINIC DIRECTOR DELETES EMAIL OFF HER PHONE:

No One Dies and Other Unexpected Outcomes

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I (Natasha Gouge) became a clinic director in 2019 after working as a psychologist embedded within medical facilities for over a decade. One stark contrast between the cultures of medicine and academia is the relationship providers versus faculty have with their emails. My physician colleagues never check their emails and are supported in prioritizing patient care. In contrast, my faculty colleagues are fused to their emails. Watches, phones, tablets, and laptops are aglow with notifications and can be monitored during every task, red light, bathroom break, and even while lecturing. The independence of the academic lifestyle is strongly tethered by the invisible chains of email, and if there was ever doubt about Pavlov's dogs—observe faculty with their cell phones and you will see some of the strongest classical conditioning ever demonstrated.

It took me longer than I'd like to admit to recognize my colleagues were at two ends of the same email-relationship-continuum. Being an early career professional, and someone who always wants to excel, I believed each of these relationships were right, expected, and necessary, but contingent upon the work setting. So, I quickly took note and entered a very committed relationship with my work email. Like many toxic relationships, things went okay in the beginning. I was new to the position and the clinic hadn't had a director in almost a year, so there was no official onboarding process with explicit expectations. Completing tasks coming through my email "proved" I was productive, so it soon became my security blanket. My email told me what to do, and I was rewarded when I responded quickly. Not only did I love the reinforcement hits, I liked the spontaneity of never knowing what my email would ask me to do—it felt familiar to my "warm handoff" days within integrated primary care settings.

Less than three months into my new role as clinic director, I was diagnosed with cancer. It took some time after my medical emergency and after sedation wore off, I emailed my appropriate "bosses" to share the news. At this point, I'd been away from my email for approximately three whole days, and I was already creating stories in my mind about what they must be assuming about me: "What if someone had needed me during that time and I hadn't responded?" Mind you, this was FALL BREAK and I was hospitalized with an emergency—an emergency that turned out to be c-a-n-c-e-r, and my mind was swirling with catastrophes about what others would think of my sudden email hiatus.

I wish I could say being diagnosed with cancer gave me the gift of perception and insight you read about on inspirational t-shirts, but it didn't. Instead, I gained the perspective that email was my lifeline—email made it possible for me to continue working from hospital beds, and worst of all, email gave me something dangerous: the illusion of control. And before the ink had dried on my consent for

treatment, COVID-19 entered the chat and my relationship with email and technology took a cortisol-spiked deep dive into depths I'd never before known. Because of the pandemic, email was now intertwined with work tasks more than ever, but because of chemotherapy, staring at bright screens and communicating through written language felt like running literal marathons. The subsequent years of burnout were intense and ugly. Email became my prison, and I had perfect attendance.

Ending a Toxic Relationship
Brave Enough: Teaching Women Work-Life Control

In 2021, I attended my first *Brave Enough* leadership conference and came to terms with the fact that I could not sustain myself with my current practices (Brave Enough, 2021). By the 2022 conference, I was ready to seriously consider being "brave enough" to evaluate my greatest pain point: my relationship with work email (Brave Enough, 2022). Some quotes that have planted roots in my mind since:

