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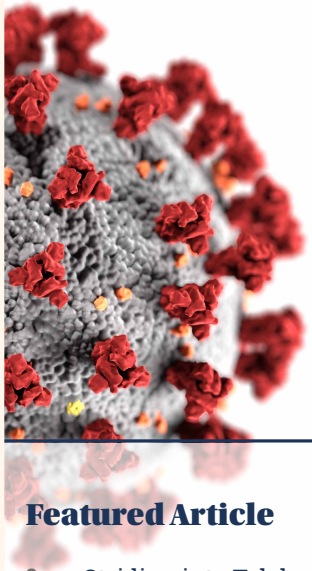

Co-Editor Statement

Heidi A. Zetzer & Karen J. White

We are pleased to offer this edition of the APTC Bulletin: Practicum Education and Training (PET) on the topic of the coronavirus pandemic and COVID-19. This issue was conceived just after the start of the pandemic and before the collective and inclusive rise of awareness, advocacy, and activism centering on anti-Black racism and the long history of racial injustice in the U.S. Given this timing, the focus of this volume is centered on COVID-19 and how educators, supervisors, students, and training clinic directors responded to the call for remote services. The Winter/Spring issue of PET will focus on diversity, equity, and social justice in the context of anti-Black racism and racial injustice. A call for submissions is included in this issue.

The pandemic created an imperative among psychology training clinic directors to move immediately from in-person services to telehealth. Suddenly, many directors found themselves in uncharted terrain. They were required to launch telepsychological services as quickly as possible; to collaborate with instantly overburdened IT experts to identify solutions that would replace in-person contact and to protect patient privacy while providing training and supervision for practicum students; to consider developmental issues for clients and trainees; and to create policies and procedures that met HIPAA guidelines, regional mental health laws, and the standard of care for patients who were hoping for help with the impact of COVID-19 on their lives and livelihoods. The response of practicum education and training leaders was swift. Systems were created to meet the needs not only of current clients, but of the increasing numbers of people throughout the world, who are struggling with anxiety and fear, depression, loss, isolation, and loneliness.

Karen J. White

We are grateful for the generous contributions of knowledge, wisdom, and expertise that comprise this issue. The authors documented their craft while still crafting it! The effort, demonstrated by training clinic directors, supervisors, practicum students, administrators, and campus IT is sure to motivate readers to sustain their own long-term projects. This was (and still is) a team approach to telehealth that is of championship caliber and worthy of deep respect.

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President's Message

Leticia Flores, Ph.D.
University of Tennessee

I imagined that I would write my first presidential essay for APTC still high off the rush from our annual conference, flush with dopamine triggered by hugs and handshakes, smiles and laughs shared with old friends or new acquaintances. Instead, I find myself writing this while sitting in my "office" (read: living room), where I attend innumerable Zoom meetings and write and respond to an unending flow of emails addressing the COVID-19 pandemic and the police killings of Black Americans. The world feels like it's falling apart all around us, and many of us may still be enduring at least partial social or self-imposed isolation at the time of this publication. These have been dark times.

We are all struggling with how to best care for our students, our patients and clients, our communities, our families and often lastly, ourselves. We are rushing to get remote testing up and running. We are organizing and facilitating discussions for students of color and for White students to process how current events are affecting them personally and professionally. We are attending departmental, school-wide, or discipline-wide meetings on racism and White privilege. Often we tear ourselves away from our computers too late at night, only to endure strange COVID-19 dreams that leave us scratching our sleep-deprived heads in the mornings. If we are ourselves directors of color, these stressors and burdens may feel even heavier, and harder to shake, than usual.

As incoming president, I have struggled with how to contain our collective stress and provide hope and leadership to not only our veteran members but our new members, who missed the opportunity to connect at our conference. But then I remembered who makes up APTC. We are never really alone as directors. We are always one email or listserv post away from an APTC friend who can make us feel a little less isolated, and who can shine some light into the darkness.

I have marveled time and again at the immense depths of generosity and compassion that APTC members have shown each other these past few months as each of us try to find our way through the confusion that the twin plagues of 2020 have wreaked on our work as trainers and service providers. Members who share stories of loss are met with numerous responses offering kindness and support. Other members proactively share tips and even full protocols for navigating new technology platforms, and we respond with multiple emails of gratitude. Resources for dismantling racism and promoting socially just actions at all levels of education, training and practice are being developed and shared by the Diversity sub-committee. The Assessment sub-committee has drafted guidelines that can help all of us develop safe and valid testing practices. APTC members continue to be there for each other, through all the highs and lows of the year. Silly pictures and stories are shared to lighten a stressful day and bring some welcome comic relief and distraction. As an organization, we will continue to ensure that our sibling clinics are prepared to continue to deliver high quality training to our students, provide high quality services to our communities, and that our directors are acknowledged and supported. We've got each other's back.

I imagined that I would write my first presidential essay for APTC still high off the rush from our annual conference, flush with dopamine triggered by hugs and handshakes, smiles and laughs shared with old friends or new acquaintances.

We know our work is not done. We know that more challenges lie ahead of us as we begin to open again for services and resume training. Our world is still sick, both medically and spiritually. Students will continue to need us, as will our clients and patients, and those needs will change over time as circumstances evolve. Some of us will trip up and make mistakes. We will engage with good intentions but falter in our execution. We will increase our risk for burnout. So we must remember to check in with each other and have conversations that we might have had in the conference hotel lobby, online, or over the old-fashioned phone. It will do us all good to remember why we enjoy being a part of this organization and to nurture our connections.

With that said, I hope you enjoy this installment of the APTC Bulletin. You'll find many great articles and essays on how we have worked through the COVID-19 fog, and you will likely find good suggestions to incorporate into your own work and your New Student Orientations for 2020-2021. I hope these submissions start new conversations and lead to fresh ideas among us. I look forward to continuing to learn from all of you on the listserv, and hope to see all of your faces at our 2022 conference.

With love and appreciation,

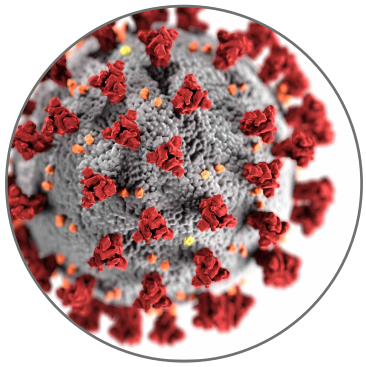
Lettie

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.

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.

...Searching my memory for a protocol that it did not have.



The Bad Virus:

The First Incidence of COVID-19 in a Psychology Training Clinic

Kim Lampson, Ph.D.
Northwest University

It was Monday. March 9, 2020. Kirkland, WA. A typical Monday, almost. I had come to our NUhope group supervision armed with hand sanitizer, alcohol wipes, and a new directive for everyone to start taking precautions. The Corona Virus, soon to be renamed COVID-19, had recently hit the news. Twenty miles north in Everett, WA, a man was diagnosed with the virus after returning from China on January 20. Subsequently, the LifeCare Center in Kirkland suddenly became the epicenter. Two cases on February 28 with the first death on February 29, and then this novel disease spread like wildfire through the facility. My colleague's father was a resident there; she was in quarantine. Quarantine—what does that mean? A word so foreign back then, yet so familiar now.

Sitting side-by-side, six *inches* apart, nine NUhope therapists, one graduate assistant and I sat in a circle for two hours, like we always did on Monday mornings for group supervision. As part of our routine, we began with a few moments of deep breathing, exhaling with mouths open into the air around us. We were talking and laughing. No social distancing—we had never heard that term—and definitely no masks. I doubt that any of us owned one. A typical Monday, except for a few new rituals metamorphosing our routine: we sterilized everything after our meeting and opened the windows. Little did we know that despite these efforts, an uninvited guest had already joined us.

After group supervision, I made some coffee, as usual, with the communal Keurig, then spent an hour in an enclosed room with the person who unknowingly carried the stowaway; it was her individual supervision time. She was feeling fine, casually commenting as she blew her nose, that she had allergies that always acted up at this time of the year. I didn't give it a second thought; neither did she.

Student therapists were getting a little nervous, but we were still open and operating business as usual, just more OCD about sanitizing, hand washing, and keeping windows open. However, our hand-washed, ceramic, environmentally friendly coffee mugs that we had provided for clients who loved the Keurig were closeted away, replaced by hopefully recyclable, poorly crafted paper imitations. We were building a fortress of alcohol wipes, hand sanitizer pumps (soon to be a coveted possession), cleaning rituals, and untouchable surfaces, but we were not impenetrable. We had the "It will never happen to me" attitude, but it did.

The next day, March 10, the student therapist I had supervised the day before called me. I was at my private practice that day. I saw her missed call come up on my phone between patients and something told me I needed to call her immediately. Her voice was strained. Her anxiety expelled her words too fast. She said she had a fever and cough, and thought I should know that I and the others at NUhope had potentially been exposed to "the bad virus." I had no idea what to do. My mind was racing, searching my memory for a protocol that it did not have. This was something new. After thinking for a few moments, I started making phone calls.

I contacted my Dean and our wellness coordinator. This was the first potential case at our university, so there were no procedures in place. Our wellness coordinator suggested calling the state coronavirus hotline. I did. The helpful, yet clearly overwhelmed woman on the line said we all had to quarantine for 2 weeks unless the student's test came back negative. I acted robotically, calling all the students at NUhope, informing them that their lives were about to change dramatically. They were stunned. None of us had ever experienced

quarantine before. This was so early in the testing process that we had to hold our breath for nine days, waiting for the results. Those nine days felt like an eternity—every little symptom- runny nose, sneeze, cough, headache- any of us experienced raising the hair on the back of our necks. The student's test was positive. As it turns out, no one else developed symptoms of the virus- at least we do not think we did, but no one really knows for sure.

On March 11, the World Health Organization declared COVID-19 a pandemic (Hames et al., 2020). No one understood what that meant back then. It was still early. This was before the U.S. declared a national emergency on March 13 or before Washington's Governor Inslee instituted his stay at home order on March 23. It was way before March 26, when we heard that there were 81,000 confirmed infections and 1,000 deaths in the United States. These numbers, so horrifying then, seem so insignificant now.

Fortunately, we had all been trained in the provision of telemental health and had practiced using it. NUhope had embraced the vision of becoming a telemental health resource long before COVID appeared. Some student therapists had already been "seeing" clients using this modality, but in the clinic.

So, a few weeks before others would follow suit, we informed our clients we would be using telemental health and instantly began the process of adapting this "viable and elegant solution" (Inchausti et al., 2020) to the problem of how to provide quality mental health care during a worldwide physical health crisis. It actually was a surprisingly smooth transition (Hames et al, 2020). Most clients were amenable and willing to give it a try. Of the few that declined, most came around within a few weeks. Working from home became the norm and continuing the sessions worked well. Our supervisors adapted quickly and under the circumstances of quarantine, soon to be followed by sheltering in place, welcomed the online option. What took time to organize was using a VPN to access Titanium and having our IT department establish a method for billing. The latter took about six weeks to accomplish.

