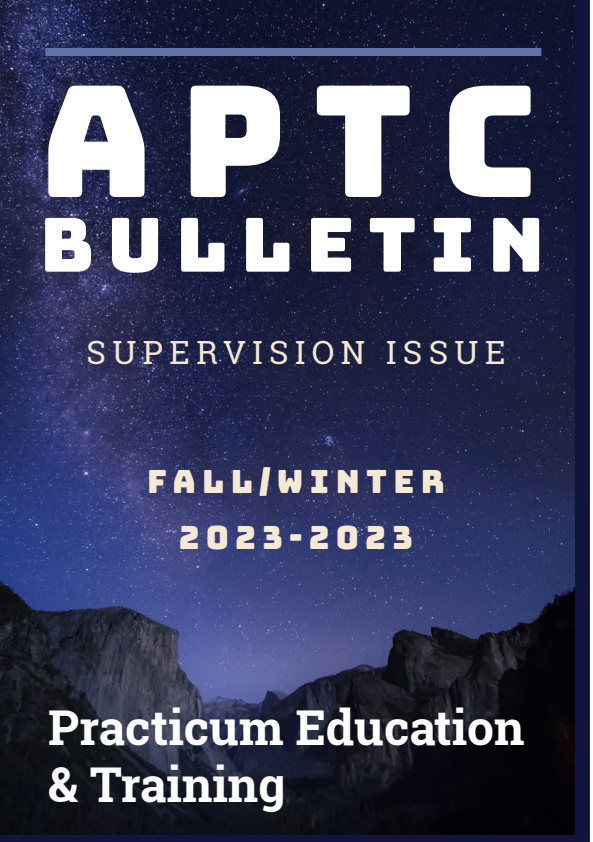
APTC BULLETIN

SUPERVISION ISSUE

FALL/WINTER
2023-2023



Practicum Education & Training

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

From the Editors

Announcements

Featured Articles (*denotes student)

Creative Corner

APTC Mission: The Association of Psychology Training Clinics (APTC) is a professional organization for directors of doctoral-level psychology training clinics and interested associates and affiliates. The organization is affiliated with the American Psychological Association (APA). APTC has established a multipurpose mission and specifically seeks to:

(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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Scott Gustafson
Ph.D., ABPP
Florida Institute of Technology
gustafson@fit.edu

President-Elect
Jennifer Schwartz
Ph.D., ABPP
University of North Texas
jennifer.schwartz@unt.edu

Past President
Leticia Flores
Ph.D.
University of Tennessee
lflores3@utk.edu

President Emeritus
Robert Hatcher
Ph.D.
Graduate Center—City University of New York
rhatcher@gc.cuny.edu

Secretary
Jennifer Hames
Ph.D.
University of Notre Dame
jhames@nd.edu

Member at Large
Stephanie McWilliams
Ph.D.
West Virginia University
srmcwilliams@mail.wvu.edu

Treasurer
Risa Broudy
Ph.D.
George Washington University
rbroudy@gwu.edu

Early Career Member-at-Large
Jacqueline Hersh
Ph.D.
Appalachian State University
hershjr@appstate.edu

Member at Large
William Salton
Ph.D.
Yeshiva University
william.salton@yu.edu

COUNCIL OF PAST PRESIDENTS

The Council of Past Presidents (COPP) is comprised of previous APTC presidents who are currently members of APTC. COPP members serve as advisors to the current president and president-elect.

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Colleen Byrne
Karen Fondacaro
Heidi Zetzer
Leticia Flores

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.

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(ajw11@nyu.edu)

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(sara.boghosian@usu.edu)

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(rob-heffer@tamu.edu)

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Robyn Mehlenbeck
(rmehlenb@gmu.edu),
Sarah Taber-Thomas
(tabers@buffalo.edu)

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(srmcwilliams@mail.wvu.edu)

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Dinelia Rosa
(rosa@tc.columbia.edu)

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Robyn Mehlenbeck
(rmehlenb@gmu.edu)

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(rhatcher@gc.cuny.edu)

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Heidi Zetzer
(hzetzer@ucsb.edu)

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(hershjr@appstate.edu)
Ryan Farmer
(rlfarmer@memphis.edu)

Supervision Group Chair:
Stephanie Graham
(srgraham2@wisc.edu)

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Miriam Thompson
(miriameadyt@ucsb.edu)

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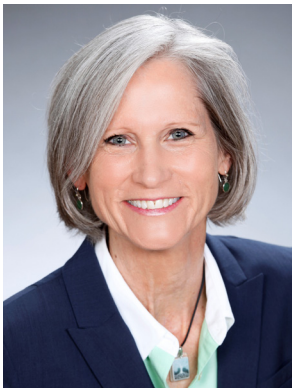
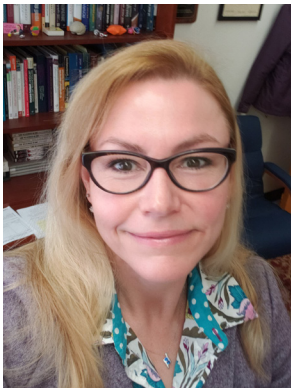


CO-EDITOR STATEMENT

We ♥ Supervision

Heidi A. Zetzer, Ph.D., University of California, Santa Barbara
& Linnea Burk, Ph.D., University of Wisconsin, Madison



Heidi: Several years ago, I made a t-shirt that said, "I <3 supervision." I love supervision because I love teaching, training, and mentoring the passionate millennials (1981-1996) and Gen Z's (1997-2012) who comprise the current and the next generation of psychology professionals (Zetzer, 2022). However, now I think I need to update my t-shirt to say, "We love supervision!" because this sentiment is abundantly clear in this issue of the *APTC Bulletin*. Graduate students in APTC settings learn about clinical and administrative supervision, as well as agency leadership, peer mentoring, and consultation while they are taking classes and engaged in clinical activities. The American Psychological Association's *Standards of Accreditation* (2018) require only that students learn supervision theory, but it is clear to many of us that basic knowledge is not enough (Falender, 2018; Hutman et al., 2023).

Hence, the gap in training between theory and practice is being filled by innovative psychology training clinic directors, faculty colleagues, paid professionals, and licensed volunteers who serve as supervisors, educators, role models, and supervisors of supervisors to ensure that students receive not only high-quality supervision, but also acquire some basic supervision skills themselves before engaging in pre-doctoral internships and postdoctoral fellowships. The pages of this issue are filled with the hard-earned wisdom that has been gained by psychology training clinic directors and their students! Supervisory relationships are among the most rewarding and we hope that reading this issue will contribute to your supervision knowledge and practice.

Linnea: I agree wholeheartedly with Heidi! I love supervision and find it to be one of the most engaging and fulfilling portions of my job. The relationships with students and the opportunity to foster their professional development as they enter this challenging field makes up for all of the other 'stuff' that leads a clinic director to daydream about running off to an isolated cabin in the woods. This issue of the *APTC Bulletin* has come at an opportune time for me—this is the semester I teach our supervision course. Last week, after a lively discussion of the working alliance and boundaries and disclosures, a student asked, "But how do I know I can do it all? How will I know I am ready?" While an excellent question, it is also of the variety that I struggle to answer concretely—because the answer is likely slightly different for each of us and because I'm not entirely sure that I have ever felt ready. For me, it seems that this question, "Am I ready?," obscures its shadowy twin, "How can I be assured of success?" But there never really is any guarantee of success. Every new case and supervisory relationship begins with the same leap from the edge and no assurance of a safe landing. What we can do is be prepared and put on a parachute! Knowledge of theory, guided practice, competency benchmarks, sup of sup, and the wisdom of all who have gone before, all get crammed into our pack of anticipation as we pull the cord! Eventually there comes a point when you are as ready as you will ever be and you…jump! Luckily, this issue of the *APTC Bulletin* has plenty of insight, technique, and suggestions for how to improve the preparation for supervision that we provide to our students. Increased investigation of the supervision process itself will further strengthen the items that end up in our packs!

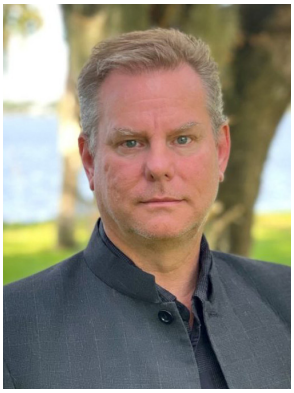
References

American Psychological Association (2018). *Standards of accreditation for health service psychology and accreditation operating procedures*. Author.

Falender, C. A. (2018). Clinical supervision—the missing ingredient. *American Psychologist, 73*(9), 1240–1250. https://doi.org/10.1037/amp0000385

Hutman, H., Ellis, M. V., Moore, J. A., Roberson, K. L., McNamara, M. L., Peterson, L. P., Taylor, E. J., & Zhou, S. (2023). Supervisees' perspectives of inadequate, harmful, and exceptional clinical supervision: Are we listening? *The Counseling Psychologist, 51*(5), 719-755. https://doi.org/10.1177/00110000231172504

Zetzer, H.A. (2022, August 5). Building a better bridge to supervision competencies [video recording]. American Psychological Association Division 17, Fellows Presentation. https://www.youtube.com/watch?v=-9KY9gkuxAI



PRESIDENT'S MESSAGE

WHAT A BRAVE NEW WORLD THAT HAS SUCH ROBOTS IN IT:

Artificial Intelligence In Clinical Record Keeping

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

Artificial intelligence (AI) is here, and it's going to stay. Not only are students using (and abusing) it for academic purposes, but health care is increasingly exploring its utility in a spectrum of ways. It has the potential to streamline processes, enhance patient care, and genuinely improve reports and documentation, but it comes with substantial risk.

One area where AI demonstrates significant potential is in clinical record keeping, particularly in the realm of psychological assessments and treatment documentation. By leveraging AI technologies, clinicians can automate tasks such as generating psychological reports and developing adaptive Data-Assessment-Plan (DAP) notes tailored to individual patient needs. However, alongside the benefits, there are important ethical considerations regarding patient privacy and the potential for medical errors that must be carefully addressed.