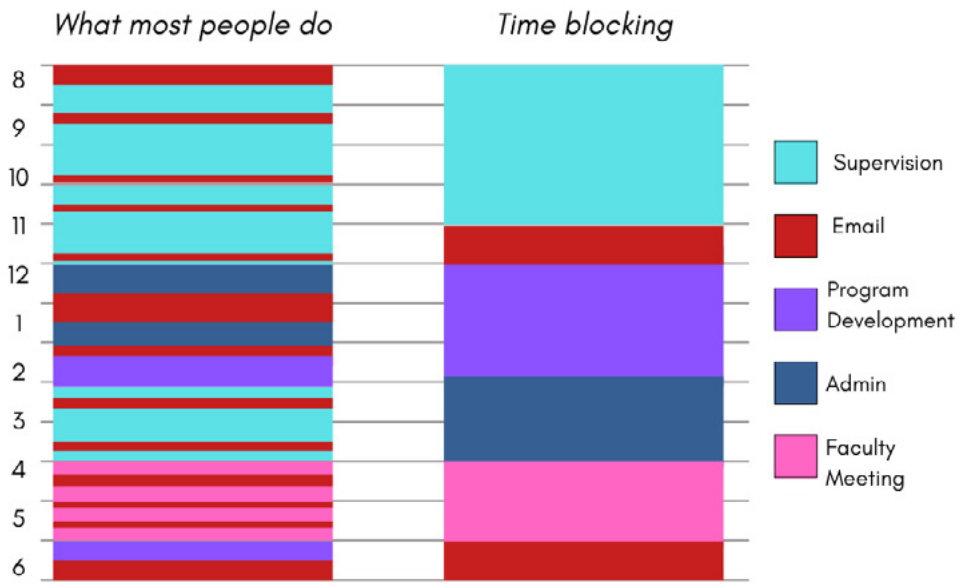
- Emailing doesn't save lives.
- Busy-ness is the new self-harm.
- You can do anything, but you can't do everything.
- Your epitaph or retirement toast will not be: "Wow, everyone who knew her knew how good at email she was."
- A boundary that lives in your head is not a boundary. It's a secret.
- You wouldn't worry about what others think of you if you realized how seldom they do.
- Are you willing to let others believe whatever they want in order to live the life of your dreams?
- What if you could be a badass at boundaries with the same tenacity you were a badass at behaviors leading to burnout?

Strategy & Resources

Implementing strategies like task batching (e.g., "I will review all flagged emails at 1 p.m."), day theming (e.g., Monday/Wednesday/Friday = email and admin, Tuesday/Thursday = supervision and teaching), time boxing (e.g., "I will review all emails in the APTC listserv folder between 1-2 p.m. tomorrow"), and time blocking (e.g., "I will focus my energy on emails every day for 30 min at 8 a.m., 11 a.m., and 2 p.m.") have proven very helpful to explore (Scroggs, n.d.). These methods allow for boundaries and structure with email, without sacrificing work productivity or emotional stability (see Figure 1). Additionally, I've let go of micromanagement and trusted in my clinic protocols and colleagues. Utilizing our on-call schedule allows the clinic to remain functional when I'm not physically present and frees me from the illusion that my email presence is required as a safety feature.

Figure 1

Example of Time Blocking



Transparency & Support

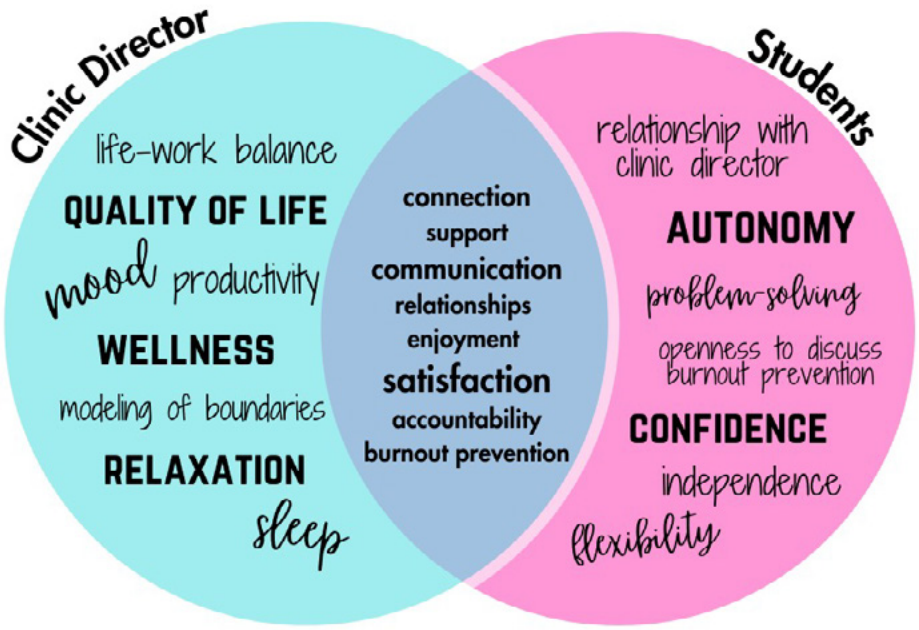
I value transparency with my students and shared with them one of my major upcoming wellness goals included deleting work email off my phone by November 1, 2022. This led to great discussion and mentorship around values and boundaries and created significant support and accountability for me—my students wanted me to succeed. They knew that my stepping away from email wasn't to shut them out or be lazy, but rather to ensure the best parts of me were prioritized to *them*—not their emails. In fact, this change actually helped improve my students' training and their own relationships with their various life-work pain points.