What have we learned?

Our student recovered. She had a rough time of it, but regained health and recuperated without hospitalization. Our clinic survived as well. Survival required being flexible, adaptable, creative, and innovative (Bell et al., 2020; Inchausti et al., 2020; Rosen et al., 2020). It is interesting to note that historically, it is the therapists, not the clients, who have been reluctant to utilize telemental health due to lack of knowledge of and comfort with this mode of therapy (Rosen et al., 2020).

There is no question that the changes implemented during quarantine and sheltering in place will last long past COVID-19. Telemental health, already an option before COVID at NUhope, will likely be a much larger presence as will telesupervision. Supervisors can take a leadership role by modeling the effective implementation of telemental health (Inchausti et al., 2020). It appears that our field will be reevaluating supervision and be much more open to telesupervision options, thereby allowing for diversity in supervision made possible with access to a wider variety of supervisors to train our students (Bell et al., 2020; Hames et al., 2020; Ichausti et al, 2020). In the near future, when in-person supervision is an option for some, allowances will need to be made for supervisors who are in high-risk groups who prefer to continue remote supervision for health reasons.

As so aptly stated by Bell and colleagues (2020, p. 12), "What was unquestionably an unwelcome and incredibly challenging occurrence, the COVID-19 pandemic also brings the opportunity to advance and even transform HSP education and training." There is no question that telemental health can benefit clients and open doors for people who may not otherwise have access to care including those whose past trauma makes driving or even leaving home an impossible obstacle to overcome (Bennett et al., 2020; Rosen et al., 2020). Bennet et al. (2020) reported that telemental health is effective in treating depression, anxiety, alcohol- related problems, and general mental health, as well as PTSD (Rosen et al., 2020). In addition, it allows for continuity of care when a therapist or client is in quarantine or under a shelter in place order in the future (Rosen et al., 2020).

Students need to be trained to help people who have been traumatized by the pandemic itself. It is thought that the majority of people will not have mental disorders as a consequence of the pandemic, but some will develop symptoms due to prolonged quarantine, death of loved ones, serious COVID illness, intubation, or social adversity (Inchausti et al., 2020). Health care professionals providing direct care to COVID patients are also at high risk for subsequent mental health consequences (Inchausti et al., 2020).

Reflections

As a training clinic director, I felt the weight of making decisions for the well-being of my student therapists, my graduate assistants, my supervisors and the clients. At times, it seemed like the weight of the world was on my shoulders. The support of colleagues at my university and through the Association of Psychology Training Clinics (APTC) listserv was invaluable. Balancing the needs of my students with the needs of clients for continuity of care was delicate and I could feel the internal struggle (Inchausti et al., 2020). The day before we stopped in person sessions, one student therapist expressed concern about seeing clients and I encouraged her to try it for one more day as we waited to see how things evolved in the community. In retrospect, I think it would have been better for me to tell her to not see clients in the clinic if she was concerned about the health risks. I am aware of the power differential between me and the students, and knew some might be reluctant to advocate for themselves (Bell et al., 2020). The quarantine made that decision for us and the shelter in place order sealed the deal, but I learned something from this experience. In WA state, mental health providers are considered essential workers, so sorting out what that meant for student workers was a new challenge faced by many of us (Bell et al., 2020). I guess this complexity in decision-making and level of responsibility has always been part of my job, but never before did the reality of it impact me like it did on March 10, 2020. Although this sounds cliché, our training clinic will never be the same, nor will I. We joke about how we will tell our grandchildren stories of this time and how intolerant we will be when, long past this pandemic, student therapists of the future will complain about having to share office space or a computer, and we will say, "You think you have it bad. Well…let me tell you about the spring of 2020…."

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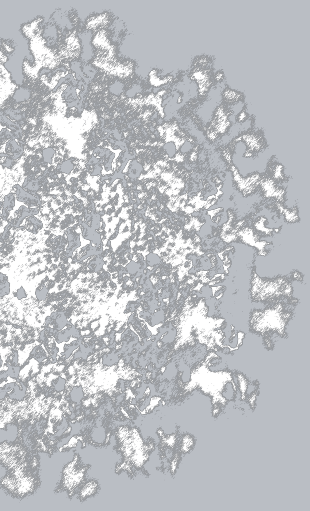

Looking Ahead:

Pandemic-Specific Clinical and Ethical Considerations in Preparation for Incoming Trainee Cohorts

Claire Lankford, MS, Alisha Desai, MS , & Jennifer Schwartz, Ph.D.
Drexel University

The COVID-19 pandemic introduced a series of ethical considerations for psychology training clinics (PTCs) that impacted patient care, student training, and supervision. This unprecedented situation underscored the "complexity and inherent ambiguity" that arises in ethical decision-making (Handelsman et al., 2005, p. 65). As the pandemic continues and a new training year begins, these ethical considerations have not only changed, but also must be balanced against competing considerations as fewer unprecedented and imminent changes occur.

COVID-19 introduced the possibility of transitioning to a telehealth model—a consideration that was fraught with conflict between competing principles and standards of the professional code (e.g., beneficence and non-maleficence, providing services in emergencies) as well as jurisdiction-specific laws governing practice (e.g., allowance for greater flexibility in conducting telehealth across state lines). Notably, clinic directors (CDs) made the initial transition to telehealth with trainees who had at least 6 months of training within the PTC, allowing for clinical and supervisory decisions to be made based on experience with the clients and trainees, and an accompanying understanding of trainee strengths and needs. As clinics prepare for an incoming cohort of trainees, who have no experience with the setting and may be conducting teletherapy for the first time, CDs must consider multiple additional factors.

Overlapping Ethical Considerations

The American Psychological Association Ethics Code (APA, 2017) provides psychologists with standards and principles to ensure best practices. The code is binding for psychologists who are members of APA, but also applies more broadly to psychologists who practice in states that have adopted some or all of the APA Ethics Code into law.

Responsibility to Train Students

CDs are responsible for training students and providing trainees with programs that support eventual licensure as outlined by Standard 7.01 (Design of Education and Training Programs) and Standard 7.02 (Descriptions of Education and Training Programs). Moreover, teletherapy enables CDs to mitigate health risks while also fulfilling their obligations to students and patients. Furthermore, many PTCs provide low cost and high-quality services to underserved community members who could not otherwise access or afford mental health treatment.

Recommendations. PTCs should strive to remain open and adapt services to adequately meet the needs of trainees, clients, and supervisors/clinic staff. CDs may need to adapt evaluation forms (Standard 7.06) to include new or different competencies (e.g., telehealth) that will be trained and assessed. They must also be mindful of the inherent power differential between student trainees and supervisors, as decisions regarding resuming in-person services are made. Trainees may worry about safety, but also have concerns about the implications that personal choices (e.g., expressing concerns about resuming in-person services) may have on their careers (e.g., quality of recommendation from a supervisor). With this in mind, CDs should strive to frame pandemic-related policies in a trainee-centric manner and to remain open to discussions about trainee concerns. For example, rather than developing an "opt-out" policy (whereby the clinic resumes in-person services and students must request to continue working from home), PTCs could offer an "opt-in" policy (whereby students must make a compelling argument for resuming in-person services if they wish to do so). Additionally, CDs should remain up-to-date on changing training

expectations to reassure students who have concerns about obtaining sufficient hours for internship and accreditation.

Perhaps more than ever, CDs should strive to encourage and support differing opinions and feedback about pandemic-related policy changes. CDs, supervisors, administrative staff, and trainees should work together to develop a training scenario that meets each group's needs, provides adequate support, and minimizes risk. Additionally, regular group check-ins would allow team members to address any concerns that arise, troubleshoot issues, and enable the PTC to adapt accordingly.

Boundaries of Competence

When COVID-19 emerged, CDs were able to make a rapid shift to teletherapy under Standard 2.02 (Providing Services in Emergencies) in order to "provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training" (APA, 2017, p. 5). However, as most mental health providers have transitioned to telehealth and many have resumed accepting referrals, CDs must now place greater emphasis on the boundaries of trainee competence (Standard 2.01). Specifically, CDs are enjoined to focus first on building trainee competence and to consider referring clients to other services, suspending clinic services, or reducing clinic caseload given the level of trainee telehealth competence in their clinic. In addition to determining how to train new students with no foundation in telehealth, some CDs may be working with students who have either no or a minimal foundation in conducting psychotherapy in person (APA, 2013).

Recommendations. To address this latest shift in ethical focus, CDs may opt to train incoming practicum students in telehealth delivery first. In doing so, CDs can incorporate didactics and web-based trainings on teletherapy (e.g., Telepsychology Best Practices 101 Series; APA, 2019) into the clinic orientation. Additionally, supervisors or advanced trainees can role-play teletherapy sessions with the incoming cohort, or confederates can be used to closely mimic a "real-world" session. Furthermore, it may be appropriate to provide more oversight of trainees as they build competence in psychotherapy and teletherapy, which can include live supervision (e.g., supervisor is an observer in the virtual therapy room) or co-therapy with a supervisor or advanced trainee.

Novelty of Students

As CDs prepare for a new practicum year, they must determine how to train new students. Although some incoming trainees may have prior psychotherapy and telehealth experience, they remain unknown to the PTC, the CDs, and supervisors. Novice clinical trainees have several needs that require targeted training and attention: documentation and procedural logistics (e.g., scheduling patients), session preparation, and thorough risk assessment skills. Additionally, novice clinicians lack confidence in their ability to make clinical judgments in session and often require reassurance.

Telehealth has been cautioned against for one's first psychotherapy training experience, particularly given that supervision and didactics will also occur via videoconferencing (APA, 2013; Association of State and Provincial Psychology Boards [ASPPB], 2020). In response to COVID-19, ASPPB provided state-specific guidance that amended prior requirements that supervision occur in person, which enabled doctoral trainees to fulfill licensure requirements through telehealth and telesupervision (ASPPB, 2020). As PTCs continue offering teletherapy during the pandemic, CDs should address the inherent differences between providing psychotherapy, training, and supervision in person as compared to remotely. Delivering these services without the support of on-site supervisors, administrative staff, and peers is a monumental task for new clinicians as they conduct psychotherapy for the first time. Clients are also in an uncontrolled setting with access to means of self-harm as compared to in the clinic building, which has implications for risk assessment and intervention.

Recommendations. CDs may opt to enhance existing supports or create new infrastructure for remote operations. Onboarding and orientations present a unique challenge because incoming trainees do not have a framework for understanding the typical procedures for the PTC, let alone having a foundation for the telehealth-based deviations. As such, CDs may find a need for longer and/or repeated meetings or trainings. Additionally, it may prove helpful for trainees to demonstrate a new skill through role-plays prior to working with clients or live supervision. Exercising patience and understanding of the stressful nature of this transition for both supervisor and trainee is critical.