One of the most remarkable advancements facilitated by AI in clinical record keeping is its ability to generate comprehensive psychological reports. Traditionally, psychologists and other mental health professionals spend considerable time manually compiling assessment data and crafting detailed reports. However, AI algorithms can analyze raw assessment scores and patient data to produce accurate and standardized psychological reports efficiently. This not only saves time for clinicians but also ensures consistency and objectivity in report generation.

Moreover, AI-powered psychological reports can be customized to align with empirically supported treatments and focus on treatment goals and outcomes. By integrating data from assessments with evidence-based interventions, these reports provide clinicians with valuable insights into the effectiveness of interventions and help guide treatment planning. This adaptive approach to documentation enables clinicians to tailor interventions to the specific needs of each patient, ultimately enhancing the quality of care and improving treatment outcomes.

Despite these advancements, there are both ethical and practical concerns regarding patient privacy and data security with the utilization of AI. Protected Health Information (PHI), including sensitive psychological data, must be safeguarded in compliance with regulations such as the Health Insurance Portability and Accountability Act (HIPAA). Entrusting AI systems with patient data raises questions about the security and privacy of that information, particularly if it is stored in non-HIPAA compliant databases or subjected to potential breaches. Personally identifying information isn't just names and social security numbers: the combination of demographic and personal variables is often enough to individually identify a patient.

Furthermore, there are risks of medical errors associated with AI-generated clinical documentation. While AI algorithms are proficient at processing and analyzing data, they are not infallible and can sometimes produce inaccuracies or misinterpretations. Clinicians must exercise caution and critical judgment when reviewing AI-generated reports and notes to ensure their accuracy and relevance to individual patient cases. Failure to do so could potentially result in misdiagnosis or inappropriate treatment recommendations, compromising patient safety and well-being.

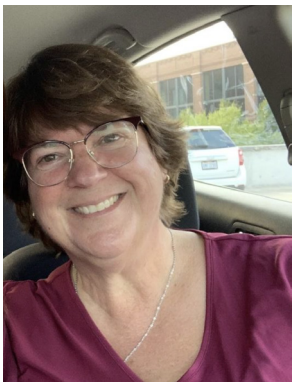
To mitigate these ethical concerns, healthcare organizations must implement robust safeguards and protocols for AI-assisted clinical record keeping. This includes ensuring that AI systems adhere to stringent data privacy regulations and undergo rigorous testing and validation to validate their accuracy and reliability. Additionally, clinicians should receive adequate training on how to effectively integrate AI-generated documentation into their practice while maintaining vigilance for potential errors or discrepancies.

There are task forces, inquiry panels, and even special editions of journals dedicated to this very topic, and the implementation is happening faster than many of us can accommodate with the thoughtfulness and care that it deserves. The integration of AI in clinical record keeping holds immense promise for enhancing efficiency, precision, and individualized patient care in psychological assessments and treatment documentation. However, it is crucial to address ethical concerns surrounding patient privacy, data security, and the potential for medical errors associated with AI-assisted documentation. By implementing robust safeguards and ethical guidelines, healthcare organizations can harness the transformative potential of AI while upholding the highest standards of patient care and confidentiality.

***Author's Note:** This article was written by AI. Although it was edited to make it sound more human, and a few lines were added for substantive content, at least 90% of the content was written by an automated algorithm. Of particular interest, a draft of this document included citations and a bibliography that the AI simply fabricated from whole cloth. This, for reasons I am unclear on, seemed to cross the line from a clever way to make a point to something that made both the author and editor deeply uncomfortable; an "Uncanny Valley" effect in written form. We are truly in a Brave New World.

Curious to try AI?
See the AI content prompt on page 19

TOP 10 REASONS TO ATTEND
the 2024 APTC Conference on Resources & Resiliency



Leslie Rudy, Ph.D.
Ohio State University

10 Come on….it's March!
What else is there to do? It's past prime time for outdoor winter sports and too early to garden. Everyone needs to take a break from college basketball after a while….

9 San Diego!
Perhaps you've been experiencing an abundance of gloomy cold days and know that spring is still in the (very) distant future. Perhaps the most interesting recent event in your area was the addition of pineapple as a topping at your local pizza place. Come to San Diego, where you will find plentiful sunshine and lots of really cool stuff to see and do.

8 Interesting and Relevant Content!
Ever had the experience of attending a conference that wasn't really applicable to clinic director work? This conference is guaranteed to provide a superior experience! We have more than 7 hours of content about RESOURCES (how to fund all the great work you're doing) and RESILIENCY (how to continually rejuvenate and train your students to do the same) to pique your curiosity and provide some possible solutions.

7 Continuing Education Credits DIRECTLY related to your work!
All the wonderfulness described in #8 plus CEs you need anyway for licensure? Yahoo!

6 Discover closely guarded secrets of Psychology Training Clinics!
Okay, well…that might be a slight exaggeration. But if you've ever wondered how your training clinic compares to others on all the nitty gritty variables (clinic director salaries, tenure status, job descriptions, client base) this is your chance to find answers. Interesting statistics from the 2024 APTC Member Survey will allow you to understand your experience in a larger context.

5 Food with thoughts!
Lunch on Friday will be provided by APTC with seating options organized by conversation topic. Want to talk about assessment or clinic research? Or maybe you'd prefer to consider the impact of current world events on clients, trainees and supervisors? We'll have a variety of table topics available so you can easily find your people!

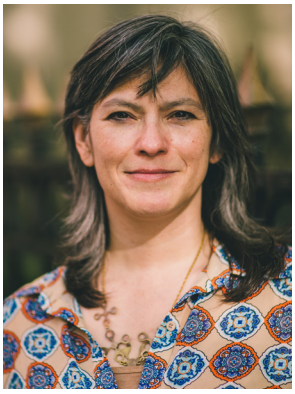
4 TWO Happy Hours!
APTC will be supporting happiness by providing light refreshments and various beverages on Thursday and Friday evenings. This is a chance to relax with your fellow conference participants, start a conversation about the conference, compare your March madness brackets, find some people to share a table with at one of the sign-up dinner options, or seek recommendations about what to watch or read when you're off the clock. The possibilities are endless!

3 Meet the people behind the listserv!
Ever wish you could meet the person who submitted the exact question you'd been grappling with? Want to thank the person who shared their clinic's paperwork process and saved you hours of reinventing the wheel? Hankering to have an in-person conversation with the group of folks you've been communicating with about how to ensure quality experiences with external supervisors? We're more comfortable maneuvering in the virtual world these days, but there is no substitute for face-to-face time. Come to San Diego and get to know the people behind all those emails.

2 Catch up with friends – old and new!
Renew past acquaintances and get to know some new people. Clinic directors are friendly, welcoming, interesting, intelligent and fun. Come and enjoy the camaraderie of this marvelous group of people.

1 Replenish your resources!
Our profession could not continue to exist without people who are passionate about providing effective training to the providers of the future. APTC could not continue to exist without all of us being willing to share our questions, answers, triumphs and disappointments. Our training clinics could not continue to exist without our determination, creativity, persistence and patience. And somewhere along the way, you need to find a way to replenish all the energy you devote to making sure these things continue. Rejuvenate at the 2024 APTC conference because you are essential and we absolutely can't do it without you.

Interested in being on the conference committee for 2025? There will be an opportunity to sign up for committees at the conference and also in the fall via the listserv. Consider joining this fun committee and make an impact on next year's experience!



Welcome to Our Newly Elected APTC Leaders!

Letitica Flores, Ph.D.
University of Tennessee, Knoxville

APTC is extremely fortunate to have the following members assume leadership roles in March 2024 at our annual conference. We had a very strong pool of candidates this year and we hope that those who threw their hats in the ring this go-around will consider trying again next cycle.

Welcome our new 2024 Dream Team!

Incoming President: Jennifer Schwartz (University of North Texas) has been an integral part of APTC for many years, pitching in on various committees and becoming an indispensable part of the APTC machinery. Her eye for detail, knowledge of organizational history and by-laws and incredible creativity (she was a 2023 recipient of the APTC Clinic Research Award) will surely make a positive and generative mark on the organization.

President-Elect: William Salton (Yeshiva University) has already proven his mettle by assuming the gargantuan task of conference committee chair and leading a wonderful conference last year (and this year, to be sure). His years as a clinic director and his sense of humor and optimism will position him perfectly as our 2026 president. He's a warm and welcoming presence, both in-person and virtually, and like Jen will be a wonderful representative for APTC.

Secretary: Jennifer Hames (Notre Dame University) assumed the position of Secretary after the departure of Dani Keenan-Miller last year. Jennifer took over what many of us believe to be the organization's most workload-intensive role, and Jennifer performed the duties with grace and excellence. We are so lucky that we didn't scare her off! We know she's going to keep the organization in tip-top shape going forward.

Members-at-Large (2): Stephanie McWilliams (University of West Virginia) came on to the Executive Committee last year as the new liaison committee chair, and has done a wonderful job keeping the lines of communication open with our fellow organizations and its members. She also helped form a telehealth working group at last year's conference that has lobbied strongly and effectively for APTC's interests with APA. Like Jennifer, Stephanie is a great example of how the next generation of directors are taking on leadership roles and driving our organization into the future.

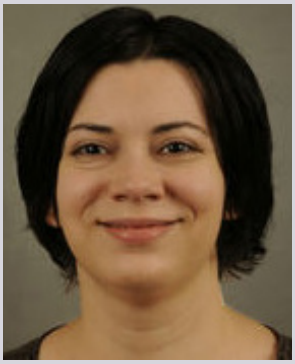
Our second **Member-at-Large, Robyn Mehlenbeck** (George Mason University), is probably best known among both the veteran directors and the new clinic directors. Robyn has done a masterful job heading the New Director/Mentoring Committee, connecting our new directors with more experienced mentors and encouraging them to get more involved with the organization, recruiting them to attend our March conference, and otherwise helping them to feel like the valued members they are.

Member at Large (Early Career): Kristy McRaney (University of Southern Mississippi) may be early career, but that didn't stop her from jumping into the deep end with conference planning in 2022. She immediately became a major team player, and we couldn't have had as successful a return to our first post-COVID, in-person conference without her. Now she's going to be able to keep contributing with her fantastic ideas and her savvy tech skills.