The Student Perspective (Cheston West, Kelly Daniel, and Kyndal Grammer)

As students, watching our clinic director navigate burnout, set email boundaries, and prioritize her wellness contributed greatly to our own wellness, problem-solving, and interpersonal connections. After the initial irrational fear of never being able to communicate with our clinic director again subsided, we found ourselves in a place of greater autonomy and deeper connection. The ability to quickly email any question (and receive a quick reply) was a crutch used in situations where we were more than capable of problem-solving ourselves. We were also able to rethink our own relationship with email and observe how excessive notifications impact our wellness. Since this change, we have a greater sense of connection and cohesion within our clinic and can create more compassionate space for each other. Severing the invisible strings of email unlocked potential for more face-to-face or voice-to-voice interactions. Our clinic director felt more approachable, and we found ourselves subbing in-person conversations for lengthy email threads—a shift that deepened our interpersonal relationships and satisfaction with clinical training (see Figure 2).

Figure 2

Improvements From the Email Hiatus



Outcomes & Reflections

I (Natasha Gouge) deleted both my personal and work email off of my phone on October 30, 2022—75 very unhealthy months after stepping into the clinic director position. The clinic didn't have to shut down or decrease its hours of operation. There wasn't a skyrocket of crisis scenarios, no one was fired, and no one died—except my relationship with Outlook. R.I.P.

The key ingredient to my success in this breakup was having communicated this boundary out loud to my students knowing that they have my rationale and that they can also give me support. An unexpected outcome that has been hugely welcomed, is that my reactivity to email content has significantly decreased. If I don't have time to sit in front of a computer and be thoughtful about the process of sorting, reading, triaging, and responding to my emails, then I am not in an emotional or productive headspace to be emailing. Before, emails often felt overwhelming, urgent, and intrusive resulting in a negative impact on my mood and stress. Now, email feels much more like laundry. There's no pressure to wash each item as it is ready. They can wait until I have the time and capacity to do a full load at once, and I can recognize this is a work chore that will never be done.

Likewise, I can model healthier professional boundaries that I hope will better inoculate students from making some of the same mistakes that I've made. As clinic directors, we have so much privilege and the responsibility of training the future mental health providers of our country. I hope to train students who are well prepared to prevent and combat burnout in our field, and I don't believe I could do this very important work while still having access to email on my phone.

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The Secret to Success:
Self-promotion in Academic Settings

Training clinic directors are one-of-a-kind professionals who do not fit into customary job classifications in academic settings. Hence, it can be difficult to demonstrate one's value without the indicators of success that are commonly known in institutions of higher education (e.g., grants, publications, committee participation, and teaching large classes). Humble yet hard working directors can feel like exhausted outliers in these settings, burdened by invisibility, fiscal scrutiny, and meager rewards. One way to counter these conditions is through self-promotion. The purpose of this article is to share wisdom and strategies for pursuing promotion in academic settings. Promotions are invigorating, rewarding and communicate the value of training clinic directors in a language that is understood within the academy. In this article we will discuss some barriers to self-promotion including systemic, intra- and inter- personal factors, as well as avenues for self-promotion for both non-tenure track directors and those with tenure-track appointments.

Training clinic directors are one-of-a-kind professionals who do not fit into customary job classifications in academic settings.

