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Systemic Challenges in Internship Training for Health-Service Psychology: A Call to Action From Trainee Stakeholders

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Abstract

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The challenges observed in health service psychology (HSP) training during COVID-19 revealed systemic and philosophical issues that preexisted the pandemic, but became more visible during the global health crisis. In a position paper written by 23 trainees across different sites and training specializations, the authors use lessons learned from COVID-19 as a touchstone for a call to action in HSP training. Historically, trainee voices have been conspicuously absent from literature about clinical training. We describe longstanding dilemmas in HSP training that were exacerbated by the pandemic and will continue to require resolution after the pandemic has subsided. The authors make recommendations for systems-level changes that would advance equity and sustainability in HSP training. This article advances the conversation about HSP training by including the perspective of trainees as essential stakeholders.

Keywords

Professional Standards; Public Mental Health Systems; Health Service Psychology; Diversity Equity and Inclusion; Training

Introduction

"Along with numerous other influences the present national emergency has brought to the fore the problem of the education of the psychologist, particularly the education of the professional psychologist" (Shakow et al., 1945)

Clinical internship is a brief but important time in a psychologist's career. In 2019 and 2020, 6,489 trainees matched to health service psychology (HSP) internship programs across the United States. As the global public health crisis of the COVID-19 (SARS-CoV-2) pandemic emerged in 2019–2020, interns adapted rapidly to escalating challenges and new demands. Medical infrastructures across the nation underwent unprecedented stress (Miller et al., 2020). As healthcare systems enacted plans to limit spread of the virus (Pinals et al., 2020; Tanne et al., 2020), corresponding changes in the responsibilities of trainees were necessitated by the demands of physical distancing and increased need for clinical services. These changes contributed to new and far-reaching challenges in training. However, crises like COVID-19 can reveal fault lines and tensions that are more easily obscured in times of relative stability. COVID-19 illuminated systemic and philosophical issues in HSP internship training that predated the pandemic. When the institutions, infrastructure, and norms of HSP training are subjected to strain, the most vulnerable trainees can bear the greatest degree of collateral damage, illuminating and deepening existing disparities (Bolin & Kurtz, 2018). These inequities underscore the need to address long-standing challenges in HSP training.

This article was composed through a collaboration of 23 doctoral psychology interns from different training programs and specializations (hereafter referred to as either "trainees" or "interns"). It aims to advance the conversation about HSP training during and after the pandemic that has been carried by training directors and other HSP educators and supervisors (Bell et al., 2020; Berenbaum et al., 2021; Gruber et al., 2020; Hames et al., 2020), who have outlined important considerations and challenges associated with COVID-19 and its impact on internship. This article extends that discussion by incorporating

the perspective of another, thus far almost entirely missing, group of stakeholders in clinical training: that of trainees. To our knowledge, there is only one other peer-reviewed contribution to the literature about HSP training authored entirely by internship trainees (see Wang et al., 2020 for an autoethnography of three counseling psychology trainees addressing racial battle fatigue in training). We draw upon the lessons learned from COVID-19 as a touchstone for a position paper from trainee stakeholders, arguing for more collaborative and equitable principles in future HSP training.

This article describes long-standing issues of concern in traineeship across diverse training settings and practice specializations that largely predated COVID-19 and were revealed or exacerbated during the pandemic. We focus on several salient features of traineeship: (1) ambiguity in the status of trainees, including essential versus nonessential status, (2) training benchmarks and competencies, (3) training aims, (4) location and locality of trainees, (5) the broad adoption of telehealth during 2020–2021, (6) economic security of trainees, (7) challenges pertaining to diversity, equity, and inclusion, and (8) trainee roles in the decision-making and policy of training.

For each of these issues we adopt the following format: First, we briefly provide “pre-COVID-19” background of the issue, and then discuss ways in which existing challenges were made acutely relevant during the pandemic. We then offer suggestions and invitations for further action, with the goal of contributing trainee perspectives to the ongoing discourse about the continued development of HSP training that has emerged in the wake of COVID-19. Given the scale of the issues we discuss, the heterogeneity of training environments, and the number of stakeholders involved in HSP training (e.g., graduate training programs, healthcare systems, patients, etc.), these are presented as recommendations and invitations for collaborative problem-solving across the field, rather than ready-made solutions. The issues we discuss are summarized in Table 1 alongside relevant recommendations, which are also numbered and referenced parenthetically in the main text. We also offer a set of questions paired with each issue, which we have termed “questions for collaborative inquiry.” In the interest of advancing transparent, productive, and stakeholder-involved decision-making that can be undertaken in site-specific ways, these questions are intended to begin dialogues within and across training programs that wish to collaboratively address these problems with their trainees. In contrast to a formal self-study (e.g., American Psychological Association, n.d.-a) these questions provide opportunities for the stakeholders within training programs to jointly and openly examine their particular training contexts. Making responses to these questions accessible to multiple stakeholders (e.g., on a training program website) might also contribute to addressing the concerns we address in this paper. The Questions for Collaborative Inquiry are summarized in Table 2. The challenges of HSP internship training are multifaceted, and often interconnected. The solutions may be interconnected as well. For example, changes that improve trainee autonomy, economic security, and involvement in decision-making may also have positive impact on diversity and equity among trainees.