During the transition, incoming trainees may be paired with peers in their cohort (for coaching, support, or assistance as needed), advanced students, or peer supervisors during therapy sessions. CDs may utilize a co-therapy or observer-participant model, with incoming trainees assuming greater responsibility as they become increasingly familiar with the clinic. As such, there may be a prolonged transition period or caseload overlap, which would also allow for peer modeling of administrative tasks (e.g., scheduling, documentation). Furthermore, PTCs would benefit from developing a protocol for obtaining assistance during a session. This protocol may differ depending on the needs and characteristics of each PTC, but may include using the private chat function if conducting live supervision of a virtual session, allowing a supervisor into the session as needed, or receiving in-the-moment text-based coaching.

A number of alterations can be made to address the need for regular supervision during initial stages of clinical training. Supervisors may plan to schedule "check-in" meetings before and after a trainee's first sessions, which may approximate the office drop-ins that frequently occur in the beginning of the training year. Based on training needs, supervision can occur more regularly to offset the limited opportunities for informal supervision that can occur when receiving training on-site. Additionally, PTCs can offer regular "office hours" intended to troubleshoot various issues that may arise during the practicum day that should be addressed prior to weekly supervision.

Conclusion

While CDs attempt to problem solve during this ongoing pandemic, they continue to encounter ethical and legal hurdles at nearly every decision point. In the absence of a perfect solution, CDs must develop a model that addresses the underlying tensions and competing needs of these various ethical considerations.

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FEATURE

Striding into Telehealth: PROGRESS, PITFALLS, AND POSITIVE OUTCOMES

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During the COVID-19 pandemic, I have benefited from some key lifelines, with the Association of Psychology Training Clinics (APTC) among the most notable. The group's wisdom, generosity, and support have been evident in listserv discussions, individual consultations, website resources, and the APTC Bulletin. So, I was thrilled to hear about the focus on COVID-19 in this issue of *The Bulletin* and happy to contribute. The article's title, suggested by Heidi Zetzer and Karen White, sounded great. *Striding into Telehealth…* filled with purpose, intention, strength, resilience, and forward-thinking action. The reality has been somewhat less elegant, at least for me, and I suspect for many others as well. Rather than a purposeful stride, I felt like our steps toward telehealth in the University of Missouri Psychological Services Clinic (MU PSC) could be characterized as careening headlong into the abyss! The path forward was poorly-lit; I felt unprepared and off-balance, but didn't have the luxury of pausing to get my bearings. COVID-19 and client needs weren't pausing. Student training needs might pause briefly, but not for long. So, our clinic forged ahead, creating our plan as we went. Over time, we began to find our stride. We regained a bit of balance, adjusted to the dark and unknown path enough to see some illumination and guideposts. The path was smooth in places, only to be followed by rocky ups and downs and sudden turns, seemingly as soon as we adjusted to one set of circumstances. We are now settling in for the long road ahead, as universities, clinics, and communities prepare for re-opening (and likely re-closing), acute pandemic responses give way to more chronic stressors and longer-term adjustments to "our new normal."

How have we, as clinic directors, found our stride, and how can we keep moving forward, using telehealth to meet client service and student training needs during COVID-19 and beyond? A lot of great energy and talent has helped the psychology education, training, and service delivery communities all work together on this journey, mapping the terrain, providing guiding lights and support, and cheering each other on. Here, I offer some thoughts (and some lists) on what I see as key aspects of our progress, challenges and pitfalls, and the positive outcomes we've seen or can anticipate as we stride into telehealth.

Progress in Telehealth during COVID-19

Despite a small but growing literature demonstrating its utility (e.g., Ascierno et al., 2017; Khatri, et al., 2014; Lin et al., 2019), telepsychology has not been a routine part of training in health service psychology. COVID-19 changed all that. By necessity, within weeks of the onset of the COVID-19 pandemic, most APTC training clinics were employing telepsychology, typically to deliver therapy to current clients and to supervise trainees' service delivery (Hames, et al., 2000). In the MU PSC, I went from a lunchtime conversation with a clinic colleague about being almost completely telehealth-naïve, but needing to think about developing "*unlikely to be needed but just in case*" plans for a potential campus closure, to transitioning our first clients to telehealth two days later, and closing the clinic and going fully remote the day after that. Hence the sensation of careening! Several key factors have supported progress toward telehealth for my training clinic and others.

Generous Information and Resource Sharing. The telepsychology learning curve is steep. Training clinic directors needed to become quickly informed on logistical, technological, ethical, and legal aspects of providing telepsychology, with simultaneous consideration of client care and student training needs, and implications for students' eligibility for internship and licensure, program accreditation, and clinic operations and financial security. It was difficult to even know where to start, which questions to ask, or where to find answers. As smart and resourceful people, we could figure it out, but we didn't have time for that! Fortunately, many people knew at least a piece or two of important information and shared their knowledge via listservs, consultations, and publications (e.g., Callahan, 2020; Hames et al., 2000). Resource repositories (e.g., APA, 2020; APPIC, 2020a) have been crucial in helping us manage the rich and overwhelming array of relevant resources.

Explicit Guidance and Recommendations. Statements from the training community (e.g., APPIC, 2020b-f; Baker, et al. 2020; Bell et al., 2020; CCTC, 2020; Wright, et al., 2020) had at least two major benefits. First, they helped prioritize issues and solutions from among the sea of potential resources & actions. Guiding principles (e.g., balance, prioritization of training, sensitivity to power and resource differences) helped frame key issues, and specific recommendations provided tangible ideas for action. Second, these statements helped address barriers to telepsychology. Some agencies were slower to adopt telehealth, often due to challenges with technological resources, institutional or governmental policies, or client services that were not ideally-suited to remote delivery, sometimes coupled with slow-moving bureaucracies unable to adapt to the speed of the pandemic. Explicit guidance from professional leaders added weight that facilitated movement toward telehealth. At my own institution, it was often helpful to share the best advice from national organizations, even if it was the same idea I had just shared (and even when I was an author of the training community guidance!).

Regulatory Action. Formal executive orders and regulatory changes that supported telehealth, relaxed HIPAA standards, and facilitated practice across jurisdictions were crucial for implementing telehealth quickly, with currently available technology, and to clients in need regardless of their location or prior status as an active client. Statements by licensing bodies and program accreditors accommodating broader forms (e.g., telephone) or greater percentages of telepsychology than typically allowed helped educators and students focus on service delivery and training without worrying that pursuing telehealth would create problems for accreditation or licensure.

Institutional Supports. For training clinics embedded in higher education institutions, the institutional response can greatly help or hinder telepsychology. University legal departments determine what clinics can and cannot do. Our General Counsel initially prohibited any telehealth services provided by trainees, based on their interpretation of a state law (we were able to work with colleagues statewide to prompt a re-interpretation). At the same time, they were incredibly helpful in crafting legal documents and identifying practices they were willing to defend (e.g., continuing to provide care to clients who had traveled to states without clear interjurisdictional practice authorization). IT departments determine what software and hardware clinics can use, and many IT departments acted quickly to help secure HIPAA-compliant communication, records storage platforms, and appropriate equipment, and to train clinic personnel to use these resources correctly. My own clinic also benefitted from the support of university communications and outreach units, who featured our clinic's telehealth services as a key

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part of the university's response to COVID-19, helping to advertise our services, expand our reach to clients in need, and elevate our profile as an important part of the campus and community pandemic response.

Within-Clinic Teamwork. As we hit our stride within the MU PSC and our sprint became a marathon, I was incredibly blessed to be running not a traditional individual marathon, but a relay marathon. Our clinic's Assistant Director, whose skills and professional passions were well matched to crisis responding, took over much of the implementation (drafting forms, crafting implementation instructions, creating online accounts and Box folders, communicating with IT and other support resources), allowing me to focus on policy and procedure development. Clinic faculty provided input on decisions, piloted new procedures, helped find and digest resources, and communicated with community partners. Student clinicians were eager and willing to meet client needs and pursue their own training needs, even in the face of procedures that were new and in a constant state up piloting, fine-tuning, updating, scrapping, and recreating, and even sometimes when there were no established procedures and students were challenged to help create them. Working together, we moved quickly and effectively into new telehealth territory, capitalizing on each other's strengths and allowing each other some time to breathe on the grueling and fast-paced path to telehealth.

Pitfalls Along the Telehealth Path

Implementing telehealth during COVID-19 has been, and will likely continue to be, accompanied by challenges and pitfalls. Many of these, including the practical, ethical, legal, and technological issues noted above, have been articulated well by a growing literature (e.g., see Journal of Psychotherapy Integration special issue: Callahan, 2020). Here, I describe a few more personal challenges that can impact telehealth during the pandemic.

The Need for Order. A decision-making approach that is orderly, deliberative, thoughtful, and based on a clear understanding of the best available evidence and guidance is generally a great advantage for clinic directors. While a thoughtful and evidence-based approach remains critical during the COVID-19 pandemic, the reality is that we are simply not in a position to have a clear grasp on all of the relevant information that seems to increase exponentially almost daily, and we don't have time to be as deliberative as we may wish to be. Low tolerance for ambiguity, reluctance to act without clear (or sometimes any!) direction, and fear of making the wrong decision can interfere with timely decision-making and increase the stress of the process.

Balancing Work at Home. Because pandemic-era telehealth delivery, supervision, and administrative oversight are largely being done from home, the challenge of work-home balance has reached unprecedented levels. The privacy and uninterrupted time needed to conduct telehealth and telesupervision sessions can be elusive, and sometimes, client work just needs to progress in spite of a barking dog or random toddler sightings. It's okay… clients often appreciate the authenticity of working around "real life."

Fatigue. "Zoom fatigue" (Jiang, 2020) seems to hit a bit sooner and harder than fatigue from in-person contacts. Compassion fatigue is also elevated as clinicians, educators, and clinic directors address the increased stress affecting everyone (Clay, 2020). In general, people are just worn out from the work of new tasks and new stressors.

Expecting Perfection. Perhaps the biggest pitfalls in implementing pandemic-era telehealth have not to do with experiencing these challenges, but with being surprised by them or overestimating our ability to handle them without ever breaking stride. Striving for "good" versus "perfect" in the current circumstance is not only more realistic, but also infinitely more adaptive for educators and students.

Positive Outcomes and Possibilities

Despite the stressful circumstances under which many clinics developed telehealth services, and the challenges of making such quick and drastic changes to clinical training and service delivery, several positive outcomes highlight the promise of telehealth as a more permanent, long-term addition to clinical training and service delivery.

Flexible System of Care. The pandemic will likely require extended or new closures or constraints on in-person clinical services in coming months. Decisions to deliver services in person or remotely may vary based on client and clinician preferences, service type, and local virus levels. The flexibility of telehealth can help clinics maintain services during these changing circumstances.