It is imperative to begin our discussion on self-promotion with a recognition that the academy and many of its existing processes related to promotion are grounded in white, male, cisgendered, heterosexist privilege. Systemic and institutional barriers continue to be largely unexamined by institutions despite diversity, equity and inclusion efforts and other organized (and unorganized) activism as well as empirical research that describes such impacts. Domingo et al.'s (2020) findings highlight how race/ethnicity (and racism) intersect with gender (and sexism) to impact the experiences of faculty in the context of service and advancement and the perceived value of service, especially for faculty of color and faculty with other marginalized identities. Additionally, Fiset and Saffie-Robertson's (2020) research suggests that racism, sexism and social class impact salary and promotion negotiations across the career span and especially the initial negotiations of early career faculty with marginalized identities. Moreover, national data continue to suggest that, despite an increasingly diversified faculty pipeline and programs related to faculty recruitment and retention, many faculty of color, female faculty and other diverse faculty are leaving the academy at high rates (Foxtree & Vaid, 2022). Finally, there continues to be decentralization of promotion procedures especially for clinical lines at institutions with large research missions. With less centralized support, it is harder to understand what is valued, how to work within the system, and how to find other existing promotion support structures.

Intrapsychic factors impacting self-promotion are numerous and likely unique to each of us, but research

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has identified several worth noting as we consider clinic directorship. First, imposter syndrome is the phenomenon of self-doubt and feelings of incompetence, despite one's accomplishments (Bravata et al., 2019). It causes individuals to doubt their successes, perceive themselves as inadequate, and experience unsettling fears of being exposed as a fraud. Additionally, speaking strategically and diplomatically about yourself and your accomplishments can cause discomfort for a myriad of reasons including fear of backlash or other negative perceptions which may have cultural, gendered, and familial roots. Fernandez and Spector (2020) suggest that a lack of self-promotion may lead others to prematurely dismiss one's capability, competence, qualifications, ambitions, and access to leadership opportunities. They suggest that these factors may contribute to underrepresentation in the academy. Moreover, exhaustion, stress and burnout and the associated mental and physical health symptoms can lead to decreased job satisfaction, which can impact performance, persistence, and a number of other factors related to promotion (Woolston, 2021). Finally, racial "battle fatigue" which is described as the physical and psychological toll taken due to constant and unceasing discrimination, microaggressions, and stereotype threats can develop in environments with chronic exposure to discrimination and microaggressions (Witherspoon Arnold et al., 2016). These factors can lead to forms of generalized anxiety manifested in physical and emotional symptoms.

Systemic change in the academy is needed, but we know this happens slowly. Hence, it's wise to learn strategies to help navigate the system related to promotion. A good first step is to tackle the hidden curriculum related to promotion at your institution by asking several foundational questions: What are the criteria for promotion? Who can help me get promoted? How can I translate my work into institutional metrics? How do I get credit for service? Where should I invest my time? Answers to these questions may vary depending on your position specifics, department policies/procedures, and larger institutional promotion processes (e.g., time in position at institution).

Once you discern the requirements for promotion and the metrics used to judge your contributions, the time has come for you to decide about applying. Do things feel too busy, like you have no time to put together a promotion packet? Congratulations! You have done enough to make a comprehensive promotion packet! You deserve a raise and recognition for your hard work. Do your future self a favor and put together that packet!

Your packet will have two sections: Items required by your university, plus items YOU choose to include. As you think about the artifacts to include, perhaps peruse your old annual evaluations. These will outline your yearly accomplishments. Consider reviewing your outlook calendar—your fulfilled obligations are already listed! Chat with others who have been recently promoted. They made it through the process, and so can you!

As we discussed at the March APTC conference in Albuquerque (Graham et al., 2023), there are several items that can be included in your packet. To refresh your memory, here is the list: The promotion application, a table of contents organizing the packet, a cover letter, copies of your university required documents (usually the offer letter), summary of teaching evaluations, teaching statement, service statement, curriculum vitae, letters from external reviewers when you are facing a "barrier review" (these are NOT added by the candidate, but coordinated through your department), document describing a live teaching evaluation (ask someone to observe your class and write a letter), syllabi, grading rubrics you have created, student comments from course evaluations, letters of support from campus partners or former students, letters from your tenure and promotion committee, copies of any print media (articles, clinic newsletter, newspaper stories about you/the clinic), visual media (new stories about the clinic/public relations video), completed grant applications, grant progress reports, survey results about your leadership/the clinic, copies of the clinic manual, awards (APTC!), copies of professional licensure or board certification, photos of the clinic/clinical events you helped organize, and more! There are innumerable possibilities and it's a good idea to see materials from colleagues who hold similar positions at comparable universities.