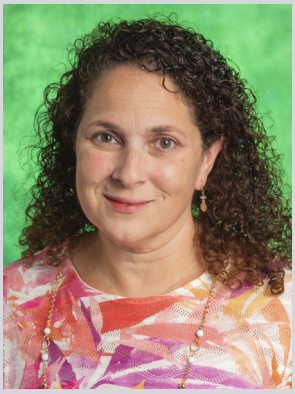
Welcome and thank you all for your leadership!

How Are Our Programs Training Supervision?

A Rationale for A Program of Study



Holly Levin-Aspenson, Ph.D.,
University of North Texas



Jennifer Schwartz, Ph.D., ABPP
University of North Texas

Standards for American Psychological Association (APA) accreditation of doctoral programs in health service psychology require training in supervision. Per the current standards, APA "views supervision as grounded in science and integral to the activities of health service psychology" and expects doctoral students to "demonstrate knowledge of supervision models and practices" and "contemporary evidence-based supervision literature" (APA, 2019, p. 18). The Psychological Clinical Science Accreditation System (PCSAS) is less prescriptive than APA regarding how to train supervision, yet still lists supervising using "scientific methods and evidence" as a requisite outcome competency (PCSAS, 2023, p. 3).

Different programs vary in how they meet these requirements, both in terms of format (e.g., standalone semester-long class, infusion across other coursework and/or training experiences, self-directed readings) and content (e.g., degree of emphasis on learning about multiple models of supervision). Variations in format and content, as well as how faculty and trainees interact with the material, may produce important differences in the supervision knowledge base graduates of these programs attain by the end of training. We have observed significant differences in both curriculum and outcomes across the training programs in which we have worked, as well as in the doctoral programs in which we each trained. These include small, mid-sized, and large graduate programs (N=cohorts of 2 through cohorts of >20) and both public and private institutions. We have reason to believe that this variability is remarkably pervasive, based on our discussions with colleagues in health service psychology, as well as our experiences interviewing clinical and counseling psychology faculty job candidates about their approaches to supervision.

Why does this matter?

As noted above, accreditation standards (APA and PCSAS) as well as the *APA Guidelines for Clinical Supervision in Health Service Psychology* (APA, 2014) describe the expectations of supervisors who train doctoral students and the training inputs and outcomes related to supervision of students in doctoral programs. All of these documents suggest that part of supervision training and provision of supervision is knowledge of supervision models or methodologies. None of the documents dictate the path to achieving this knowledge base or delineate how to measure: a) whether an adequate knowledge base has been imparted or attained or b) whether the student/supervisor implements the models that are taught. Our experiences and observations suggest that programs vary substantially in their coverage of supervision in terms of content and experience. Potential explanations of this lack of consistency include: a) that we do not know enough about models of supervision at present (empirically), yet we are instructed (via accreditation and guideline documents) to teach the models (e.g., Simpson-Southward, et al., 2017; Watkins, 2020;) or b) that programs do not have enough guidance on what needs to be included in training and/or what is the target outcome for this training.

Hartwell-Walker (2017) acknowledges that while varied theoretical orientations might yield similar outcomes, theory-driven work is still essential for the following reasons: "to ground us, to organize our thinking, to develop a mutually understood language with our clients, to serve as the basis for assessment, to set treatment goals, to determine who should be in the session, to determine the type of intervention, to measure progress, and to help when we're 'stuck.'" In many ways, supervision is a similar process to therapy. Supervisors

work with someone who: (a) is seeking expert guidance in order to guide behavior change, (b) is attempting new skills that require various levels of coaching as they begin to implement new behaviors, (c) is encouraged to use metacognitive strategies in the moment to guide decision making, and (d) has goals for the successful outcome of the intervention. Therefore, it is reasonable to surmise that Hartwell-Walker's nine points regarding the importance of theory guided intervention would generalize to theory-guided supervision. When considering supervision, theory-guided work may take the form of supervision driven by theoretical model (e.g., cognitive behavioral therapy supervision, psychodynamic supervision), developmental model (e.g., Integrated Developmental Model (Stoltenberg, 1981), technique (e.g., Deliberate Practice; Rousmaniere, et al., 2017), or skill acquisition (e.g., Competency-Based Supervision). Often, in practice, supervisors utilize a combination of models, or an integrative approach, not dissimilar from how clinicians might integrate techniques from different theoretical orientations. Studies have shown support for developmental models of supervision, but have been mixed and/or non-supportive of the added benefit of the other model types (Watkins, 2020). This does not mean that supervision models do not have an added benefit, but may represent a lack of standardization of supervision models in their design, implementation, fidelity, and evaluation of supervision. So, more rigorous examination of the elements of effective supervision, operationalization of supervision model elements, and evaluation of the outcomes of supervision for trainee and client all appear warranted. We see a need for a program of study aimed at understanding how supervision models are being conceptualized and imparted, followed by examination of how they are being selected, operationalized, taught, and evaluated. A necessary first step is to survey programs to gather data about current training approaches to supervision models.

Investigating Supervision Training

We will be disseminating a survey to training clinic directors and directors of clinical training regarding the nature of supervision training in the programs where they work. This survey will ask about how our programs cover supervision training (including both didactic and experiential learning opportunities), as well as the nature of training on different models of supervision. The goal is to explore the differences in how psychology programs are training supervision as a first step in systematically exploring the varied ways doctoral programs in psychology cover the training of supervision.

References

American Psychological Association. (2014). *APA guidelines for clinical supervision in health service psychology*. Retrieved from https://www.apa.org/about/policy/guidelines-supervision.pdf

American Psychological Association. (2019). *Commission on Accreditation implementing regulations section C: IRs related to the* Standards of Accreditation. Washington, DC: Authors.

Hartwell-Walker, M. (2017). *Why a therapist needs a theory*. Retrieved from https://psychcentral.com/pro/why-a-therapist-needs-a-theory

Psychological Clinical Science Accreditation System. (2023). P*sychological Clinical Science Accreditation System purpose, organization, policies, and procedures*. Authors.

Rousmaniere, T., Goodyear, R. K., Miller, S. D., & Wampold, B. E. (Eds.). (2017). *The cycle of excellence: Using deliberate practice to improve supervision and training*. Wiley Blackwell. https://doi.org/10.1002/9781119165590

Simpson-Southward, C., Waller, G., & Hardy, G. E. (2017). How do we know what makes for "best practice" in clinical supervision for psychological therapists? A content analysis of supervisory models and approaches. *Clinical Psychology & Psychotherapy, 24*(6), 1228–1245. https://doi.org/10.1002/cpp.2084

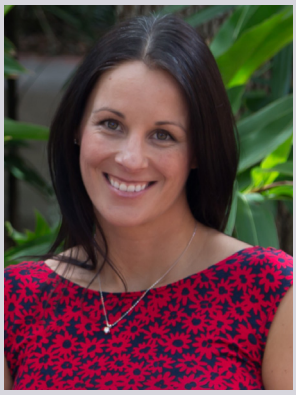
Stoltenberg, C. D. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. *Journal of Counseling Psychology, 28*, 59-65.

Watkins Jr, C. E. (2020). What do clinical supervision research reviews tell us? Surveying the last 25 years. *Counselling and Psychotherapy Research, 20*(2), 190-208. https://doi.org/10.1002/capr.12287

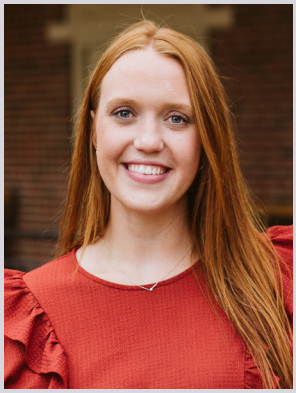
Supervision Trends:

Perspectives and Practices of University Supervisors

Kacey Gilbert, Ph.D. and Tegan Hoff*, M.S.
Oklahoma State University



Kacey Gilbert, Ph.D.



Tegan Hoff, M.S.

Introduction

Supervision of students in the field of psychology is an integral component of professional training programs. Engagement in supervised field-based experiences is noted by both the National Association of School Psychologists (NASP) and the American Psychological Association (APA) as a core requirement of graduate preparation for candidates enrolled in accredited programs (APA, 2019; Gadke et al., 2019; NASP, 2020). Quality field-based experiences that are developmentally-sequenced provide candidates with a foundation for applying essential skills, as well as opportunities to build collaborative peer relationships and to acclimate to practitioner job responsibilities. While this field experience is required, lack of specificity in the training standards likely results in variable experiences across placements (NASP, 2020). This ambiguity yields challenges for university-based supervisors as they collaborate with professionals in the field to provide supervision to psychology graduate students.

Although several variables contribute to valuable field-based experiences, quality supervision is vital to the long-term success of the trainee. Essential to providing quality supervision, supervisors must have a deep understanding of current professional practices, legal and ethical guidelines, and all standards for both content mastery and professional dispositions, as well as the ability to communicate effectively. Moreover, supervisors must initiate critical conversations and provide ongoing constructive feedback to supervisees completing field experiences to facilitate necessary growth during this foundational time. Noting these responsibilities as crucial, it is recommended all supervisors complete formal training targeting the unique knowledge and competencies required to the provision of supervision, including supervision structures, methods, and professional skills across the domains of practice (NASP, 2018). While the importance of these qualities and skills is widely noted, most psychology supervisors receive limited formal training in the development of supervisory skills, and empirical research demonstrating characteristics of effective supervision is limited (Guiney & Newman, 2021). Relatively little research is available regarding the application and effectiveness of recommended supervision processes, practices, and models in the field (Newman et al., 2018). The absence of specificity in training standards paired with lack of formal supervision training and gaps in literature, then, lends itself to challenges in understanding what constitutes high quality supervision, as well as how to ensure its implementation in training settings. The purpose of this study was to investigate current practices in supervision and help inform best practices in university-based supervision.