Broader Access to Care. Telehealth may open services to a broader range of clients than usual. At MU PSC, for example, new clients enrolled in our COVID-related services are more ethnically diverse than our pre-pandemic clientele. Although this may be due to several factors, the telehealth treatment modality may offer advantages for clients who may feel more comfortable participating in therapy from their own environment, without the challenges of the time, transportation, and child-care arrangements needed to attend in-clinic sessions. We are also using our new telehealth practices to extend our services to rural citizens, who have limited access to local services and who tend to prefer the privacy and convenience of telehealth.

Access to Training in New Competencies. Students are broadening their competencies in areas such as evidence-based and ethically-guided practice, use of supervision and consultation, self-reflective practice and self-care, all as relevant to the telehealth modality of service delivery and supervision. Interestingly, many of the skills needed to implement telehealth during COVID-19 require making decisions in the absence of established information or procedures, characteristics of several of the advanced "readiness for practice" competencies (APA, 2011). The pandemic has also created the need for students to develop metaskills such as a tolerance for ambiguity and an ability to see opportunities within challenges.

Strengthened Training and Service Collaborations. Hitting our stride with telehealth has required collaboration across our campuses and local communities, and across the national professional community. Together, we are developing best practice procedures, sharing resources, and joining forces to advance the science that informs training and service delivery. These partnerships are important not just for the current situation, as we rapidly deploy telehealth during COVID-19, but will also pave the way for coordinated action around other community needs and initiatives.

Conclusions: Putting It All Together

As I consider how to use what I've learned from the experience of implementing telehealth during COVID-19, my thoughts settle on four recommendations that can be applied to telehealth implementation or other new challenges.

1) **Communicate/collaborate**—to share information, resources, and support.

2) **Work with key decision-makers and leverage points** (institutional, state, and national administrators, legislators, organizations)—to impact policies that drive practice.

3) **Breathe**—to relax, focus, and prepare to move into new territory.

4) **Just do it**—whatever new, uncharted task the crisis at hand requires. It won't be easy or perfect. But it will happen, and with communication, support, and focus, it will be fine.

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When Life Gives You a Lemon, Make Lemonade for Those Most Thirsty

RESPONDING TO THE COVID-19 PANDEMIC & REACHING OUT TO UNDERSERVED COMMUNITIES

Personal Reflections by Randall J. Cox, Ph.D.
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Spring Break 2020, seemed a little less of a spring or a bounce and more like a full-throttle launch into outer space! I am quite certain that many or most of my training clinic director colleagues can relate to the experience of being suddenly transported to a drastically unfamiliar place. Seemingly overnight we were tasked with what appeared to be an impossible task—finding a way to maintain our shared mission of training, research, and community service from an entirely remote/telehealth platform!

I must confess, my abrupt experience of floating aimless in a vacuous space of uncertainty and unfamiliarity was perhaps less horrifying than many. At least I was blessed to have the semblance of a spacecraft equipped with minimal life support. Thanks to the incredible efforts of my University of North Texas colleagues, Jennifer Callahan and Camilo Ruggero, our program had landed a $1.2 million Health Resources and Service Administration training grant (HRSA GPE grant #D40HP33372), intended to address gaping health disparities in substance abuse treatment by increasing training in emerging tele-behavioral health technologies.

Although we were in no way prepared for the many consequences of the COVID-19 pandemic and the associated training issues it posed, we were already planning to integrate telehealth training and service provision into our clinic on a limited basis starting in the Fall 2020 semester. This truly ended up to be an unexpected blessing because we were able to hobble along until managing a semi-predictable orbit out here in this new frontier!

Perhaps some already saw the UNT Telehealth Training Manual[1] our team was able to put together and share with the listserv relatively early on in this process. This was only possible because we had already initiated the collection of multiple resources as well as conducted preliminary technology infrastructure discussions with our IT team. In addition, Jennifer Callahan was very busy, as Editor of the *Journal of Psychotherapy Integration*, putting together a special issue devoted to telepsychotherapy in the age of COVID-19 (Callahan, 2020).

Now it was time to turn on the after-burners and reach full orbit! After countless hours and meetings with IT, we now had infrastructure in place to launch telehealth psychotherapy sessions, including HIPAA compliant recording and storage capabilities as well as remote access to Titanium Scheduler (Ti) and a payment portal located on the clinic's webpage. We were also able to transition from an in-house-only web component of Ti to a remote web component that allowed clinicians to access intake materials, screening assessments, and engage in data collection (e.g., OQ). Through the herculean efforts of Dr. Callahan and several of my graduate student assistants, we were also able, in very short order, to launch an entire system to conduct psychological evaluations in a telehealth format.

As everything began to run smoothly (for the most part ☺) with the clinic's daily operations, the HRSA team turned our attention to making the absolute most out of all this incredible hard work! We decided this challenging time afforded us an excellent opportunity to make a real and concerted outreach effort toward those who would otherwise have little or no access to mental health services. After developing a flyer to describe our program, we coordinated directly with the staff at the Texas Psychological Association (TPA) to get the word out to the Austin offices of elected officials from the surrounding north Texas counties. Additionally, I personally sent a letter or email to each of the county's department of health offices asking them to please circulate information about the rural outreach program to all agencies they determined could benefit from this referral resource.

It is richly rewarding for our team to be able to take this unfortunate set of circumstances and in response, build a sustaining rural mental health outreach program. Through the quick training of our clinical faculty and ability to hire several consultants with significant prior expertise in tele-mental health, we are now positioned to offer training in tele-behavioral mental health to future generations of students. In the spirit of continuing our efforts toward addressing disparities, we also hope to incorporate the rapidly evolving area of ehealth technologies into training, research, and service (see Bennett et al., 2020).

[1] The UNT Telehealth Training Manual is available: https://aptc.org/

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Cultural Barriers to Obtaining Mental Health Services: The Unique Impact of COVID-19 on Refugees

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Since 1980, over three million refugees have resettled in the United States (Refugee Processing Center, 2020), often having suffered trauma, political atrocities, and torture (Campbell, 2007). Although refugees exhibit remarkable resilience following trauma, many also experience mental health challenges such as anxiety, depression, and post-traumatic stress (Bogic et al., 2015; Ghumman et al., 2016; Marshall et al., 2005; Steel et al., 2009). The current COVID-19 pandemic and subsequent challenges (e.g., job loss, health concerns, closures in daycare facilities and schools) may disproportionately exacerbate mental health concerns in refugee populations due to higher poverty levels, economic instability, health conditions, and underlying diseases (Mattar et al., 2020; Orcutt et al., 2020; Volkin, 2020). Although most mental health providers across the U.S. halted face-to-face services at the outset of the pandemic and shifted to virtual platforms, some evidence exists that refugees may not be receptive to telemental health services. A study conducted before the COVID-19 pandemic found that only 45% of Syrian refugees who experienced post-traumatic stress symptoms were open to telepsychiatry (Jefee-Bahloul et al., 2014). Thus, there is a pressing need to identify barriers that prevent refugee populations from engaging in telemental health services.

Telemental health platforms introduce cultural barriers often classified as structural (Ayers et al., 2018; Kiselev et al., 2020). Structural barriers relate to institutional systems and socioeconomic status, including linguistic challenges, financial problems, logistical issues, and waiting lists for specialized services (Kiselev et al., 2020). These structural barriers often stem from economic disparities and have contributed to the difficulty of disseminating telemental health services to refugees. Barriers particularly pertinent to a technological platform include lack of access to necessary technology (e.g., computers, tablets), problems with internet connectivity, interpreters' availability, and linguistic challenges (Hassan & Sharif, 2019; Kiselev et al., 2020). Moreover, it is common for refugee families to live in high-density homes with multiple families, increasing the risk of illness, and hindering the privacy necessary to receiving services through technological platforms (Volkin, 2020). No empirical studies to date have addressed the challenges associated with the virtual delivery of mental health services to resettled refugees. This pilot study aimed to examine structural barriers to accessing and utilizing telemental health services during COVID-19 and comparing the delivery of telemental health services to refugees and non-refugee clients.

Connecting Cultures is a program established in a clinical psychology training clinic (Fondacaro & Harder, 2014) for the provision of refugee mental health services. Since 2007, Connecting Cultures has served well over one thousand refugees originating from over thirty countries of origin. During the COVID-19 pandemic, Connecting Cultures clinicians have provided telemental health services to new and continuing refugee clients. An anonymous 13-item survey was explicitly created for this study through Qualtrics and distributed via email to clinicians practicing within the Connecting Cultures program. The survey included questions regarding access to the necessary technology and the extent that specific barriers have been a problem for clients and therapists while participating in telemental health services. The possible barriers included interpreting services, privacy, language, cost/billing, and scheduling/cancellation concerns. Lastly, the clinicians were asked via survey to compare their experience of telemental health to face-to-face services regarding several topics (e.g., transportation, privacy). Nine clinicians completed the survey for this pilot study. Notable findings from preliminary analyses are highlighted below.

Regarding technology access, clinicians reported that only 31.44% of refugees had access to computers compared with 95.29% of clients in non-refugee populations. Refugee clients were also less likely to have tablets (18.89%) than non-refugee clients (62.71%). The majority of refugee and non-refugee clients had access to phones (95.78% and 100%, respectively). Refugee and non-refugee clients differed in the devices used for telemental health services. Refugees primarily used phones (80.22%), while non-refugee clients were most likely to use computers (87.86%). Clinicians reported the degree with which technology-related structural barriers were a problem for clients on a scale of "not at all," "a little," "somewhat," and "a lot." The majority of providers reported either "somewhat" or "a lot" for refugee clients regarding the following barriers, "access

Language barriers were also **"worse or much worse"** than with face-to-face services.

to a computer, phone, or tablet," "challenges with technology," "internet connectivity," the "ability to have a three-way meeting with an interpreter," and "concerns about privacy." Internet connectivity and privacy concerns were also challenges for non-refugee clients, with the majority of clinicians reporting these barriers as at least "a little" problem. Concerning the barrier of language, the majority of clinicians working with refugees reported that language barriers were a problem with telemental health services. Language barriers were also "worse or much worse" than with face-to-face services. Interestingly, the majority of clinicians reported refugee clients' access to childcare, transportation, and cancellations were, "Better," or "Much Better." In contrast, almost all of the clinicians stated that for non-refugee clients, access to childcare and number of cancellations was the "same" when compared to face-to-face services.

The current study found that numerous structural barriers exist and negatively impact refugees' access to and utilization of telemental health services. There appears to be a large discrepancy in access to computers between refugees and non-refugee clients. Language emerged as a barrier to telehealth services compared to face-to-face services. In contrast to barriers, some of the possible benefits of technology for the delivery of mental health services include access to childcare and transportation and fewer cancellations. The small number of participating clinicians and the lack of assessment specific to the socio-cultural barriers that stem from inconsistencies between the host country's cultural systems and country of origin are evident limitations of this study. Future studies should utilize a larger sample of clinicians across the U.S. and add the assessment of socio-cultural factors (e.g., perceptions of etiology of mental illness) to better clarify the barriers to telemental health in this population. This information is critical to the essential task of reducing barriers preventing refugees from receiving mental health services.