Finally, we'd like to encourage you to use your APTC colleagues to help with the what, how and who of promotion. Your promotion and its benefits positively impacts ALL training clinic directors! So help us all out by promoting yourself!

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APTC CONFERENCE WRAP UP:

ALBUQUERQUE NEW MEXICO • MARCH 9-12, 2023

In March of this year, APTC had its annual conference at the Hotel Albuquerque in beautiful Albuquerque, New Mexico. It was our first conference since 2019. It was truly an uplifting and informative event. In recognition of the fact that at least a quarter of APTC's directors had been "replaced" in the last four years, the theme of the conference was "Back to Basics."

Since the theme of this bulletin is music and the theme of my introduction to the conference in the last APTC bulletin was Joni Mitchell's "The Circle Game", I thought I would take the liberty of re-writing the words to this wonderful song as they might apply to the conference. If you are interested in the original version, you can go to YouTube to hear it. In fact, it might be a good idea to give it a listen (if you don't already know it) so that you can imagine Joni singing the stanzas that follow. (Trust me, her voice is a lot more melodious than mine.)

William Salton, Ph. D.
Yeshiva University

"BACK TO BASICS"
Verse 1
In twen-ty three, we went to Al-bu-quer-que,
The pan-dem-ic, it had kept us all apart,
Some were new, some were old, and some were quir-ky
And it was time for us to make a fresh new start.

Chorus
Back to Ba-sics, that is what we did,
All the secrets of our jobs became un-hid,
No one else, can do the things we do.
But to suc-ceed, there's in-put we need,
From them and you and me,
That's the beau-ty that we find in the A.P.T.C.

Verse 2
New directors, they had panels, and they had bing-o,
Drinks and din-ner, where they bon-ded one and all.
And the keynote, was in-spi-ring, don't you think so?
And dis-cus-sions o-ver lunch they did en-thrall.

Verse 3
A free meal on Fri-day, brought us more to-ge-ther
As we talked a-bout the jobs we love and know
We trad-ded se-crets, like directors "of a fea-ther",
And we learned new ways, to make our cli-nics grow.

Chorus
Back to Ba-sics, that is what we did,
All the secrets of our jobs became un-hid,
No one else can do the things we do.
But to suc-ceed, there's in-put we need,
From them and you and me,
That's the beau-ty that we find in the A.P.T.C.

Verse 4
On Sa-tur-day, there were panels and some pos-ters,
Cli-nic moves, di-ver-si-ty, pro-mo-tions too.
We learned tech-no-lo-gy, from all of the spon-sors
And we learned a-bout the things, that we all do

Final chorus
Back to Ba-sics, something we now know,
And we use them, to make our cli-nics grow,
Scott and Let-tie, led us like two pros!
We learned a-lot, but we know that there is oh so much much more,
So we'll see you all in March of twen-ty four.

This year's awards committee consisted of Drs. Sara Boghosian (chair), Lettie Flores, Miriam Thompson, Lee Cooper, and Scott Gustafson. Some processes were changed to streamline the effort and make it easier to nominate awards candidates. We had a great group of nominees and award recipients this year!

APTC AWARDS 2023

Sara Boghosian, Ph.D.

Mentor Award

Mary Beth Heller (Virginia Commonwealth University)

Mary Beth Heller
Virginia Commonwealth University

This year's recipient of the APTC Mentor Award was Dr. Mary Beth Heller, Director of the Center for Psychological Services and Development at Virginia Commonwealth University. Beth was described by her nominee as the "Meta-Mentor" of APTC! Beth chaired the mentor program for at least seven years and she dedicated thorough, thoughtful attention to this role. She was proactive in reaching out to new members and matching them with current members who could provide helpful perspectives on the role of psychology training clinic directors. She was also reliable in supporting both the mentees and the more experienced directors she paired with them. According to her peers, it's clear that she was very serious about engaging new directors and ensuring that they felt supported through mentoring. In addition to overseeing the mentor-mentee dyads, Beth also periodically hosted Zoom meetings focused on supporting new members. From the perspective of her peers, she exceeded the expectations of her leadership role by ensuring that the new directors' needs were met, mentoring volunteers in their mentorship roles as their relationships with new directors evolve, and modeling inclusiveness and career-long growth for both mentors and new directors. This was Beth's last year as a clinic director, and we are sorry to lose such a valued mentor and member—her always beautiful shoes are impossible to fill, and we will miss her dearly.