Method

Participants were recruited through email solicitation that included a brief description of the study and a link to complete the survey. Emails were sent to all NASP approved school psychology graduate program directors and state organizations for dissemination. Recipients of the email were encouraged to forward on the survey, thus response rates were not able to be calculated. The survey consisted of open ended and multiple choice questions regarding current supervision practices including number of supervisees and placement decisions, communication between supervisor and the university program, evaluation of supervisees, and the training they received prior to being placed with a supervisee along with demographic information of the respondents. Participants included 32 university-based supervisors from graduate-level school psychology programs in the United States. Most of the sample reported identifying as female (88%) and 94% reported identifying as White. Of the participants, 84% reported having a Ph.D. and being a university supervisor within an accredited program, with the majority of those being accredited by APA, NASP, or both (96%). Participants reported working with students at the masters (25%), specialist (81%), doctoral (41%), or a combination of these levels. The average years of experience in practice was 10-15 years.

Results

The survey results revealed a high level of communication between university and field-based supervisors, with 96% indicating contact at least once a semester; however, the consistency and formality of this contact varied from emails and brief check-ins to more formal scheduled evaluations via survey or evaluation form. Despite the encouragement of governing bodies to provide formal training for supervisors, only 26% of the participants reported to have provided training for field-based supervisors. For those that did report training, it did not appear to be extensive or formal in nature and consisted of brief meetings (less than two hours) to discuss the expectations of the supervisor and trainee. It is interesting to note that 100% of respondents require a formal evaluation aligned with professional benchmarks, yet there is a gap in the provision of formal training for supervisors, which highlights a potential area for improvement within training programs.

Finally, participants were asked to identify the greatest challenges they face as university-based supervisors. The most commonly reported challenges included time constraints due to cohort size or job responsibilities, concerns about the varied quality of supervision provided, difficulty in finding qualified sites for fieldwork, and a perceived lack of constructive feedback from field-based supervisors. These challenges underscore the need for addressing issues related to time management, supervision quality, and site placement in order to enhance the overall effectiveness of the field-based experience.

Conclusion

While the response rate was low for this survey, it sheds light on the critical role of supervision in the field of psychology and the challenges faced by university-based supervisors. Overall, the importance of high-quality supervision in shaping psychology graduate students is emphasized, as it provides them with essential skills, an understanding of ethical guidelines, and a foundation for successful entry into the field.

Despite the acknowledged significance of supervision, the findings reveal a notable gap in formal training for supervisors, with a majority not providing such training. This raises concerns about the consistency and adequacy of supervision across different placements, indicating a potential area for improvement within training programs. Moreover, the study highlights the existence of challenges faced by university-based supervisors, including time constraints, concerns about supervision quality, difficulty in finding suitable fieldwork sites, and a perceived lack of constructive feedback. These challenges underscore the need for development in areas such as time management, quality assurance in supervision, and collaborative efforts to identify qualified placement sites.

This study provides insights into the current practices and challenges faced by university-based supervisors. It draws further attention to the need for providing formal training and support to supervisors and is a call to action for professional organizations and universities to develop support mechanisms (e.g., building partnerships with new sites) and comprehensive training programs for both university- and field-based supervisors. By addressing these issues, the field can ensure a more standardized and effective approach to supervision, ultimately enhancing the overall quality of field-based experiences for psychology trainees.

References

American Psychological Association. (2019). *Standards of accreditation for health service psychology and accreditation operating procedures.* https://www.apa.org/ed/accreditation/about/policies/standards-of-accreditation.pdf

Gadke, D. L., Valley-Gray, S., & Rossen, E. (2019). *NASP report of graduate education in school psychology: 2017–2018* [Research report].

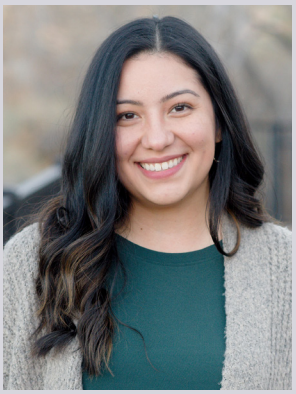
Guiney, M.C. & Newman, D.S. (2021). A grounded theory of model school psychology internship supervision. *School Psychology Review*. https://doi.org/10.1080/2372966X.2021.1946379

National Association of School Psychologists (NASP). (2018). *Supervision in school psychology* [Position statement]. https://www.nasponline.org/assets/Documents/Research%20and%20Policy/Position%20Statements/Supervision_in_School.pdf

National Association of School Psychologists (NASP). (2020). *Standards for the graduate preparation of school psychologists.* https://www.nasponline.org/assets/Documents/Standards%20and%20Certification/Standards/1_Graduate_Preparation.pdf

Newman D.S., Simon D.J., & Swerdlik M.E. (2018). What we know and do not know about supervision in school psychology: A systematic mapping and review of the literature between 2000 and 2017. *Psychology in the Schools. 56*: 306–334. https://doi.org/10.1002/pits.22182

Bilingual (Spanish) Supervision:
Lessons Learned and Hopes for the Future



Sarah Ramos, Ph.D.
New Mexico State University

The 2021 American Psychological Association (APA) Survey of Psychology Health Service Providers reported that merely 4% of psychologists were able to provide mental health services in Spanish (APA, 2022). These numbers are alarming given that Spanish is the second most spoken language in the United States (Dietrich & Hernandez, 2022). As a Latina psychologist who grew up witnessing the mental health needs of the Spanish speaking community, this discrepancy has greatly fueled my approach to clinical work and training. Throughout much of my clinical training and practice, I was frequently the only Spanish speaking clinician available. As a result, I maintained an increasingly large and complex caseload with little to no supervision or support to provide services in Spanish which ultimately led to burnout. Thus, I became increasingly intentional about seeking out additional support for my development as a Spanish-speaking psychologist.

The lack of appropriate training provided to bilingual trainees is well documented as are the additional barriers faced by bilingual trainees (Biever et al., 2002; Biever et al., 2011; Castaño et al., 2007; Gonzalez et al., 2015; Valencia-Garcia & Montoya, 2018; Verdinelli & Biever, 2009). To give an example of these challenges, I will highlight two personal experiences during my graduate training at a site with a large Latinx and Spanish-speaking client population. I was training in the child and adolescent track and was the only trainee in that cohort who spoke Spanish. None of my supervisors spoke Spanish. At minimum, 80 percent of my caseload had some component of Spanish speaking work, and many times the child or adolescent was bilingual, but the parents or guardians were Spanish speaking only. During group supervision, our cohort members took turns bringing in audio recording clips of our sessions to provide a conceptualization and consultation opportunity on any stuck points we were having with that particular client. As no one else in my clinical support team spoke Spanish, I had to decide between limiting the pool of cases I could pick from to English-only clients or bringing in a clip in Spanish and providing the translation to my peers. Of these options, the former would limit the opportunities for additional valuable feedback and guidance I could receive on complex cases and the latter would require the additional labor of translating for my supervisors and peers. Ultimately, I decided to present a Spanish-speaking case and provide in vivo translation to English. Although my peers were able to provide me with feedback based on my conceptualization, the depth of this feedback was limited due to many nuances being lost in translation.

Another situation that occurred at this training site highlights the ethical implications faced when little to no support is provided for bilingual trainees. As I previously noted, I was on the child and adolescent track. Our adult treatment team received a referral for a Spanish-speaking adult male whose goal was to address his long standing pornography addiction. I was asked to take on this case as the client requested a Spanish speaker. The assumption being made was that since I spoke Spanish, I was a good fit to work with this client. However, this did not take into account the training emphasis I was enrolled in (child and adolescent, not adult) and the fact that I did not have the appropriate training at that time to treat a sexual addiction. Although I was told I could decline to take this client on, I felt pressure to say yes due to the evaluative nature of the training and due to the guilt I felt knowing that if I said no, this client would not receive services. One of my supervisors had experience working with sexual addictions and provided me with some resources, however, these were all in English, leaving me with the responsibility to translate these materials myself without support to ensure I was translating the concepts accurately. Thus, I pose the question, "Was I receiving appropriate supervision in working with this client who was perhaps out of my scope of competence and definitely out of my scope of responsibility given that I was not contracted to work with adult clients?" These examples highlight the clinical training implications for bilingual trainees when the appropriate support systems are not in place. I firmly believe that if a training site recruits students who are bilingual, appropriate support must be in place. If not, sites run the risk of being exploitative to these students, in addition to compromising the clinical training of future mental health providers.

Recommendations

Drawing from my lived experiences, existing literature, and my program of research and supervision praxis, I provide recommendations for psychology training clinics to support the professional development of Spanish-speaking mental health providers. Although my experiences are centered on the Spanish-speaking

community, these recommendations may be adapted for bilingual trainees of languages other than Spanish.

1. **Provide trainees with opportunities for supervision and consultation with Spanish-speaking mental health providers.** I fully recognize that this may be difficult due to the shortage of Spanish speaking mental health providers available. However, as seen in the scenarios described above, there are significant clinical training and ethical implications when bilingual trainees do not receive adequate support. These training and ethical implications can subsequently impact client care in a negative manner. As psychologists, we are tasked with doing no harm. As training programs, we must ask ourselves, is our lack of support to bilingual trainees providing avenues for harm? Supervision and consultation can be formal or informal. Training clinics may hire clinical faculty or community providers to provide supervision support. Consultation groups can also serve as a valuable training resource. These groups can be a mixture of didactic presentations and discussion, or case presentations. To further address issues of limited resources, training clinics may benefit from joining with one or two other training clinics and hosting these groups virtually.
2. **Seek funding support to strengthen the quality of bilingual training.** Traditional training structures do not take into account the additional resources needed to support the professional development of bilingual trainees. As such, training clinics who service the Spanish-speaking community may benefit from seeking additional financial support to aid in this training. This may be through university funding, grants, or philanthropic support. Funding can be used to contract licensed community mental health providers to provide supplementary supervision and consultation to bilingual trainees or build a Spanish language resource library.
3. **Assess trainees' bilingual abilities.** In all my years of clinical training, I was not once assessed to determine if my level of Spanish was proficient enough to provide clinical services in Spanish. This is alarming given that none of my supervisors in my clinical training spoke Spanish, thus, they had no way of knowing if what I was saying I was doing was what I was actually doing in therapy. Now, in my clinical training and supervision role, I frequently hear from Spanish-speaking trainees that they worry that their level of Spanish is not "good enough" to provide services in Spanish. This is a very valid concern, given that clinical work can be negatively impacted if the trainee is not able to effectively communicate in Spanish. As such, some level of assessment is necessary and should be done in consultation with a licensed Spanish-speaking mental health provider.
4. **Be mindful of and proactive in addressing the additional labor bilingual trainees experience.** Bilingual trainee experiences are many times full of additional labor not experienced by their non-bilingual peers. I cannot emphasize this enough; Spanish speaking trainees are not free translators. As a student trainee, I was asked many times to help other clinicians in calling a parent to schedule and translate an intake document into Spanish. I did this in addition to my own responsibilities. As noted in the example above, I felt pressure to say yes due to being evaluated and guilty if I said no due to the lack of resources for Spanish speaking clients. This additional labor was also present in having to take what I learned about therapy in English and translate these concepts into Spanish to put into practice with my clients. Furthermore, the pressures of being the only Spanish-speaking provider was many times not acknowledged. When possible, trainees should be compensated for this additional labor, whether that be through an additional stipend or additional administrative time built into their schedule (which may mean adjusting caseload numbers).