Authors and Writing Process

This manuscript was prepared during the COVID-19 pandemic by doctoral psychology interns who completed training either in 2019–2020 or 2020–2021. The author group includes trainees engaged in training programs in hospital, academic medical center, community clinic, counseling center, and Veterans Affairs (VA) settings, with training specializations across adult, pediatric, general child, health psychology/behavioral medicine, and neuropsychology training tracks.

Importantly, as is the case with any position paper, not all clinical settings and perspectives can be represented in this article. For example, none of the authors had school-based or correctional facility-based internship placements, and the lack of contributions from trainees in these settings is a limitation. In addition, although COVID-19 precipitated many important changes to HSP training (Bell et al., 2020) and the provision of clinical services more broadly (e.g., Hames et al., 2020; Gruber et al., 2020), reviewing all of these would fall outside the purview of the present article. The focus of this article is on challenges in clinical internship training that pre-existed and were exacerbated or revealed by the pandemic. HSP training is, of necessity, dynamic and continually evolving. In this document, we identify some training practices that have worked well while highlighting areas in need of improvement. As the opening quotation to this paper suggests, an emergency provides the opportunity to evaluate where we are and inform future directions. Our hope is that these observations will not only identify ways to adapt to this ongoing crisis but also inform recommendations for future HSP training.

The HSP Trainee Role in Historical Context

Clinical internship has been an important component of HSP training since the mid-twentieth century, when it was deemed vital to the professionalization of clinical psychology (Morrow, 1946; Shakow et al., 1945). Internships helped ensure that trainees' knowledge included clinical experience, advancing what came to be known as the "Boulder Model" or Scientist-Practitioner model of clinical training (Frank, 1984). Internship training was established on the blueprint of the medical residency model, with enough flexibility to enable the emergence of additional models for training, including the scientist-practitioner, clinical-scientist, and scholar-practitioner models, among others (McFall, 2006).

Recurrent concerns have nevertheless required periodic realignments in the priorities, regulations, and structures of internship training. These have included the need to balance the supply and demand of psychologists to ensure that there are enough jobs for those currently in training, and enough psychologists to meet clinical needs (Bodin et al., 2018; D'Angelo, 2014; Grus et al., 2011; Hoch et al., 1966, Wells et al., 2014). The psychology workforce has also begun to undergo long-overdue diversification (Callahan et al., 2018; Kohout et al., 2014), with corresponding attention to developing equitable and fair practices that do not discriminate against marginalized individuals and communities. Throughout these transitions, the statements on training (cited above) have consistently identified the importance of trainee morale, the professional conduct and ethics of trainees, training programs' responsiveness to pressures on the discipline of psychology itself, and the

economics of internship at all levels. These issues have predominantly been problematized from the standpoint of the future of the field itself, and the discussion in the published literature has typically been advanced by faculty experts or groups of experts (for accounts of HSP training history and its recurrent concerns, see Atkins et al., 2014; Berenbaum et al., 2021). Although these efforts are laudable, there remains comparatively little input from trainees themselves in shaping their training experience, with corresponding gaps in the development of HSP training.

When given voice, trainees have spoken to problems often sidelined in the broader training literature. For example, Kaslow and Rice (1985) described the stress of training from the standpoint of a trainee and a training director, both co-authors. They were unique in raising a range of issues that deserve, but have not received, greater attention. They described challenges that included: (1) role confusion for trainees, (2) the difficulties of juggling multiple responsibilities between life and internship, (3) the importance of bonding among intern cohorts and between interns and supervisors, (4) the challenges of relocation for trainees, (5) the role of training staff in mitigating the novelty of training experiences, (6) the tacit pressure for trainees to "prove" themselves, (7) the unique workplace politics of internship, and (8) concerns about parity with medical residents. Notably, virtually none of these concerns have been addressed, even in the most recent series of guiding documents intended as a "blueprint" to improve training in professional psychology after the 2007 "match crisis" (D'Angelo, 2014; Health Service Psychology Education Collaborative, 2013). In many ways, the COVID-19 crisis brought pre-existing core issues in HSP training to the fore, as they were exacerbated or made especially salient during the pandemic.

Challenges in Health Service Psychology Training

1. Trainee status: Are trainees essential or non-essential personnel?

We begin with a primary concern that animated many trainees' discussions early in the pandemic: Are HSP interns essential personnel? The difficulty of arriving at a simple answer to this question points to a longstanding challenge in training, related to how trainees are regarded within the healthcare system, the rights and privileges they are accorded, and their agency as both providers and students. As such, we regard this question as among the foundational issues in HSP training.