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IMPACT OF COVID-19 ON PSYCHOLOGY TRAINING IN EGYPT

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Do you remember the 1965 Beatles song "Help"? Let's share a few lyrics to refresh your memory. *"I need somebody (Help!) not just anybody, (Help!) you know I need someone, Help! Help me if you can, I'm feeling down. And I do appreciate you being 'round."* Now the stage is set for what happened to our Psychology Training Clinic in Egypt in response to the COVID-19 pandemic. Our story is not unique, we all experienced drastic changes. However, the challenges faced, and lessons learned may differ given the uniqueness of the individuals involved: interns and supervisors. But more importantly, the uniqueness of this region of the world, where similar programs are rare and training clinics are almost non-existent.

In the immediate phase of the rapid shift, our role as supervisors evolved from pre-planned educators to crisis managers and mentors. While the shift was overwhelming, we found comfort through consultation and collaboration with each other to make the most of an unparalleled situation. Our interactions role-modelled effective partnership and joint decision-making. We prepared several of our classes together, and when needed, brought all of the interns together so that our message and approach would be unified. Our discussions shifted from an individual mentality to a collective one. This gave the interns an opportunity to see their supervisors discussing ethical, clinical, and survival issues.

Supervising to Mentoring

Our most consistent message was, "We are in this together and we will all make it." We had ten days from the official campus closure announcement to prepare for online teaching and supervision. We combined the two internship classes to introduce plans for moving forward and preparing them for teletherapy. We focused on the basics of teletherapy: from re-obtaining consent, to becoming aware of body language and changing boundaries during virtual sessions. What was natural in a clinic, was unnatural online. Yet, through careful self-monitoring and humor the interns regained their confidence and style.

This shift led to each of us seeing one another beyond mentors, supervisors, students or peers as we all became individuals who could relate to one another on a more personal level. Virtual classes allowed for veiled females to unveil in the presence of their female supervisor, resulting in more transparency. We had all inadvertently entered each other's homes and sometimes even our respective kitchens. So, we often discussed food and cooking. This level of transparency gave interns comfort in asking personal questions. These questions indicated a desire to know about who we are as persons beyond our professorship. This led to revelations of the more personal side of our students. In some cases, we met their family members, spouses, children and pets online. This would have never happened in our normal setting.

In supervision, the goal became to help the interns feel as whole individuals. We shifted our focus during the first few weeks of supervision from client welfare to intern wellbeing so that they could parallel the process with their clients. The interns shifted from focusing on completing their clinical hours to providing counseling that helped clients grow and restabilize. This afforded the interns an opportunity to grow in their own professional identity.

Infrastructure

In Egypt, internet access is often variable and unstable. Unlimited data plans do not exist. Internet speed varies depending on where you live. Accessibility became more unstable just before curfew during a 12-week period. So, meeting times were adjusted. Client sessions were scheduled at atypical times including 10 or 11 pm. Many times, video sharing had to be turned off to maintain the conversation. Despite these inconveniences, we were able to ensure a continuous connection with the interns and clients.

Concluding Thoughts

The song concludes with *"Help me get my feet back on the ground. Won't you please, please help me, help me?"* We believe that we helped our interns do just that. It was a challenging process. We would be surprised if anyone was prepared for the drastic impact of the pandemic. Yet in some ways, these experiences humanized us more, brought us closer, and shifted the power differential and hierarchy. We collectively grew closer and went beyond being supervisors and transitioned into becoming mentors.

What Was Lost and What Was Gained? Trainee Perspectives On Switching to Telehealth During The COVID-19 Pandemic

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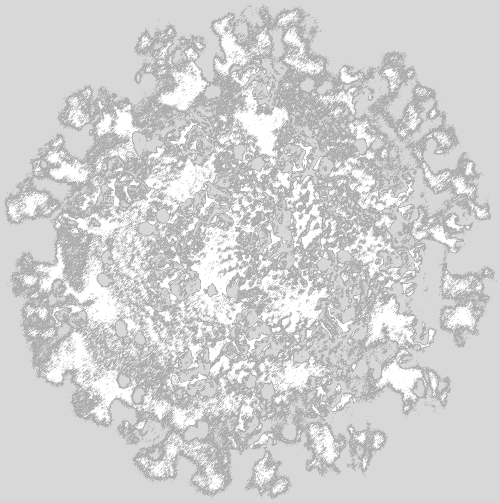

On March 10, 2020, fifteen doctoral students from the New School for Social Research convened in a cramped Manhattan classroom for what was, unbeknownst to them, the final in-person psychotherapy practicum class of their first year in clinical training. The same day, thirteen advanced doctoral students met in the same room for their assessment service supervision. The director of the in-house training clinic explained to both groups that the university would be closed for the next couple of weeks, at least, and that the program would be moving to *remote learning activities in an abundance of caution* due to the COVID-19 health threat.

A plan was presented to move the psychotherapy training to telehealth during this closure, a transition that multiple students openly opposed. Students imagined that their psychodynamic work, in particular, would suffer from the imposed distance. The clinical training at New School for Social Research, and particularly the Safran Center for Psychological Services (SCPS), has a relational legacy. Students wondered if it would be better to pause their sessions and resume again when they could see their patients in person. In service of continuity of care, these requests were denied.

The assessment trainees were also presented with a plan to complete psychological and psychoeducational assessment via telehealth where possible. The students reviewed their in-progress assessments, and brainstormed potential measures that could be administered remotely. Clients who had not yet begun the intake process were put on hold, unless an interview and standardized on-line assessment could suffice.

Back in March, there was still hope that in-person services would resume before the end of the semester; however, it quickly became clear that in-person activities would be halted for quite some time. Though New York City is slowly re-opening (at time of writing, Phase II occurred a few days ago), the students have completed (via telehealth) their training cases for the year.

The Survey Project

In an attempt to understand how the rapid shift to telehealth, tele-assessment, and tele-supervision impacted the students' perception of their training, we created and sent out a questionnaire to the students who experienced this shift at SCPS. We had two hypotheses: 1) students would report that the shift to telehealth/tele-assessment had a negative impact on their overall clinical training experience and 2) students would express that they had gained new clinical skills and understanding through the process.

A request to complete a qualtrics survey was sent by email to twenty-seven clinical doctoral students who received training at SCPS during the COVID-19 pandemic (Spring 2020 semester). Eighteen students responded. Due to the need for anonymity of response, demographic information is not available. The email was sent on June 3rd, about three months after New York State's "pause" order, corresponding with the move to telehealth and, for sociocultural context, a week after the murder of Mr. George Floyd, which catapulted the current movement for racial justice.

The Survey

The measure consisted of six items, four of which were scored on a 7-point scale (1 = "Not at all", 4= Somewhat, and 7 = "Completely"). The four questions included the following: 1) To what extent do you feel that conducting sessions via telehealth has negatively impacted the quality of your clinical training? 2) To what extent do you feel that conducting sessions via telehealth has positively impacted the quality of your clinical training? 3) To what extent do you feel that conducting sessions via telehealth has allowed you to develop new clinical skills? and 4) To what extent do you feel you are concerned you are not getting adequate clinical training? Students were also asked to report whether they see clients for therapy or assessment. Lastly, a text box was provided for students to share any other thoughts on how COVID-19 has impacted their clinical training.

Quantitative Results

Among the respondents, ten students saw clients for therapy and seven saw clients for assessment. One student left this question unanswered. Students were recognized as having endorsed an item if they selected a point beyond the midpoint on the scale (e.g., a "5," "6," or "7"). In the two groups working via telehealth, there were no significant differences on any of the quantitative items.

Regarding our first hypothesis, only three of the eighteen students said that they felt that the switch to telehealth had more than somewhat negatively impacted the quality of their clinical training (M = 3.06, SD = 1.35). Four of the eighteen respondents indicated that the switch to telehealth had more than somewhat *positively* impacted the quality of their clinical training (M = 3.72, SD = 1.27). The majority of this sample indicated neither negative nor positive impact of telehealth on their training. There was no significant difference between therapy and assessment trainees on these responses.

Consistent with our second hypothesis, the majority of students (N = 11) felt that they had been able to (more than somewhat) develop new clinical skills through telehealth (M = 4.44, SD = 1.50). Two students reported feeling that they had not gained any new clinical skills at all. Students used the text box to expand on what they learned in the process of telehealth. One therapy trainee stated: "I feel that the transition to tele-health platforms has allowed me to test and adapt my clinical skills in a new domain." An assessment trainee wrote, "I think it was great to learn to conduct assessments online, know what's possible and what isn't, and experience for myself the pros and cons." And another student noticed different reactions between clients, "While some struggled with the transition, others actually became more engaged with therapy."

Regarding the final question on the survey, "To what extent do you feel you are concerned you are not getting adequate clinical training?", five students endorsed a "5" or above ($\boldsymbol{M}$ = 3.41, SD = 1.94). This concern was positively correlated with feeling that telehealth had negatively impacted the quality of their clinical training (r = .54, p < .05). Given the wording of the item, it is possible that some students felt they were getting inadequate training independent of the switch to telehealth, or perhaps they felt something was lacking with tele-supervision and remote courses. Further exploration is warranted.

Qualitative Results

A review of the typed, qualitative, responses revealed some differences between the two groups. Students conducting therapy reported that the transition was easier than they anticipated, particularly with clients with whom they had already built a strong alliance. Students conducting assessment, however, reported feeling more limited by telehealth, particularly regarding acquiring the required hours and number of assessment cases for internship, as they were not able to take on new cases. Both assessment and therapy clinicians expressed some difficulty feeling connected to their clients. One student wrote "remote assessment is limited in many ways. It is harder to form a connection with the client and draw meaningful conclusions from the assessment." Others noticed that it was particularly difficult to work via telehealth with clients in crisis, noting "at these times, I have found it harder to not be in the same room with [my clients]". Both therapy and assessment trainees also expressed a need for supportive supervision, which acknowledges the students' own emotional states and capacity due to the pandemic.

Discussion

The results of this study indicate that there was no overarching consensus among students on the valence of the impact of social distancing due to COVID-19 on their training; while some students reported feeling that they had gained new clinical skills, others expressed concern about being at a disadvantage in terms of their clinical training. It is important to note that this study only questioned students about the onset and early months of social distancing, and that students experienced a smaller percentage of their training year remotely than they experienced in-person. As such, students may have perceived that finishing out the semester remotely did not have a sizable impact on training. However, as graduate programs and training clinics face the continuing use of telehealth into the fall (and potentially beyond), perceptions of the extent of the impact on training may increase. In the words of one student: "I don't feel that it has detracted from my clinical training experience yet [but] I am concerned that it'll impact my training experience in the future."