This list of recommendations is by no means exhaustive. However, my hope is that these can serve as a starting point for training clinics who aim to provide quality services to the Spanish speaking community and quality training experiences for bilingual trainees.

References

American Psychological Association. (2022). 2021 Survey of health service psychologists: Technical report. https://www.apa.org/workforce/publications/health-service-psychologists-survey/full-technical-report.pdf

Biever, J. L., Castaño, T., de las Fuentes, C., Gonzalez, C., Servin-Lopez, S., Sprowls, C., & Tripp, C. G. (2002). The role of language in training psychologists to work with Hispanic clients. *Professional Psychology: Research and Practice, 33*(3), 330-336. https://doi.org/10.1037//0735-7028.33.3.330

Biever., J. L., Gomez, J. P., Gonzalez, C. G., & Patrizio, N. (2011). Psychological services to Spanish-speaking populations: A model curriculum for training competent professionals. *Training and Education in Professional Psychology, 5*(2), 81-87. https://doi.org/10.1037/a0023535

Castaño, M. T., Biever, J. L., González, C. G., & Anderson, K. B. (2007). Challenges of providing mental health services in Spanish. *Professional Psychology: Research and Practice, 38*(6), 667-673. https://doi.org/10.1037/0735-7028.38.6.667

Dietrich, S. & Hernandez, E. (2022, December 6). *Nearly 68 million people spoke a language other than English at home in 2019*. United States Census Bureau. https://www.census.gov/library/stories/2022/12/languages-we-speak-in-united-states.html

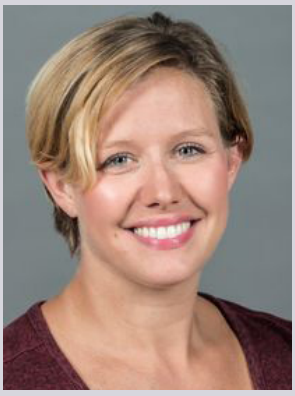
Gonzalez, L. M., Ivers, N. N., Noyola, M. C., Murillo-Herrera, A. C., & Davis, K. M. (2015). Supervision in Spanish: Reflections from supervisor-trainee dyads. *The Clinical Supervisor, 34*, 184-203. https://doi.org/10.1080/07325223.2015.1058208

Valencia-Garcia, D. & Montoya, H. (2018). Lost in translation: Training issues for bilingual students in health service psychology. *Training and Education in Professional Psychology, 12*(3), 142-148. http://dx.doi.org/10.1037/tep0000199

Verdinelli, S. & Biever, J. L. (2009). Spanish-English bilingual psychotherapists: Personal and professional language development and use. *Cultural Diversity and Ethnic Minority Psychology, 15*(3), 230-242. https://doi.org/10.1037/a0015111

TRAINING IN THE "WILD"

Stephanie R. McWilliams, Ph.D.,
Gabriella R. Johnson*, Matt J. Kasopsky*, B.Mds., Rebecca I. LaQuaglia*, B.S., & Johnathan R. Meier*, B.A.
West Virginia University



Stephanie R. McWilliams, Ph.D.

The training of our students is something we all take very seriously. We think a lot about the why, and the how, and even the when…but what about where? Imagine that the four protective walls of your clinic room or office were gone. What would your student training interactions look like? Now take away the comforts of home, where our students go after a challenging day of cases to unwind and recoup. Gone, poof! How does this change the game? What would you do differently as a mentor and supervisor in this less familiar environment? In this article, I will share some first-hand experiences of student training in a camp setting, including personal anecdotes and student experiences, and how we navigated the camp environment, provided quality mental health services, and maintained self-care… in the "wild." My report and reflections are followed by the students' narratives and my conclusions.

In July 2023, I had the opportunity to take 11 students (5 undergraduate, 4 clinical psych Ph.D. students, and 2 counseling students in our Master's program) to the National Scout Jamboree, hosted by the Boy Scouts of America (BSA). BSA stands as one

of the largest youth organizations in the United States, having provided various programs and activities to more than 100 million youth since its establishment in 1910 (Boy Scouts of America, n.d.). Although BSA initially only offered programming to young boys and men, in February 2019, the organization became known as Scouts BSA and programming opened to girls and became increasingly inclusive of different sexual orientations and genders, including transgender, nonbinary youth (Boy Scouts of America, n.d.). This policy change was visibly seen at the Jamboree as we interacted with scouts with different sexual orientations and gender identities, though many troop and unit leaders seemed to be slow to accept this change and repeatedly used scouts' "dead-name" and misgendered them.

Once every four years, members of the BSA, including Scouts, Venturers, Sea Scouts, and International Scouters, along with numerous volunteers from across America, join together for The National Scout Jamboree. World Jamboree events theoretically can be held anywhere in the world, and much like the Olympics, states and countries bid to be chosen as the next location for this huge gathering. National Jamborees are held at the Summit Bechtel Reserve in Glen Jean, WV, which includes 70,000 acres of managed wilderness. During the Jamboree, participants come together to camp and take part in skills training, outdoor activities, and volunteer service projects. Participants of the National Scout Jamboree, like many attending summer camps, encounter environments that differ from their daily lives (e.g., changes in sleep environment and food, high levels of physical activity, and being away from their family, social network, and community), which can be stressful. Although many adolescents adjust well to these challenging situations, some youth have trouble dealing with the emotional and physical stress triggered during camp. The American Camp Association (ACA) has widely recommended the establishment of mental health and behavioral supports within camp settings (ACA, 2009; 2022). Thus, mental health services, such as brief mental health interventions and risk management (i.e., creation of a safety plan for suicidal ideation), are provided during the camping period to help attending youth campers (ages 12 – 18) and staff.

In July, at the 2023 Jamboree, students from West Virginia University were tasked with providing mental health services to scouts and scout leaders over 10 days in Glen Jean, WV. We utilized a tiered mental health care system integrated into the medical care system. The tiered system was organized into four levels, based on severity of the case as well as location at camp (Table 1).

Our team was presented with a wide variety of cases in the clinic, from homesickness to severe manic episodes sprinkled with a little of everything in between. As the clinic director, I had confidence in my students and their clinical competence. They have treated cases of depression, anxiety, and bipolar disorder before. However, at camp, the purpose is not treatment, but rather safety and stabilization (Bisbing, 2023). Encouraging budding clinicians to understand that the purpose of their work at camp was to apply first aid rather than heal the wound was very different from our work in the university clinic.

Preparation

Students attended a number of planning meetings prior to the Jamboree in order to meet some of the medical and mental health staff they would be working and living with at camp. Training modules included psychological first aid (https://www.coursera.org/learn/psychological-first-aid; a review for graduate students, but a comprehensive introduction for less experienced undergraduates), youth protection training (which included information and procedures regarding "two-deep leadership" and reporting protocols for violations), and electronic medical record (EMR) training (Cerner was the program used; Cerner Ambulatory EHR - Pricing, Features, Demo & Comparison; https://www.ehrinpractice.com). As the primary supervisor, I was less concerned with these more cut-and-dried elements of preparation, and more concerned about the things that are not as easily put into a PowerPoint or a manual. Our team had many discussions about which interventions would work at camp and why. Behavioral activation...yes! Exposure therapy...maybe. Cognitive processing therapy...probably not. Time was a huge challenge as we knew we would likely only see an individual for an hour at most and then need to send them on their way. Getting student clinicians to consider how they would feel about not having a nice, neat ending to their "cases" was essential to our preparation.

This lack of neat and tidy spilled over into preparing for being away from the comforts of home and the potential challenges of a camp environment. Before Jamboree, all I could do was chat with my team and encourage them to pack well, be prepared for the daytime heat, the nighttime cold and any other weather, and consider what they would need to be as comfortable as possible. As easy as it is to provide a packing list for physical items, some mental preparation was also needed. I warned them that they, too, might get homesick, so leaning on the team will be imperative on this journey.

Jamboree Experience

When we arrived, we built our clinic from plywood and shower curtains. Yes, we had clipboards and even a clinic phone, but heavy rain and mosquitos are certainly different from what the team was used to while providing therapy. Our clinic ran 24/7 for the entire 10-day camp. Night shifts were also a new thing for the team, so we discussed sleeping schedules and how to divide up the early morning and late evening hours.