Clinic Research Awards

The APTC Clinic Research Award, which recognizes a training clinic each year for successfully conducting research through or in the training clinic, was given to two directors this year: Dr. Jennifer Schwartz at the Drexel University Psychological Services Clinic and Dr. Nancy Liu at the UC Berkeley Psychology Clinic.

Jennifer Schwartz
Drexel University

Jennifer Schwartz (Drexel University)

Dr. Jennifer Schwartz and clinicians at the Drexel Psychological Services Clinic received this award for their recent work in developing and empirically validating a program for the treatment of justice-involved individuals. This project was a direct result of a review of the literature, which revealed that there is little evidence-based guidance available for treating exonerated individuals. Accordingly, two faculty members, Drs. Heilbrun and Schwartz, collaborated in developing a "toolkit" featuring relevant assessment and intervention strategies, the regular supervision of services offered to exonerated clients, and the routine collection of process and outcome data facilitating the development of evidence-based services for these individuals. This project offered trainees the opportunity to work on program development and program evaluation as well as receive meaningful training and the opportunity to work with one of the most harmed and marginalized populations in our community. An article based on their work is currently in press. I was especially grateful to get to present Dr. Schwartz with this award at the APTC conference in Albuquerque because she has been an invaluable guide to me in my role as the awards committee chair!

Nancy Liu
UC Berkeley

Nancy Liu (UC Berkeley)

Dr. Nancy Liu and her team at the UC Berkeley Psychology Clinic conducted a systematic review of the literature on cultural adaptations of Dialectical Behavior Therapy (DBT; Haft et al., 2022). This review, which is now published in the *Journal of Consulting and Clinical Psychology*, makes a clear argument for the importance of culturally adapted DBT and provides a definition of cultural adaptation that will be useful for the field. Specifically, the authors evaluated culturally adapted DBT across seven domains, including language, persons, metaphors, content, concepts, goals, and methods. Their review pointed to progress in cultural adaptations of DBT as well as barriers that need future attention. They conclude with several key recommendations for the field in both clinical delivery of DBT and research on DBT in different cultures that serves as a model for the kind of work our field ought to be doing in all domains. I was excited to present this award to Dr. Liu as both DBT and cultural adaptation of interventions are topics near and dear to my heart.

Clinic Innovations Award

M. Colleen Byrne
University of Maryland

M. Colleen Byrne (University of Maryland)

The APTC Clinic Innovations Award was presented to Dr. M. Colleen Byrne and The University of Maryland (UMD) Psychology Clinic for their work in implementing an innovative approach to assessment training. UMD's substantially modernized training involves pairing Q-Interactive iPad-based assessment and Titanium-based questionnaires with the Lyssn platform for supervision. UMD's brand new and innovative assessment training clinic leverages available technologies to improve patient experience while strengthening clinical skills acquisition through immersive and engaging training. Moreover, the project provides clinical supervisors with the tools to closely and efficiently supervise doctoral students with a high degree of accuracy.

Jean Spruill Achievement Awards

The Jean Spruill Achievement Award was presented to two training clinic directors this year: Drs. Danielle Keenan-Miller and Heidi A. Zetzer. This award is meant to honor directors who demonstrate longstanding, active involvement in APTC, commitment to excellence in training, and dedication to innovative and best practices in doctoral training clinics.

Danielle Keenan-Miller
University of California Los Angeles

Danielle Keenan-Miller (University of California Los Angeles)

One nominator for Dr. Danielle Keenan-Miller remarked on the innumerable contributions she's made to the supportive culture and effective functioning of APTC over the years. Dani was described as an active, highly regarded leader within APTC. She has served as APTC Secretary and Co-Chair of the Research Committee as well as participated in several other committees, including the Diversity and Supervision Committees. She has served on APTC's Executive Committee since 2018, helping to steer the organization through notable challenges in health service psychology training, including adapting best practices in training and supervision to the circumstances associated with the COVID-19 pandemic. Notably, she stepped up to serve in the important role of secretary when a long-time former Secretary Dr. Karen Saules (may she be retired in peace) departed APTC. Dani stepped up to fulfill this critical role in order to ensure that APTC continues to run smoothly.