Furthermore, the therapists who completed the survey had all started their training and treatment of these particular clients in-person. Several students noted that they felt that having already built an in-person alliance with clients eased the transition to telehealth. If remote training continues, student perspectives on training may change as they experience the treatment of new patients remotely. Finally, several students expressed concern about completing hours and meeting competencies required by the APA for doctoral internships. They also reported a desire for supportive supervision during this difficult period when they were required to balance clinical training with personally navigating the COVID-19 pandemic.

In summary, clinical doctoral students and supervisors everywhere were hit with an incredible challenge in Spring 2020. They faced the harsh realities of a global pandemic, social distancing and isolation, and a drastic overhaul of the planned clinical training, specifically, a rapid shift from in-person services to telehealth. According to this small sample of therapy and assessment trainees, there was a spectrum of responses. Further exploration is necessary to understand more about the influences of individual and contextual differences on students' perspectives (i.e., the negative, neutral, and positive impact of the shift). We have just begun to slow down and reflect on what was lost and what was gained so that we may thoughtfully move forward, better for what we have learned.

Utilizing a Values-Driven Approach to Training First Year Therapy Practicum Students in Telehealth

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Training first year therapy students (i.e., students in their first year of therapy practicum) in the age of COVID-19 has come with no shortage of challenges for graduate psychology training programs and their associated training clinics (Council on Chairs of Training Councils, [CCTC] 2020). Frameworks for how to navigate the process have been guided by national education and training organizations (i.e., CCTC, 2020); however, implementation has largely been left to programs. In response to these challenges, the authors incorporated a values driven approach to implementing telehealth training with beginning level therapy students in the Center for Behavioral Health (the Center), our program's psychology training clinic. Values of the Center include: high quality training, cultural inclusivity and humility, safety, support, and self-care. The Center trains students at all developmental levels. However, for this article the authors provide a chronological overview of how we oriented our first year trainees to general Center mechanisms that are aligned with the Center's values. We will conclude with three recommendations for implementing first year training programs in other clinics.

General Support and Safety

Several supports are woven into the Center policies and procedures for all students and are more frequently utilized by first year students to promote values of high quality training, safety, and support. Most have translated well to telehealth based services. First year trainees consistently share that consistent and reliable contact with supervisors (i.e., feeling safe to contact supervisors with questions and concerns outside of supervision time) is paramount to the sense of safety they feel. In addition, weekly case conferences, access to a Supervisor on Duty, and the support of a full time administrative assistant are useful for having multiple spaces to process questions and nuances in their clinical processes. As students moved their clients to telehealth and became more comfortable with the technology, more complex training questions arose (e.g., how do we balance access to technology with social justice and equity issues during COVID-19?) .

Cultural Inclusivity and Humility

Early in the transition to telehealth, students acknowledged finding it challenging to balance telehealth ethics while also being culturally inclusive. More specifically, beginning level clinicians wondered how to apply various telehealth trainings when clients were faced with significant challenges of having "the right" technology, adequate internet bandwidth, and/or private spaces to meet. Through case conference and supervision, the authors offered the American Psychological Association Telepsychology Guidelines (APA, 2013) and Multicultural Guidelines (APA, 2017) to guide a response to their needs.

We applied these guidelines by supporting first year trainees to use their telehealth informed consent process to: a) name the unique ethical considerations that threaten cultural inclusivity, b) discuss what preventative measures could be taken to outline best ethical practices and standards of care within the parameters of technology and space that were available to the client; c) discuss and name any known potential concerns for ethical issues, and d) discuss at what point flexibility with clients' access to technology and space makes telehealth unethical and/or not effective for their care. Supervision can also be a space to promote client care that is accessible and equitable.

Leaning into emotional processing through technology. Beginning students also described challenges in emotional processing through telehealth, and staying connected to client experience while also managing their own feelings. Researchers noted concern about the potential reduction of empathy as well as sensitivity to non-verbal cues over telehealth (Perle, Langsam, & Nierenberg, 2011). Several studies reported similar positive outcomes regarding the strength of the therapeutic working alliance when comparing telehealth to traditional therapy (Germain et al., 2010). Although these studies suggest that therapists can create an emotionally affirming space utilizing a telehealth platform, new therapists trained in traditional therapy may struggle navigating emotional facilitation online, attending to strong emotion, recognizing nuanced emotional experiences, and managing their own emotional experiences.

Supervisors can support new therapists developing skills to create an emotionally affirming space via telehealth by teaching them to ask meaningful process oriented questions when their clients are "emotionally checking out," and/or not attending to the emotional pace, intensity, or content of their session. Supervisors may also check in on first year trainees' self-care routines, to ensure they are practicing wellness strategies themselves and are able to stay leaned into the work with their clients.

Future Directions and Recommendations

Navigating the shift from in-person services to telehealth delivery with first year students will inform future directions for training cohorts of students who are new to their therapy practicum. We offer three primary recommendations based on our values and the experience we gained training first year students in telehealth. First, offer general mechanisms of support through case conferences and supplement with additional mentoring for first year students. We often hear that first year students do not want to bother supervisors and we want to stress that experienced professionals are available and want to increase a sense of safety among trainees by checking in proactively. Second, while you might routinely offer telehealth training as part of your case conference, we add greater attention to professional development topics like guidance on ethical decision making around cultural inclusivity (i.e., access to technology, when does flexibility becomes unethical?). Finally, we recommend that you incorporate role-plays that focus on processing emotion and encouraging self-care and compassion through technology.

Conclusion

Supporting first year therapy trainees come with unique considerations in face-to-face training environments; however, moving to telehealth modalities offers opportunities to consider how our professional and Center values inform how support is translated through technology. It is hoped that infusing values within the guidance of professional organizations will serve as a compass that will help navigate implementation of high quality training for those who will be the future of the "new normal" in our field.

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The Benefits and Challenges of the Home Environment for Teletherapy with Children and Adolescents

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The recent rapid change to teletherapy by most mental health providers has highlighted the unique benefits and challenges of using this modality with youth in the home environment. To date, the extant literature on teletherapy has been primarily focused on ethical considerations, business infrastructure, and technical requirements, rather than concrete strategies for effective teletherapy, particularly with youth (Pollard et al., 2017; Reed et al., 2000). The current article highlights strategies for conducting effective teletherapy with children, adolescents, and families during stressful circumstances that lead to necessary telehealth, including COVID-19, natural disasters, immunocompromised clients, etc.

There are many benefits to using telehealth with youth clients and their caregivers. Logistically, telehealth appointments can allow for multiple family members to be present simultaneously (e.g., caregiver #1 from work, caregiver #2 from home). Engagement from all caregivers in certain intervention modalities like Parent Management Training (PMT) and parent-supported re-feeding treatment is crucial, and yet is often challenging to obtain for in-person appointments. Similarly, telehealth allows for greater flexibility in timing, duration, and pacing of sessions. For instance, telehealth therapist-assisted exposures for anxiety can easily be done for 25 minutes twice per week to increase consistency, whereas

Table 1.
In vivo evidence-based intervention examples for teletherapy

Intervention	Specific Example(s)
Behavioral activation practice in session	Client plays fetch with dog during session and monitors mood before and after
Create a distress tolerance box in session with items in the home	Candle, stress ball, family photo, list of coping thoughts
Diaphragmatic breathing practice during mealtime to treat rumination syndrome	Utilize online videos to enhance diaphragmatic breathing practice
Parent management training coaching during periods of high conflict	Morning or bedtime routines
Mindfulness activities	Outdoor mindfulness “scavenger hunt” if client has yard space; go on a mindful walk during session
Family-based therapy for eating disorders	Family meal in the home kitchen
In vivo frustration tolerance exposure	Use of an online game to induce frustration through losing
In vivo anxiety and/or OCD exposures	Therapist turns off his/her video while parents are temporarily out of the house to facilitate a separation anxiety exposure; therapist and client practice exposure to items in the home relevant to symptoms
Sleep hygiene intervention preparation	Client/family show therapist sleeping space and make on-the-spot modifications to prepare and improve sleep routine
Organization skill intervention for ADHD	Client and therapist screen-share to create morning to-do list items and visual reminders from relevant items on the list

holding two brief in-office appointments per week may feel pragmatically demanding. Finally, many youth-based interventions have enhanced ecological validity when conducted in the home setting (see Table 1).

There are also challenges specific to telehealth with youth. Transparent discussions with the caregiver(s) regarding their role in sessions is important. For some adolescents, privacy during sessions is key, while for others, parental involvement is necessary to facilitate between session practice. For younger children, caregivers may be required to participate in part or all of sessions to increase engagement. Table 2 provides examples of opportunities to increase youth engagement in teletherapy. Explicit discussions at telehealth service initiation can set expectations and boundaries for frequency of sessions to maintain consistency. Problem solving in the first session (and ongoing) can address accessibility issues: in which space(s) will the youth/family participate, and does this differ depending on the activity conducted (e.g., youth's bedroom to learn new skills, yard for behavioral activation)? Not all families will have a private space for telehealth, and that may require discussion and creativity to maintain the youth's confidentiality. Depending on the family and context, the home environment may serve as a stressor, which would make learning new skills challenging. Thus, to increase retention, consider targeting stress reduction in the home through treatment. Early sessions might focus on emotion management or behavioral activation to improve mood. Session content might be adjusted to repeat concepts and practice skills. Finally, clinicians should consider the potential that they may witness events in families' homes that are reportable by law, and how this intersection between the APA ethics code, state/county reporting laws, and the telehealth setting is reflected in their consent form.

Although teletherapy with youth introduces some challenges as compared to in-person sessions, it also may provide distinct benefits. As with in-person therapy, approaching teletherapy with intentional anticipation of challenges, direct conversations with families to problem solve, and implementation of creative solutions will increase opportunities for client success using this modality.

Table 2.
Opportunities to increase youth engagement in teletherapy

Strategies for Engagement	Specific Example(s)
Reinforcers in the home to incentivize participation	Clients can introduce therapist to their pet or share their favorite online video as a reward for successful participation in session
Virtual sticker chart	Client earns stickers for every 5 minutes of successful participation which can be traded for a reward
Technology features	Engaging videos to introduce content; Chat feature to encourage participation; Shared erase board for clients to draw or write
On screen timer	Time session participation periods and session breaks
Shared on screen agenda	Collaboratively create agenda including timed break and work periods

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Tackling Separation and Social Anxiety During COVID-19

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The current article presents information and advice about teletherapy for separation and social anxiety, based on two youth case studies. For both families, treatment is ongoing and began prior to a clinic transition to telehealth services due to novel coronavirus (COVID-19). Our clients include "Juan," a 5-year-old, Hispanic male presenting with separation anxiety, social anxiety, and school refusal, and "Isaac," an 8-year-old, Caucasian male presenting with social and separation anxiety and worries about germs. Treatment goals included reduction of symptoms of anxiety, with specific goals to increase participation in academic and social activities for Juan and to reduce avoidance and compulsive behaviors for Isaac.