As the primary supervisor and director for the clinic, a large part of my role was to ensure everyone stayed healthy and relatively happy. We had a long team meeting in the

Table 1
Concept of Operations: 2023 National Jamboree Mental Health Services

Provider	Coverage	Common Issues	Services and Objectives
Listening Ear (LE)	Seven LE stations in Base Camp A/B, C1-4, D1-2, and D3-4.	"Whatever a participant wants to discuss."	Provide emotional respite, empathy, and guidance
Sub-Camp Chaplains (SCC)	2 SCC per sub-camp. 2 coordinators per Base Camp.	Homesickness. Intra-unit conflict. Socialization difficulties. Spiritual/Faith issues. Uncomplicated Grief.	Assist contingent leaders in managing behavioral and spiritual matters.
Base Camp Mental Health (BCMH)	Base Camp Medical Clinic. Min. of 4 licensed MHP per clinic with back-up provided by the Mental Health Clinic.	Referrals from LE and SCC. Significant but not serious mental health issues.	Mental health resources and liaison between medical staff, sub-camp operations, commissioners, and contingent leaders
Mental Health Clinic (MHC)	5-7 experienced Mental Health staff from varying disciplines. Rotating schedule – intended to provide coverage 24/7.	Referrals from BCMH. Serious mental/behavioral matters. Psychotropic medical consult. Trauma related. Potential discharge from Jamboree.	Oversight of all mental health services.
External Outreach (EO)	On-site Quarantine Area and Off-site Medical Facilities.	Emotional impact associated with medical condition/ treatment. Separation from the contingent. Loss of Jamboree time.	Provide emotional and/ or spiritual comfort.
Critical Incident Stress Management (CISM)	24/7 On-Call Response. Jamboree wide.	Emotional issues arise from being impacted by a critical incident.	Coordinate with and respond to Emergency Management Plans.

Note. Information presented adapted from Bisbing (2023).

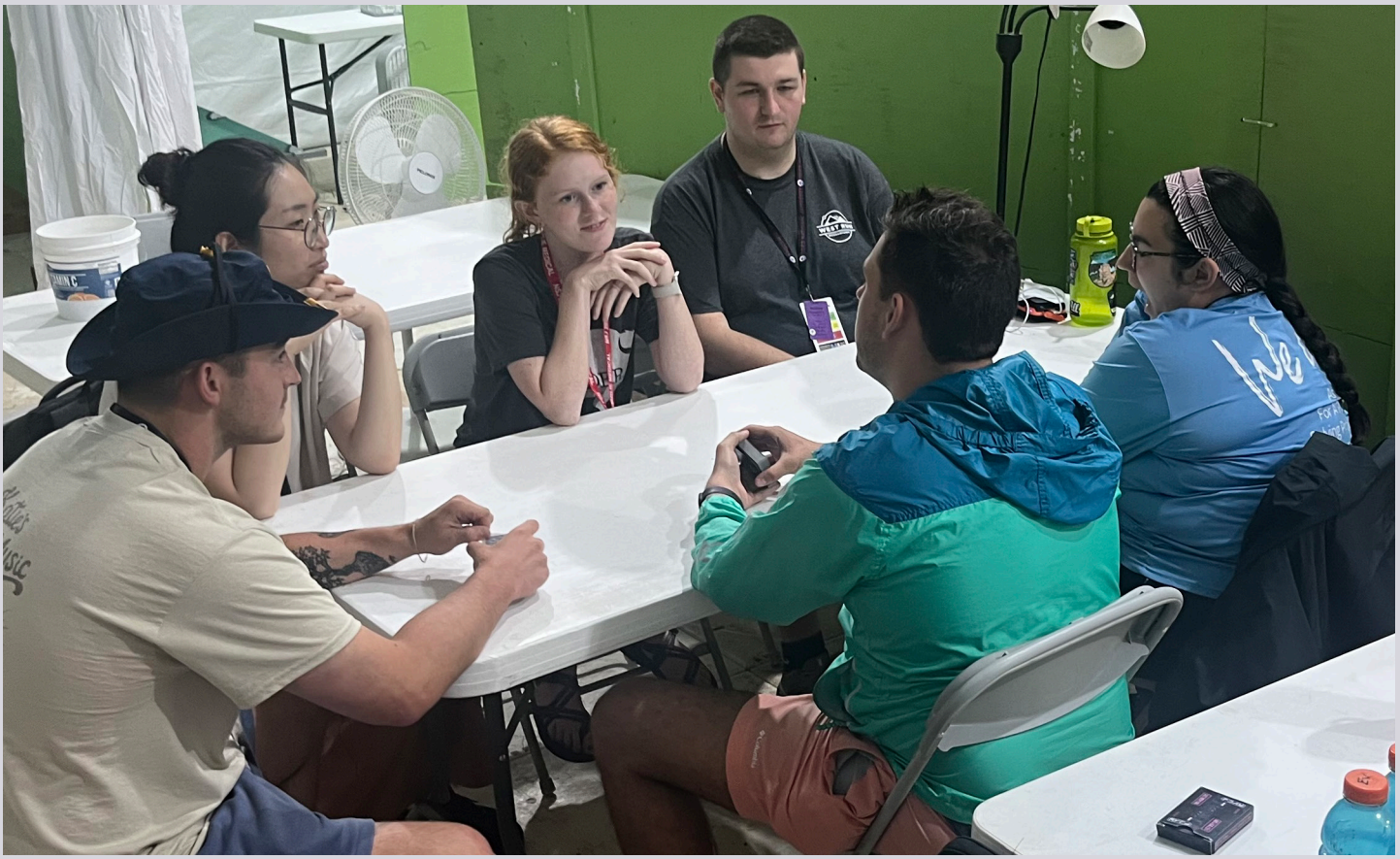
days prior to camp about how self-reflection was essential to success. Requesting a shift change did not mean failure and honesty would be a valuable asset for us all to make it through camp. Individual and team meetings occurred daily, and often were spontaneous. We were together for much of the day, and conversations organically gravitated from case consultation to personal problem-solving, much as it does in our planned supervision meetings at home.

Initially, I was worried about maintaining professional boundaries while creating a nurturing environment in the workplace. Luckily, with well-trained, self-aware students, it was not an issue. I imagine if the supervisor-supervisee relationship was not comfortable and open, however, these 12 days (including 2 days of prep and 10 days of camp) could have played out very differently for our team. Helping my students, many of whom had never camped before, navigate being away from the comforts of home and still provide quality mental health care was a challenge, but also immensely rewarding.

Student Reflections

GABI (an undergraduate student in her senior year field experience practicum):

The 2023 National Scout Jamboree was my first clinical experience and I learned a great deal and felt fulfilled by the outcome. The Listening Ear Team was especially unique since it was comprised of individuals like myself who had little to no clinical mental health experience. (Listening Ear was the start of the tiered mental health system for Jamboree and consisted of peer support individuals



Students unwinding with a game of cards....still in the clinic though

and unlicensed adult consultants. See chart above for reference.) The majority of the training was delivered through an online course on Psychological First Aid (PFA). Although this course was thorough and set clear expectations, it was still challenging as it did not necessarily prepare us for the real cases that we would encounter. If we were ever unclear on how to handle a case, however, the supervisors would listen attentively and offer feedback on the best steps to take moving forward. Additionally, they were very attentive to the work that was being done by all members of Listening Ear and provided routine feedback so that we knew what we should continue doing as well as what might need changing.

A unique aspect of Listening Ear was that our hours of operation overlapped with dinner time. Consequently, every single day our supervisors would drive around and, one by one, pick up individuals from the teams so that they could eat a sufficient dinner. There was never a question of whether they cared about the team – it was very apparent that each of us meant a great deal to them, and they did everything that they could to make our experience comfortable. A specific instance I remember involved a scout, with complex needs, who felt comfortable only talking to me. Of course, this did not fit the conventions of Listening Ear so, after bringing this to his attention, my supervisor immediately jumped in and helped me move the scout to base camp mental health. After this, my supervisor, as well as a team of others, debriefed with me. They not only offered support through the challenges that I was facing, but they also offered constructive feedback that allowed me to see the positive ways I handled the situation as well as what I could do to improve in the future. Overall, my experience at the Jamboree would not have been as positive without the wonderful supervision that I received. I will undoubtedly carry this experience with me throughout my future career.

MATT (2nd year Masters in Counseling student):

As an M.A. Counseling student, Jamboree was my first experience providing direct therapeutic interventions outside of an academic setting. The tiered and base-camp system at the Jamboree provided me with a well-rounded experience working at two basecamps with lower acuity clients, as well as assisting in the mental health clinic as needed. The Jamboree provided me with numerous unique and hands-on learning opportunities. One particular experience that I found to be valuable was consulting with medical professionals such as RNs, MDs, and PA-Cs (Certified Physician Assistants) to provide well-rounded care plans for scouts to reenter Jamboree activities.

Though there were challenges throughout, I felt well prepared by my program and well supported by my direct supervisor and other licensed professionals from various backgrounds including, social work, marriage and family

therapy, counseling, psychiatric nursing, and psychology. This provided me with not only an integrated consultation experience but also valuable insight into the different approaches preferred by various professions within the mental health field. This was not my first camping experience, however it was my first time using my graduate education in a field setting. Sleeping arrangements added an additional layer to this unique clinical experience. With sleep being subpar, meals less than ideal, and long days that oscillated between hot and humid or rainy and windy, I found myself feeling run down toward the end of the Jamboree. The support of our supervisors was incredibly helpful, as they provided us with professional insight as well as empathizing with our shared circumstances.

REBECCA (2nd year Clinical Psychology doctoral student):

Working clinically in a camp environment was a unique opportunity that I was fortunate to be given during my graduate training. I had a clinical site-specific training at which each member of our team introduced themselves and described what presenting concerns and treatments we felt most comfortable with, so that we could reach out to each other for additional support or consultations if needed. Once Jamboree began, we worked 12-hour shifts, including overnights, with one full day off to engage in other camp activities. During these shifts, I was supervised by at least two licensed professionals. These supervisors often allowed me to take the lead and practice a number of clinical skills that I had not yet had the opportunity to use in the field before, including treatments for depression and conducting independent suicide screening and safety planning.

Once every couple of days, the graduate-level clinicians would sit down with Dr. McWilliams to discuss cases that we had seen and provide each other with advice and constructive feedback. I felt that during my time at the Jamboree, I had the opportunity to engage in supervision and consultation with both licensed and student providers from a variety of clinical backgrounds. Each member of our team brought their own unique skills to the table, which provided me with an invaluable opportunity to learn new skills in situations that would not be available within my institution's training clinic.