As co-chair of the Research Committee, Dani reinvigorated a once-quiet committee and encouraged APTC members to produce research that directly informs policies and practices around clinical training and supervision. She spearheaded a large, national study of health service psychology trainees' perceptions of telesupervision, coordinating a group of almost 20 APTC members in conducting all aspects of the study. This research offers a timely contribution with clear implications for training practices and American Psychological Association policies on supervision. The study's results are summarized in a forthcoming paper in *Training and Education in Professional Psychology*, of which Dani is co-first author.

Dani's efforts at bolstering APTC's contributions to research on supervision and training are clearly having an impact in our field and promoting our mission of providing the highest quality training experiences for our students. One letter writer stated, "I give Dr. Keenan-Miller my strongest support in nominating her for this APTC award. Since becoming a training clinic director myself, Dr. Keenan-Miller has been someone I have often looked to for guidance, and she is someone I greatly respect and admire in the world of training clinic directors. A training clinic director wears so many different hats, and is often bogged down in administrative duties, and Dr. Keenan-Miller has done an exceptional job balancing the many responsibilities of clinic directorship with contributing to the scientific literature and serving the larger training field in so many important ways." Dani has not only been recognized with the clinic director mentor award (2021), but she has also won the clinic research award (2020). In words that I think we'd all echo, Dr. Keenan-Miller is described as a diamond in the rough, and we cannot think of anyone more deserving of the Jean Spruill Achievement Award to recognize her contributions to APTC in her final year as clinic director.

Heidi A. Zetzer
University of California Santa Barbara

Heidi A. Zetzer
(University of California Santa Barbara)

Dr. Heidi A. Zetzer, Director of the UCSB Carol Ackerman Positive Psychology Clinic (2020-present), and former Director of the UCSB Hosford Counseling & Psychological Services clinic (2006-2020), is described as a bright and shining star in our organization, who in numerous ways has been a scholarly workhorse for APTC and for these reasons is highly deserving of this top level recognition. According to her peers, Heidi's contributions, dedication, and service to APTC are numerous, enormous, and tangible. These include being elected for APTC executive board positions including Member-at-Large, during which time she chaired the awards and new director committees, as well as President Elect, President, and Past President from 2014 through 2022. This longstanding commitment to our organization was noteworthy for her kind, wise, supportive, calm, and brilliant leadership during an enormously challenging period for our profession, specifically navigating the COVID-19 pandemic, which brought about unprecedented, massive change and reorganization to all of our psychology training clinics. Another amazing contribution has been her leadership in establishing and co-editing our association's APTC Bulletin: Practicum Education & Training since 2018. She has contributed to and co-edited five fantastic issues. These efforts have created a thoughtful, scholarly forum for our members, allowing them to contribute and learn, while leaving an essential historical document of our association. For each of these, Heidi invited contributors who she often helped to mentor. She has created a legacy of high quality, compassionate leadership and participation. According to her nominator, Dr. Heidi Zetzer has shown a legacy of enduring, meaningful contributions to our organization. It is truly difficult to imagine a more deserving recipient of this award.

Love Letter to APTC

Heidi Zetzer, Ph.D.
March 10, 2023

—in response to receiving a Jean Spruill Achievement Award
and with tremendous gratitude for my colleagues in APTC

Dear APTC,

You are a talisman, touchstone, and good luck charm
You are sunlight, a spindrift, a comfort when alarmed
You are a treasure, a toolkit, a cheering squad
You are heartfelt collegiality both here and abroad

You are a community, a family, a voice in the dark
You are an inspiration, uplifting, like the flight of a lark
You are people, thoughtful, compassionate, and deep
You are leaders, healers, supervisors, who see

The potential in your students, your colleagues, and each other
For growth, for change, for connection with the other
Who resides in each of us, sits quietly and waits
For affirmation, appreciation, acknowledgment, and praise

Take hold of yourself and reach out for your kin
You stand at the crux of so much held within
The kinship of directing, means you'll never be alone
You will stand on shoulders even stronger than your own

This group is a foundation a source of relief
A place where you will always find connection and peace