The transition to teletherapy created challenges to conducting exposures related to meeting unfamiliar people and engaging in social activities. We sought to maintain key ingredients to exposures over telehealth, namely progressing through graded exposures via an exposure hierarchy, reducing avoidance behaviors, supporting child self-efficacy, incorporating family involvement, and assigning outside homework (Bouchard et al., 2004). We drew from prior work demonstrating that exposure therapy delivered via telehealth is associated with clinically significant improvements in child anxiety (Gloff et al., 2015; Spence et al., 2008; Stewart et al., 2017; Storch et al., 2011).

Here are our suggestions for telehealth exposures:

A. Technology can serve as an effective tool for social exposures. We planned exposures involving FaceTime calls with relatives and virtual exercise classes with Juan, as well as phone calls to restaurants with Isaac. Additionally, other therapists joined in on Isaac's Zoom sessions to practice talking to an unfamiliar adult.

B. We used telehealth video features to facilitate engagement and in-vivo therapy exposures. With Isaac, we used video to facilitate live "germ" exposures, such as touching the toilet bowl in his home. We utilized the Zoom whiteboard feature to play games and encourage speech with Juan. Lastly, we used screen-sharing to allow for rewards, such as Isaac playing a computer game while the therapist observed.

C. Separation-related exposures are possible during a stay-at-home order. With collaboration from Isaac's parents, Isaac spent 20 minutes coping with the distress of being home alone while his parents drove around the block. (Parents provided their contact information in the event of an emergency.) Juan and Isaac both practiced independent activities at home (e.g., sleeping independently or going to the bathroom alone). We facilitated changes in sleeping arrangements, such as reducing Juan's mother's involvement in night-awakenings and supporting Isaac in sleeping in a separate room from his sibling.

D. Imaginal exposures can be very beneficial in anxiety treatment. We played "pretend school" with Juan and his siblings; the therapist role-played as teacher while the "class" completed ice-breakers and academic activities. Both in session and as homework, Isaac imagined anxiety-provoking events and practiced tolerating the associated distress before continuing with life activities.

E. Managing avoidant behaviors during exposures requires awareness and planning in a telehealth format. We planned with Juan's mother to send her a text for assistance when Juan attempted to leave the room during exposures. We recognized that Isaac was attempting to avoid *verbal* expression of feelings by sending a chat message that he was sad, and attempting to avoid distress during exposures by looking at distracting internet sites. We consistently redirected Isaac to share his feelings aloud and to close other webpages.

F. We utilized brief online measures to monitor progress, rather than paper-and-pen forms. Juan completed online measures (*Helping Give Away Psychological Science*, n.d.) and abbreviated verbal measures (e.g., behavior rating scale from 1-10). Isaac's family completed standardized forms programmed via Qualtrics, an online survey software.

Juan and Isaac both showed reductions in anxiety symptoms during the course of telehealth therapy. Juan's mother's report on the Screen for Child Anxiety Related Disorders (SCARED) has decreased from a total score of 31 to 20 over the course of therapy (clinical cut-off of 25). For Isaac, self-reported SCARED scores have decreased from 6 to 2 for the social anxiety subscale (clinical cut-off of 8). Given the possibility of continued social distancing measures due to COVID-19, children may continue to face fewer social experiences and separations from parents. It will be important to ensure that therapists support anxious youth in challenging themselves and engaging socially. Despite the challenges in conducting exposure therapy over telehealth, we have identified opportunities to innovate and be flexible in the ways we approach clinical care.

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Making the Transition to Teleassessment in a Clinical Child Psychology Training Clinic: Case Considerations, Logistics, and Supervision

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In response to the COVID-19 pandemic, our clinic has shifted to using telehealth to perform comprehensive evaluations with youth. This article offers recommendations for transitioning to child-focused teleassessment based on our experiences. Although current research on teleassessment is limited, existing literature suggests broad equivalencies between in-person and remotely administered assessment in general (Brearly et al., 2017; Wadsworth et al., 2018; Wright, 2018), and specifically with children (Harder, 2020; Hodge et al., 2019; Waite et al., 2010). Based on previous research and suggested guidelines from professional organizations (APA, 2020; IOPC, 2020), we generated teleassessment protocols designed to uphold the standardization and rigor of in-person assessment. Herein, we address three key aspects of our experience: determining client eligibility, establishing testing protocols, and adapting training and supervision.

Determining Client Eligibility

In transitioning to teleassessment, it is essential to consider whether these services are appropriate for each case. Thus, discussions as to the suitability of teleassessment should take place on a clinic-wide level and also be specific to each client.

Initial Considerations

Consistent with organizational re-commendations, we first consider clients' presenting concerns, including potential attention and behavior difficulties. We critically examine the feasibility of measures appropriate for each child's age and developmental level (e.g., WPPSI manipulatives are not conducive to at-home telehealth administration) and obtain a caregiver report of the child's functioning. Much younger children (e.g., those under six-years-old) or those with significant regulatory challenges may have difficulty engaging with teleassessment protocols, making remote assessment inappropriate.

Trial Teleassessments

In some cases, we conduct preliminary "trial teleassessments," which include a reading-related and math-related task from measures not used in the actual assessment. In the context of difficulties described above, children with more significant academic challenges may struggle with the teleassessment format for tasks examining those domains. Conducting a "trial teleassessment" when possible provides an opportunity to assess challenges firsthand to determine whether teleassessment is an appropriate format for all measures.

Remote Testing Protocol

Teleassessments are conducted over two to four sessions each lasting one to three hours. Clients are situated in private, quiet spaces with good internet connectivity and encouraged to wear headphones to ensure privacy. Examiners prompt children to take breaks (e.g., for snacks, to walk around) at least every 30-45 minutes, and children are also told that they may request breaks. Breaks typically last 5-10 minutes. At the start of sessions, caregivers are reminded to remain accessible in case issues arise.

Preparation and Set Up

Before the initial testing session, an agreement regarding test security and potential limitations of teleassessment is reviewed and signed. We prepare and deliver sealed testing materials to clients, which are typically delivered by clinic personnel or through U.S. mail, depending on the family's distance from the clinic or other travel considerations. Sealed envelopes are labeled by testing day with materials labeled by subtest. Clients are provided an audio recorder, document camera, and security stickers for resealing materials at the end of each session. At the conclusion of the evaluation, materials are collected by clinic personnel or returned via provided mailing supplies.

At the start of sessions, examiners complete a checklist with the family to practice operating the video technology (i.e., Zoom) and ensure that the testing environment is setup appropriately. Caregivers are then instructed to open the appropriate envelope and place materials beside the child prior to exiting the testing room.

Testing Protocols

Test administration primarily utilizes screen sharing of Pearson Q-Interactive iPad software or digital stimulus books provided through Pearson Q-Global and other test publishers. Further details can be found on publishers' telepractice support pages (e.g., https://www.pearsonassessments.com/professional-assessments/digital-solutions/telepractice/about.html). If materials are unavailable on these platforms, paper versions are also provided in the sealed envelopes. With the exception of tasks with manipulatives (e.g., WISC-V Block Design), the usual assessment measures are administered.

Video and Viewing

For written tasks, the document camera is directed at the client's paper. Parents may be asked to briefly return to the testing room to facilitate document camera manipulation, if needed; however, in most cases, children have been able to manage the document camera without assistance. Clients are also asked to read responses aloud and hold their work up to the camera to confirm completion of tasks. For tasks that require pointing, the document camera is oriented toward the client's screen or clients are given mouse control to indicate their answers.

Audio

In addition to live scoring, audio recordings are used for rescoring oral tasks, as well as to verify completion times in case of any potential video delays.

Security of Paper Materials

Examiners take screenshots of all written materials to ensure clients do not modify their work. Caregivers are asked to return to the testing room at the end of each session to assist with resealing materials using the provided security stickers. Before leaving the room, caregivers are asked to remain accessible in case issues arise and to assist children at the end of the session. Once the session is completed, children are asked to bring their caregiver back to the testing room. Examiners also have parents' phone numbers and can call them, if needed.

Adapting Training and Supervision

As a training clinic, supervision and training of students were major considerations in adopting teleassessment policies and procedures. Our transition to teleassessment occurred with doctoral-level graduate students with in-person assessment experience. We consequently developed the comprehensive teleassessment training model described below, with understanding that training needs will vary with experience.

Administration Training

The transition to teleassessment introduced novel challenges for trainees, including using protocols and stimuli in new and varied formats (i.e., paper, digital, iPads), managing technological issues while maintaining standardization, and finding creative ways to monitor nonverbal or written responses. To address these challenges, students practiced extensively with each other to increase comfort with administration methods before working with a "live subject." Weekly meetings were held to share strategies and troubleshoot.

In Vivo Support and Supervision

Holding true to our pre-COVID-19 model, the clinical supervisor joined trainees for intake and feedback sessions via telehealth. Families do not appear perturbed by attending to two different videos, and we are therefore able to continue this crucial aspect of supervision. To ensure consistency across trainees and testing sessions, a supervisor now also accompanies trainees during the review of logistics and expectations in initial sessions. Using the "hide video" feature on Zoom allows for in-vivo supervision or shadowing advanced students without distracting the child and will be heavily utilized in training future students.

Scoring Verification and Administration Feedback

Logistics and procedures for scoring verification involve close communication and organization of physical materials. The graduate clinic assistant uses both video and audio files to review administration and scoring and provide feedback. A secure network is used to access case materials.

Conclusion

Using the considerations and protocols described above, our experience with teleassessment has yielded promising results. Not only do trainees and supervisors feel comfortable with administration and protocols, but we are finding consistent neuropsychological profiles across assessments in children who have previously participated in in-person evaluations. These efforts pave the way for future opportunities, including continued assessment services during the ongoing pandemic, increased accessibility for families living in rural areas or with other barriers to traditional assessment, and hybrid models of in-person and teleassessment as situations evolve.

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Reflections on a Career as a Clinic Director

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University of North Carolina at Chapel Hill

I am truly honored to have been invited to write an article for the APTC Bulletin about my career. Like many training clinic directors, I rarely take time to *reflect* on my professional experiences. As I am sure is true for everyone in this group, my workdays (that often extend into the evenings and weekends) tend to be immersive. They are filled with supervision, teaching, scheduled and unscheduled meetings, emergencies, emails, projects, and tasks. This sense of immersion has vastly intensified for me since mid-March when the impact of COVID-19 abruptly discontinued in-person services. And, as I write this article, the murder of a Black man in Minneapolis has given birth to our country's first painful steps towards a broader reckoning with our 400-year history of slavery, racial injustice, and deep disparities. Taken together, we are truly living in unprecedented times. Despite the current climate of uncertainty, fear and stress, each day includes deeply meaningful activities. I am extremely grateful that my clinic was able to rapidly implement telehealth for our clinic (with much support from our listserv!); we continued to treat over 80% of our therapy clients.