JOHNATHAN (2nd year Clinical Psychology doctoral student):

Attending the National Scout Jamboree and having the opportunity to connect and network with members of the healthcare community from across the country was an incredibly valuable opportunity for me as a student. Firstly, it opened up a world of diverse perspectives and experiences within the healthcare field. Meeting professionals from various backgrounds and regions allowed me to gain insights into different healthcare systems, approaches to patient care, and clinical interviewing styles I may not have encountered otherwise. Networking with professionals in the clinical psychology field allowed me to gain insights into the real-world practices and challenges of the profession while allowing me to build meaningful relationships and establish connections that could be beneficial throughout my education and career. Meeting experts and practitioners from various backgrounds exposed me to diverse perspectives and approaches, broadening my understanding of the field beyond what I could learn in a classroom setting.

Learning from those who have already achieved success in the field of psychology can be incredibly inspiring and offer valuable guidance on navigating my own career path. Jamboree nurtured a sense of camaraderie and belonging within the scouting and clinical psychology community. The connections made during this event extend far beyond the Jamboree itself, to create a network of support and collaboration that will likely endure throughout one's career. Lastly, participating in such a unique experience spurred significant personal growth. The Jamboree offers a chance to develop interpersonal skills, communication abilities, and adaptability in a diverse and vibrant environment. These qualities are highly transferable and will be beneficial not only in a clinical psychology career but also in various other aspects of life.

Conclusions

Psychologists in training have many experiences that contribute to making them into their future clinician selves. Getting out from behind the traditional four walls, such as in our training clinics or at a practicum or internship site, is a less frequent opportunity, however. We recommend that when an opportunity arises to train somewhere (or supervise others training somewhere) out of the ordinary like the Scout Jamboree, take it! The challenges are great, but the rewards are greater. My confidence in my competence as a supervisor increased greatly throughout this experience. I also learned to integrate more self-reflection into the supervision I do regularly in our clinic. We preach self-awareness and self-care, but do we practice what we preach? In the "wild," you must practice these skills in order to survive and avoid burnout. The students have expanded their horizons as well and (hopefully!) will be more willing to take on greater challenges in the future.

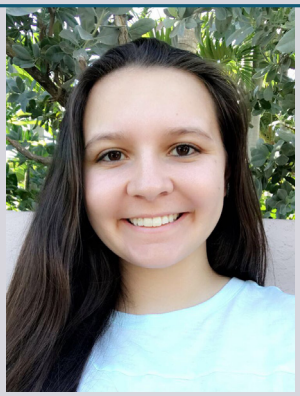
References

American Camp Association. (2009, January). *What now? Understanding and supporting campers with mental health issues.* https://www.acacamps.org/article/camping- magazine/what-now-understanding-supporting-campers-mental-health-issues

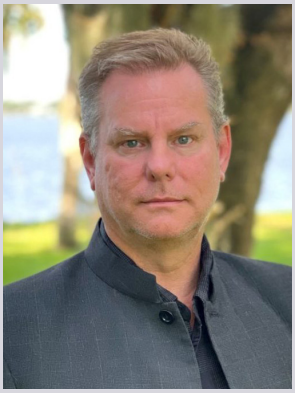
American Camp Association. (2022, November). *Considerations for implementing mental health and behavioral supports at camp.* https://www.acacamps.org/article/camping-magazine/considerations-implementing-mental-health-behavioral-supports-camp

Bisbing, S. (2023). Mission statement & primary objectives. 2023 *NJ Mental Health Services: Base camp mental health officer resource book.*

Boy Scouts of America. (n.d). About the BSA. https://www.scouting.org/about/



Katelynn Jones, MS, NCC, LMHC



Scott Gustafson, Ph.D., ABPP

Training Students in Administration:

The Role of Student Directors in Clinical Training

Katelynn Jones*, MS, NCC, LMHC
Scott Gustafson, Ph.D., ABPP
Florida Institute of Technology

Psychology training clinics serve as a pivotal environment for developing psychologists to gain hands-on leadership experience (Hage & Ayala, 2020). In these settings, the collaboration between a Graduate Student Assistant and a Clinic Director holds immense value, fostering a mutually beneficial relationship (Jarmon & Halgin, 1987). In fact, administrative/management competency is part of the APA competencies rubric (Fouad, et. al., 2009), but there is a dearth of current literature that examines training and outcomes in this area. In fact, this topic seems to have a richer examination in the literature of the past than currently (Miller, 1946). This article aims to explore the advantages of having a graduate student assist a psychology training clinic director, emphasizing the reciprocal benefits for the Student Director's training as an administrator, and the clinic's operations through enriched perspectives and input. The funding of this position is addressed and a case can be made to university administrators that the work can be cost neutral through increased clinic efficiency.

Benefits for Student Directors

Amongst doctoral training programs for clinical psychology, there are limited opportunities for administrative training of doctoral candidates (Rickard & Clements, 1981). Nearly 80% of surveyed directors of APA accredited clinical training programs believed that administrative training should be made available to graduate students within clinical training programs (Rickard & Clements, 1981). Implementing Student Directors who assist the Clinic Director offers graduate students a unique opportunity to cultivate administrative skills vital to their professional growth. Through this opportunity, they gain practical experience in managing clinic operations while honing leadership, decision-making, and organizational abilities. The skills and practical experience that can be gained through the role of Student Director helps to fill this gap within students' training experiences. In addition, engaging in administrative tasks exposes students to real-world challenges, teaching them to navigate complexities within healthcare systems, budgeting, scheduling, and personnel management (DeMuth et al., 1984). Student Directors benefit from mentorship, receiving guidance and insight from experienced professionals, including the clinic's administrative staff.

Overall, administrative training has historically been neglected in APA-accredited clinical training programs (Rickard & Clements, 1981) and the published literature (evidenced here by the lack of current citations, even though a thorough literature search was conducted). As a result, these programs are training graduate students to become competent clinicians and preparing them for a career in the clinical realm, but graduate students are not fully equipped with the necessary administrative skills required to succeed in leadership and management roles.

In an employment survey of psychologists, 25.9% worked in a university or college setting, 25% worked in a hospital or health service setting, 16.3% worked in a government or VA medical setting, 10.4% worked in a business or nonprofit setting, 8.1% worked in a school setting, 6.3% worked in a medical school setting, and 5.7% worked in independent practice (Michalski et al., 2011), though these statistics may be outdated because of the profound changes that COVID-19 brought to health service psychologists (Bell et al., 2020). In each of these settings, administrative skills are critical. Providing the opportunity for graduate students to serve as Student Directors in their program clinics is a unique opportunity to build these skills in a hands-on environment; not simply classroom preparation.

Benefits for the Clinic

Historically, graduate students have not been directly involved in decisions and policy making in training clinics (Serafica & Harway, 1980). In the experience of the authors, the inclusion of graduate student input injects fresh perspectives and innovative ideas into clinic operations. Graduate students offer perspectives on clinic functioning

of which the director or administrative staff may be unaware, and students can facilitate the training focus of the clinic by having their "ear to the ground," listening for gaps and challenges in providing clinical services to the clients served within the clinic. Allowing graduate students to hold leadership and administrative roles within the clinic has real-time benefits not only to their clinical training, but to the day-to-day operations of the clinic. The ability to detect a problem, suggest a solution, and see it through to implementation and improvement of the clinic has a real, palpable empowering effect on students who also gain a sense of ownership in their clinical training.

Infrastructure and Funding

The position of Student Director can be structured in a number of ways, including paid or unpaid practica, graduate student assistantships, and fellowships. Importantly, graduate students can enroll in course credit for these experiences, which can offset position costs for the university. Since administration is an APA competency area, programs would benefit from having a graduate seminar in mental health administration. Serving as a Student Director can be part of an internal practicum that bolsters academic skill development. In addition, having a Student Director also alleviates the administrative burden on hourly employees and other administrative staff. As such, fewer full-time or part-time employees may be needed to complete administrative duties essential to the operations of the clinic.

For example, the Student Director position at Florida Institute of Technology's psychology training clinic has increased clinic efficiency, client outreach, client screening, and incoming student training. The paid position for the Student Director has been close to budget neutral and has allowed the Clinic Director to engage in increased program development and outreach with the student's assistance. In this setting, the student is paid for a 10 hour assistantship and enrolls in a one hour practicum. The income to the university is greater than the expenditure on the position. The assistantship is paid through the department rather than clinic operational funds. The minimum eligibility requirement in our clinic is to have passed the second year clinic practicum and to have passed our Graduate Seminar on Mental Health Administration. The Student Director practicum generally has many applicants, and is selected by the Clinic Director.

The Student Director brings a vibrancy and creativity, with a realistic perspective on how program development would help or burden existing graduate therapists. Moreover, the ability of the Clinic Director to delegate some clinic and administrative duties to the Student Director has facilitated the Clinic Director's ability to be more involved within the doctoral program as a faculty member, whereas Clinic Directors sometimes have less involvement as core faculty which is often less than ideal for the whole program (Serafica & Harway, 1980).

References

Bell, D. J., Self, M. M., Davis, C. III, Conway, F., Washburn, J. J., & Crepeau-Hobson, F. (2020). Health service psychology education and training in the time of COVID-19: Challenges and opportunities. *American Psychologist, 75*(7), 919–932. https://doi.org/10.1037/amp0000673

DeMuth, N.M., Yates, B.T., & Coates, T.C. (1984). Psychologists as managers: Overcoming old guilts and accessing innovative pathways for enhanced skills. *Professional Psychology: Research and Practice, 15*(5), 758-768. https://doi.org/10.1037/0735-7028.15.5.758

Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B., Collins, F. L., Jr., & Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology, 3*(4, Suppl), S5–S26. https://doi.org/10.1037/a0015832

Hage, S.M., & Ayala, E.E. (2020). The experience of doctoral students at program-affiliated practicum training clinics. *Training and Education in Professional Psychology, 14*(3), 209-218. https://dx.doi.org/10.1037/tep0000264

Jarmon, H., & Halgin, R.P. (1987). The role of the psychology department clinic in training scientist-professional. *Professional Psychology: Research and Practice, 18*(5), 509-514. https://doi.org/0735-7028/87/$0075

Michalski, D., Kohout, J., Wicherski, M., & Hart, B. (2011). 2009 Doctorate Employment Survey. Retrieved from *https://www.apa.org/workforce/publications/09-doc-empl/report.pdf*

Miller, J. G. (1946). Clinical psychology in the Veterans Administration. *American Psychologist, 1*(6), 181–189. https://doi.org/10.1037/h0055143

Rickard, H.C., & Clements, C.B. (1981). Administrative training for psychologists in APA-Approved clinical programs. *Professional Psychology, 12*(3), 349-355. https://doi.org/10.1037/0735-7028.12.3.349

Serafica, F.C., & Harway, N.I. (1980). The psychology department clinic: Its organization and development. *Professional Psychology, 11*(5), 741-748. https://doi.org/0033-0175/80/1105-0741$00.75

AI Content Prompt

Scott A. Gustafson, Ph.D., ABPP
Master of Time, Space, and Dimension
Florida Institute of Technology

(See the President's Message on page 3) Write an article about the use of AI in clinical record keeping. Focus on the fact that AI can write psychological reports if you put in the raw scores and data, that it can write adaptive DAP notes that focus on treatment goals and outcomes, integrated with empirically supported treatments, and the ethical concerns of entering PHI in a non-HIPAA protected database, along with the potential for medical errors in record keeping. Word limit 600 to 1000 words.