Internships vary widely in the expectations and responsibilities placed on trainees. An important aspect of this variation has been described as the "training versus service distinction" by Stewart and Stewart (1996): At some sites, although trainees supplement the clinical staff, they are treated as individuals in training first, and individuals at work second. This approach is consistent with the priorities of the Association for Psychology Postdoctoral and Internship Centers (APPIC), which states in its first criterion for membership that "the primary focus and purpose [of internship] is assuring breadth and quality of training" (APPIC, 2020b), as well as American Psychological Association (APA) Commission on Accreditation (CoA) requirements for internship sites, including that "intern service delivery tasks and duties are primarily learning-oriented and training considerations take precedence over service delivery and revenue generation" (APA, n.d.-a). On the other hand, however, some internship sites rely on interns as a de facto workforce such that

they are vital to site functioning and revenue generation and, without them, significant disruptions in operations would arise. In extreme instances of this arrangement, interns may effectively function as full-time clinicians who receive lower pay than their licensed counterparts, bridging sites' financial gaps and staffing needs.

Such financial considerations may play a role in the training vs. service distinction. Trainees' contributions to the sustainability and revenue of an internship program can influence its reliance on them as a workforce. Several models for funding internship programs have been elaborated, which include monotonic relations between intern direct service and gains (vs. losses) by the internship, with more service hours contributing to greater revenue (Loucks et al., 1980; Rosenberg et al., 1985; Schauble et al., 1989; Weiskopf & Newman, 1982). Although in many states it is not possible to bill for services provided by interns, recent efforts have expanded the capacity to do so, including from Medicare. As of 2016, 18 states either allowed or were the site of negotiations with licensing boards to allow reimbursement through Medicaid (Ameen et al., 2016). Per a 2014 report, 43% of non-accredited programs and 47% of accredited programs reported that intern services were reimbursable (DeHay et al., 2014). Enabling interns to be reimbursed for their services can support the creation of much-needed internships and make training sustainable. However, it may also provide incentives to view interns as sources of revenue, and may exacerbate tensions in service vs. training priorities.

In the received (though unpublished) wisdom of internship grapevines, applicants are commonly advised to assess whether a site "can function without them" during the internship interview process, as an indicator of the culture of the training setting. Sites that rely on interns as labor have reputations for unduly challenging work environments, reduced didactic and supervision opportunities, valuing institutional needs above the intern's clinical training goals, as well as conflicts of interest and exploitative practices. The distinction between these types of sites is difficult to assess and may even be subject to shifts within individual institutions, leaving trainees potentially subject to both sets of expectations—that they should be workers first, and (also) trainees first. This pre-existing underdetermination of trainee roles—lack of consensus on whether interns are primarily necessary workers or on-site learners—contributed to ethical dilemmas and health risk vulnerabilities during COVID-19.

During the COVID-19 pandemic, training programs were confronted with a decision about whether trainees should be considered essential personnel. Designating trainees as essential implies that critical aspects of the service cannot function without them, and could result in the expectation that trainees carry out their duties and training activities with minimal restrictions (including in-person service delivery and its associated risks). A non-essential designation, on the other hand, is consistent with the philosophy that trainees are on site primarily to learn, and thus may not be expected to deliver care under hazardous circumstances. However, this approach may subject trainees to stay-at-home orders, furloughs, deprivation of the opportunity to learn how to respond to a crisis, and disruptions in training.

Because *a priori* models of trainee roles during a global public health crisis do not yet exist, the designation of trainees' roles was determined by training programs and training sites on an individual basis (APPIC, 2020a), with eventual (and sometimes conflicting) guidelines from accreditation agencies (for extended discussion of the initial adjustment period, see Bell et al., 2020). Essential/non-essential designations were influenced by training programs and institutional considerations. For example, the Fourth Mission of the US Department of Veteran Affairs (VA) states that VA hospitals strive to provide reserve medical care for civilian populations during national emergencies (Veterans Affairs/Department of Defense, 1982; Veterans Health Administration, 2020). This mandate was interpreted by some VAs to automatically render their trainees essential personnel who were expected to be able to staff on-site positions during a crisis. Essential/non-essential designations were also influenced by the type of service the trainee was providing. For example, inpatient psychiatric services were deemed essential at some sites, conferring essential status to trainees who provided these services.