Although it is a challenge to see beyond the current context (and my retirement on July 1), it is also a pleasure to take a step back to consider the broader framework and landscape of my career as a training clinic director. With some irony I will note that a longtime friend, also a psychologist, pointed out to me that I began my position at the UNC Chapel Hill training clinic in the summer of 2001—just a few months before 9/11. Although my logical self makes no sense out of this confluence of events, it does indeed seem that my time as a training clinic director has been bookended by globally transformational events.

So, what do I want to say? I will focus on two themes. The first is a quote (attributed to Ray Bradbury): "Love what you do and do what you love." The second is my attraction to intersections. I had initially intended to write about these themes separately, but it turns out that these themes are themselves intertwined conceptually and in my experiences.

There is a critical intersection between our shared knowledge base as psychologists and our ability to make a positive impact on the world—both through and beyond our direct clinical work. My passion for navigating this intersection informs my clinical practice and social justice activities, and it has been deeply satisfying to include graduate students in this work. One thread of my work has been to write and present on self-care, ethics, and professional competence (e.g., Wise, Hersh & Gibson, 2012). In collaboration with a graduate student I have recently expanded this conceptualization to include the communitarian ethics perspective (Wise & Reuman, 2019) and to apply this work to other health care professionals. Several years ago, engagement in social justice advocacy to challenge state level LGBT discriminatory legislation resulted in several national presentations, including a wonderful collaboration with Leticia Flores, current APTC president, and graduate students from UNC-Chapel Hill and the University of Tennessee-Knoxville at a national multicultural conference (Flores, et al., 2017) and a panel presentation at the APA annual conference (Wise, Chen & Pentel, 2018).

During my two terms on the APA Board of Educational Affairs (BEA) I had the opportunity to work closely with colleagues across the country on a variety of projects including the creation of a proactive statement related to trainee value conflicts in the context of court cases and legislation that impact diversity training (Wise, et al., 2015). On my own campus I chaired a 26-person Mental Health Task Force that resulted in positive changes on campus (link below). Currently, in North Carolina, I am volunteering for and providing consultation to the NC Hope4Healers program that offers brief pro bono telehealth services to front line health care workers.

I will end here with my very best wishes to all of you in navigating the challenges and opportunities that lie ahead. Use each other as the truly invaluable resources that you are for professional wisdom, technical knowledge, and personal support. Please stay in touch and check in with me if you plan to be in the Chapel Hill or Durham area. I will greatly miss all of you and my time as a training clinic director!

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ASSESSMENT TRAINING GUIDANCE FOR CLINICS DURING COVID-19

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Mary Beth Heller, Ph.D.
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As the COVID-19 pandemic forced training clinics to transition to telehealth, clinic directors were left with the daunting task of identifying ways to continue assessment training for their doctoral students. Assessment is one of the nine Profession Wide Competencies in the Standards of Accreditation (SoA) required for doctoral trainees (APA, 2017), one of the APA competency benchmarks for professional psychologists (APA, 2011) and is infused throughout the 10 practice domains for school psychologists (NASP, n.d.). Not only is assessment a required training competency for doctoral students (SoA; APA 2017), it also is a core professional activity for clinic directors, many of whom have daily oversight of assessment training, serve as assessment supervisors, and depend on assessments as their clinics' "bread and butter." Thus, thoughtful (yet rapid) consideration of ways to resume assessment training and service provision via telehealth was paramount.

Given its important role, many directors expressed the need for a forum to discuss the unique challenges associated with assessment training during the pandemic. In response to this need, a group of clinic directors (22 members), under the guidance of Co-chairs, Mary Beth Heller, Ph.D. and Saneya H. Tawfik, Ph.D., came together to form the APTC Assessment Workgroup (AWG). Although the AWG will continue beyond the current crisis, the urgent need to resume assessment training dictated the focus of the group's first project, which resulted in a document that has been distributed nationally and can be found in our APTC website https://www.aptc.org/?module=Members, as well as in APA's Division 12, Section IX (Assessment) website under their COVID-19 resources: https://apadiv12secix.com/covid-19/.

The aim of the document was to offer guidance on how to teach and develop trainee competencies in assessment skills, despite physical distancing, as well as how to provide assessment services for clients both remotely and once clinics reopened. All these considerations were at play despite little equivalency data or other evidence to fully support remote administration. While the overarching aim of the AWG document was assessment training, the safety of students, supervisors, clients, staff, and the broader public was recognized as the highest priority, and, thus, recommendations on how to safely re-open clinics was also a focus of the document. We hope that this document is a helpful resource for clinic directors and others involved in assessment training who are charged with the task of continuing an important training competency during these difficult times.

Below are the AWG members by subgroups who contributed to the document:

1. Teaching Assessment Courses Remotely
Saneya H. Tawfik, Ph.D. (University of Miami) – Chair
Tony Cellucci, Ph.D. (East Carolina State University)
Jacqueline Hersh, Ph.D. (Appalachian State University)
Sarah Beth Kirk, Ph.D. (University of Kansas)
Philip Sayegh, Ph.D. (University of California – Los Angeles)
A. Jordan Wright, Ph.D. (New York University)

2. Practicum Training and Supervision in a Telehealth Environment
Norah Chapman, Ph.D. (Spalding University) – Chair
Elizabeth Akey, Ph.D. (Purdue University)
Kelly Atwood, Psy.D. (James Madison University)
Matthew Calamia, Ph.D. (Louisiana State University)
Jason Herndon, Ph.D. (University of North Carolina – Greensboro)

3. Conducting Psychological Assessment in a Telehealth Environment
Dina Vivian, Ph.D. (Stony Brook University) – Chair
Richelle Allen, Ph.D. (The New School)
Linda Campbell, Ph.D. (University of Georgia)
Kristy Kelly, Ph.D. (University of Wisconsin – Madison)
Tara Rooney, Ph.D. (St. John's University)

(This subgroup acknowledges the important contributions of Brady Nelson, Ph.D., of Stony Brook University, to their work).

4. Safe Return to In-Person Assessment
Natalie S. Murr, Ph.D. (North Carolina State University) – Chair
M. Colleen Byrne, Ph.D. (University of Maryland)
Chitra Pidaparti, Ph.D. (University of Georgia)
Jennifer Steward, Ph.D. (University of Tulsa)

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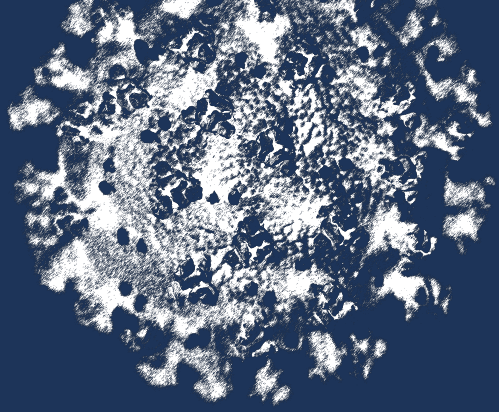
THE VIRUS



by Kathleen Kim Lampson
(Inspired by The Raven, by Edgar Allen Poe,
this poem reads best if read aloud)

Once upon a March day clearly, sitting close and talking nearly,
Over many a deep and glorious study of our clients galore -
While we chattered, quite gregarious, suddenly crept in an awareness,
As of some thing most nefarious, knocking at our clinic door.
"Tis only a client", I muttered, "knocking at our clinic door -
Only this and nothing more."

Oddly we all felt a shudder, then turned away as if a rudder
Turned us back to normal days when walking freely in the door
Clients came to see us gladly, telling stories distressed and sadly,
Finding empathy needed badly, healing wounds found at the core;
Yet some visitor was still lurking, lurking behind the clinic door -
"Tis a shadow and nothing more".

Then it came though uninvited, despite its offer unrequited,
Forcing us to leave the clinic that we loved and all adored.
"Quarantine!" its voice commanded, refusing to be reprimanded,
So many changes it demanded; freedom squashed upon the floor.
"My name is COVID. I show no mercy," - lurking behind the clinic door-
Quoth the virus: "Shut your doors!"

"You cannot steal our clients health!" we cried aloud, yet moved with stealth,
While resurrecting telehealth, something that we learned before;
With flames of panic burning fireless, seeking students working tireless,
Connecting to their clients' wireless, their needs refusing to ignore.
E-mails flying, networks crackling, crusading for the open door.
Quoth the virus: "Shut your doors!"

And the virus, always smirking, still is lurking, still is lurking,
On the dais just outside the hallway to the clinic door,
But its ruthless path's undoing, was the students fast pursuing
Connection with clients willingly viewing, screens at home forever more.
Then turning, shaking, and retreating from the online world explored,
Quoth the virus: "Nevermore!"

Announcements

Citations for other COVID-19 pubs by our members

Hames, J.L., Bell, D.J., Perez-Lima, L.M, Holm-Denoma, J.M., Rooney, T., Charles, N.E., Thompson, S.M., Mehlenbeck, R.S., Tawfik, S.H., Fondacaro, K.M., Simmons, K.T., & Hoersting, R.C. (2020). Navigating uncharted waters: Considerations for training clinics in the rapid transition to telepsychology and telesupervision during COVID-19. *Journal of Psychotherapy Integration, 30*, 348-365. http://dx.doi.org/10.1037/int0000224

Desai, A., Lankford, C., & Schwartz, J.(2020). With crisis comes opportunity: Building ethical competencies in light of COVID-19. *Ethics & Behavior, 30*, 401-413. https://doi.org/10.1080/10508422.2020.1762603

Call for Contributions to the Winter/Spring 2021 Issue of the APTC Bulletin: Practicum Education & Training

The Winter/Spring, 2021 issue of the *APTC Bulletin* will focus on **Social Justice and Diversity Issues** in psychology training clinics. APTC members are invited to submit the following types of articles:

- Provide a written report on the poster, presentation, or symposium that was planned for the 2020 Annual APTC Conference and could not be shared because the conference has been postponed until 2022.
- Describe and discuss the ways in which your clinic, department, and school are addressing Anti-Black Racism and Racial Injustice. Tie your discussion to the literature on clinical training and social justice.
- Consider writing about diversity and social justice, training clinics, and:
  - International issues
  - Education, training, & supervision principles and practices
  - Psychological services including assessment and psychotherapy
  - Health disparities
  - Access and utilization concerns
  - Recruitment, retention, and mentoring of underrepresented students, postdocs, and professionals
  - Innovations that address social justice concerns

Send your ideas in the form of a 250 word proposal to Heidi Zetzer and Karen White, co-editors of the APTC Bulletin, hzetzer@ucsb.edu and kwhite1@niu.edu. Tentative deadline for proposals is **October 31, 2020**.