The White Supervisor and the Ghetto[1,2]

William Salton, Ph.D.
Ferkauf Graduate School of Psychology
Yeshiva University

PART 1

It was a typical supervisory hour at my doctoral psychology training clinic in the Bronx. My supervisee "Charleen" (not her real name), an extremely talented African American third year graduate student, was telling me about a patient from an under-resourced school. Her most recent session with 16-year-old "Flash" (not his real street name), who is also African American, was in a hospital room. Flash, who is from an extremely emotionally and financially impoverished background, had spent a recent evening "running" with his gang and got shot in the leg. Thankfully, it seemed like he would be as OK as anyone could be after getting shot, meaning that he was conscious, cognitively clear and was going to survive. However, walking would be a challenge for a while.

Quickly, the focus of our supervision hour changed. After discussing Flash's character in some length, it seemed clear that he was neither sociopathic nor manifesting any other character pathology. Although he was no stranger to gangs, he also had a girlfriend for the past six months who was not in "the life." He was doing well in school, and he had written some extremely insightful poetry. In fact, he told Charleen that he felt quite guilty about choosing not to go to a party with his girlfriend on the evening he got shot, and he spent much of the session reflecting on this choice and other internal conflicts. So, Charleen and I discussed what might have been going on for Flash psycho-dynamically to lead him to choose to be with the gang, rather than with his girlfriend that evening. We discussed his ambivalent feelings over the various identities he espoused and the causes of the challenges to his self-esteem. We also discussed his mixed feelings about intimacy, given his family of origin, and how his girlfriend might have contrasted with his internalized representation of his mother. And finally, we discussed the various multicultural challenges of being an African American male from an economically disadvantaged neighborhood. Eventually, Charleen and I talked about ways that she could help Flash gain more insight into his inner life so he could make more informed choices that would give him more control over his outer life.

Because I often try to be conscious of the various dynamics of any supervisory relationship, I wondered aloud whether Charleen felt any limitations or challenges discussing these issues with me, a White Jewish middle-class supervisor. We both acknowledged our inadequacies in understanding gang culture, inadequacies which came from completely different places, and I expressed that I probably had even more inadequacies, given my demographics. Yet, Charleen stated that she was comfortable with our interaction and had a clear sense of how to proceed with Flash's therapy, and she thanked me for my help. I also felt generally comfortable with our meeting, and I went on to my next academic commitment.

PART 2

In Manhattan's Harlem neighborhood, 125th street is where I sometimes catch the commuter train to my home in the suburbs. It is one of the most dangerous streets in New York. The evening after my supervision with Charleen, I just missed my 9:30 pm train and the next one wasn't for an hour. I definitely didn't want to wait there and so, I walked a block to the nearest subway station so that I could take another train home from a safer part of the city. The scene on that block could have been right out of the TV series "The Wire." There were many people around who seemed like drug addicts, drug dealers, criminals, street sex workers and their "handlers," hustlers and homeless people. I was the only White person I could see, and I did NOT feel like the comfortable and competent supervisor I believed I had been just hours before. In fact, I was scared! "Just keep walking and don't make eye contact," I said to myself, repeating the words that my parents told me as a boy; the short, fat, blond, visually impaired boy who was afraid to walk around the city. I got on the subway safely and felt better.

[1] A quarter of a city in which Jews were formerly required to live
[2] A quarter of a city in which members of a minority group live especially because of social, legal, or economic pressure (Merriam Webster 2022)

PART 3

Who am I and what the heck am I doing, both in the Bronx and on 125th street? Am I really qualified to help Charleen with Flash? What are the conscious and unconscious issues that I must face as I try to help her work with him? Certainly, I am trying to "help people" (like we all said, and meant, in our graduate school interviews), and our clinic achieves a modicum of success with this. However, I know I cannot be truly successful unless I understand my own cultural and personal agendas. Culturally, I think I am trying to come to terms with the racism that I believe is inherent in all of us. As the child of Holocaust survivors, the concept of "us" and "not us" was drummed into my head at an early age without ever having an overt conversation about "in-group favoritism" (Fu et al, 2012) with my family. Instead, I was taught that the Bible referred to the Jews as "God's Chosen People," but no one ever told me how that meant I was supposed to think about everyone else. I think that this was my family's way of coping with their own "external and internal" ghettos. Some of my relatives were forced to live in the (Nazi created) ghettos of Warsaw and Cracow (Poland) and they all faced repeated "othering" from the many anti-Semitic Poles until they escaped. And so, like all cultures, they developed (and passed on to me) their own subconscious versions of an "us" and "not us" belief system which would partially help them, like all cultures, to survive.

Yet, if unspoken racism is un-thought about, un-understood and un-dealt with, it has the potential to become extremely toxic to patient care, supervision, interpersonal relationships and basically all aspects of our beings. We cannot change centuries-old racial beliefs as supervisors and therapists unless we think about them and somehow find the courage to talk about them. According to Kenneth V. Hardy (2018), we must force ourselves to understand how we inadvertently either hurt, or have the potential to hurt, those who are not like us with our words and actions. Just saying that we "didn't mean to do it" (his concept of "intentionality") doesn't undo the hurt.

And what happens with all this "us" and "not us" stuff with me on 125th street? Well, it's a bit tougher to understand. Demographically, I'm in a position of power, but I'm still frightened. My training and clinical experience help me understand certain aspects of the people surrounding me (a little bit) but that's not going to keep me safe. I certainly can relate to the wish to be "invisible" that I've heard from many African American friends when they walk through predominantly White neighborhoods.

And then there's my personal agenda. I would really like to "undo" the persona of that scared, overweight, fragile, and clueless White Jewish boy who was afraid to leave his home because he might get mugged in the big bad city. Instead, I want to make that city a warmer, safer, friendlier, and yes "better" place for me and everyone else and I don't care if this is some sort of reaction formation. Unfortunately, this agenda is easier for me to achieve while supervising an African American therapist about an African American patient in my "secure" training clinic in the Bronx (where I know I'm the boss) than while walking in a rough neighborhood on 125th street at 9:35 in the evening when I'm scared.

So, in the Bronx, I am the "White supervisor," and on 125th street, I am the scared White Jewish boy in the "ghetto." I use this somewhat outdated term to bring attention to the many ghettos of my soul. Specifically, the historical ghetto of my persecuted family and the intra-psychic ghetto of the once frightened child who had to force himself to be a part of the world. Additionally, in the Bronx, I am trying to teach my students to "be with" their patients (instead of just "understanding" them) and on 125th street, I am surrounded by people I am (understandably) frightened to be with. I spent the last 16 years learning to (and succeeding at) making our clinic's patients comfortable and teaching myself to be comfortable being with them, but on 125th street, I feel nothing but discomfort. Indeed, I am coming to realize that if I want to be effective as a therapist, supervisor, and person, I must first try to figure out who Flash, Charleen, the people on 125th street and me are as fellow denizens of New York, rather than just as psychological entities. I truly enjoy this figuring out process but unfortunately, like Freud (1937) said about psychoanalysis, it is "interminable."

I had all these thoughts as the downtown express subway sped me towards another part of the city where I would patiently wait for the next commuter train home. Additionally, I thought about how we supervisors can help our students like Charleen to regard their patients as valid combinations of both psychic AND cultural entities. I also thought about how our training and our cultures have the potential to influence the supervision we provide, both positively and negatively. But mostly, I concluded that we all have our personal versions of external and internal "ghettos" which we must learn to live with effectively, since they will never go away. I smiled to myself. It had been a reflective day.

References

Freud, S. (1937). Analysis terminable and interminable. *Int. J. Psycho-Anal., 18* (4), 373-405. (Tr. Joan Riviere.) 1950. C.P., 5, 316-57.

Fu, F., Tarnita, C.E., Christakis, N. A., Wang, L., Rand, D.G., Nowak, M.A. (2012). Evolution of in-group favoritism. *Sci Rep* **2**, 460, https://doi.org/10.1038/srep0046

Hardy, K.V. (2018, September) "How to be a good enough White therapist.' Interview in the *Family Networker*, https://www.psychotherapy.net/interview/kenneth-hardy.

Merriam-Webster. (n.d.). Ghetto. In Merriam-Webster.com dictionary. Retrieved January 30, 2024, from https://www.merriam-webster.com/dictionary/ghetto

Our Cognitive Evolution

Poonam Dubal, Ph.D., LSSP, NCSP
Southern Methodist University

inquiry guides those of us that
are capable of carrying forward
thought- those that
are the product of cognitive evolution
those that seek truth or Truth
some explorers make sense of the world
through the lens of a microscope, or by
measuring and weighing
theory against theory—
me? i've got ten bucks on postpositivist critical
other explorers desire to create anew
the original form in a sterile
petri dish or in the womb
of a desperate woman-would-be-mother
beaker? check. survey? check. scalpel? check
answer?

and what of those softer scientists: the
philosophers who go as deep
into the mind as far as astronomers
seek external insight...
nature of man vs. water on mars
we are fiction. we are science.
does newton's second law apply here as well?
our friction only carries us forward—
we will dissect ourselves into tinier and tinier
pieces, our fleshy fragments
dissolving into naught,
and in the very smallest bit, we will find
the Grandeur.