These decisions raise a number of important questions related to trainees' roles and status. Are trainees who are learning to provide an essential service also themselves essential? If a trainee is designated as "essential," to what extent should this entail an expansion of the role, responsibilities, or autonomy of the trainee? On one hand, HSP trainees have the potential to contribute considerably to the healthcare system's response during a national emergency, when increased demand for on-site mental health professionals is to be expected (Gruber et al., 2020). On the other hand, psychology trainees have less autonomy and remuneration as well as fewer legal protections and employee benefits than many of their professional colleagues (e.g., staff psychologists) despite being placed in similarly high-risk situations (Kainz, 2002). Illustrating the complexity of this issue, two recent papers written by medical students offer divergent perspectives: In one, considerations of the reduced power, autonomy, and status of students led to the recommendation that they *not* be considered essential personnel (Menon et al., 2020). However, another paper also authored by medical students deemed it important for medical schools to offer students opportunities for service and training during the pandemic (Miller et al., 2020).

In a statement on training adjustments during COVID-19, APPIC reiterated its position that the primary focus of the internship year is training "in contrast to supervised experience or on-the-job training" (2020b). If the focus of clinical internship is education, rather than labor, one may conclude that these positions are not essential to the immediate delivery of critical clinical services. However, the success of teaching hospitals illustrates that education and service delivery are not mutually exclusive (Ayanian & Weissman, 2002), and the education of psychologists is also a public health need. In practice, based on their roles and training guidelines, psychology interns simultaneously are, and are not, essential personnel. This impasse reveals an important, long-standing lack of clarity about the trainee role itself, with impacts for the ethical obligations both of, and to, trainees. Furthermore, role confusion contributes added distress for trainees (Olk & Friedlander, 1992; Shapiro, 2020), and may manifest in uneven, seemingly mercurial policy that can shut trainees out of key decisions that affect both their training and their health.

Rethinking Essential vs. Nonessential Status—This article does not advocate for the ubiquitous adoption of either essential or non-essential status for trainees, but rather urges consistency and transparency, as well as consideration of power dynamics, equity in benefits, and the inclusion of trainees as critical stakeholders in decision-making about their essential status (Recommendation 1). Policies and practices currently in place may require adjustment in order to meet these needs. For example, because internship placement is allocated by a match process, trainees at VA sites experience a more restricted choice than VA staff in taking on the responsibility of the Fourth Mission and its implications for essential status. This puts trainees in a more vulnerable position than other staff, who did not acquire their positions via match and can more freely change their sites of employment. These features of the trainee role should be made transparent and consistent with its responsibilities.

Sheridan (1981) recommended that internships at medical centers be designated "residencies" partly because of the advanced skills and essential nature of trainees' work, especially in the context of multidisciplinary teams that include providers across medical and behavioral health specialties. In their report, intentional use of the term "residency" served as a heuristic for multidisciplinary care team members to understand the competency and potential contribution of psychology interns, especially for patients experiencing both medical and behavioral health concerns. Numerous programs have adopted this nomenclature for the clinical internship year. Although this name change recognizes and attempts to clarify the status of the psychology trainee and facilitate more seamless integration of psychology interns into the existing medical training model, a name change alone is not sufficient. Notably, Berenbaum et al. (2021) have renewed a call that internship be made postdoctoral rather than predoctoral (Boggs & Douce, 2000), a proposal that should be given serious consideration (Recommendation 2). Berenbaum et al., (2021) likened this to a medical residency model, which others have also called for (Gee et al., 2021). Such a shift may help to disentangle trainees' roles in their placements from their status as graduate students. It may also contribute to clarifying their positions as essential vs. non-essential personnel. Concerns about this proposal would also need to be addressed, such as potentially deleterious consequences of reducing the amount of required training at the predoctoral level, ramifications for licensure, and ensuring equity among postdoctoral trainees (Gee et al., 2021). Further, if internship is no longer a requirement for doctoral training, would federal programs that currently financially support internship training still be available (e.g., through the VHA's Office of Academic Affiliations), and would payment schedules for student loans be affected?

Trainee roles should also be consistent with their rights, benefits, and obligations (Recommendation 3). It would be reasonable to assume that if trainees were expected to fill the roles and duties of essential employees, they should also be accorded the staff benefits of essential employees, and vice versa. As an initial consideration, we recommend that if trainees are expected to fill the roles and duties of essential employees, any benefits provided to essential employees that mitigate risk (e.g., employer-covered health insurance, provision of PPE, and access to testing and vaccinations) must also be extended to trainees. However, if such benefits are not awarded, expecting the same duties confers inequitable hardships and

risks to trainees. In a survey of HSP interns who completed internship during the pandemic, 172 out of 400 trainees felt unsafe at work and nearly half of those trainees indicated that there was inadequate protection against risk (Schneider et al., 2021). These hardships might have a disproportionate impact on certain trainees over others because risk is not equally distributed across our society (Caplan, 2000). For example, in the context of COVID-19, many trainees with disabilities face increased risk of being infected and developing more severe complications; this exacerbated existing concerns about their health and safety.

Questions for Collaborative Inquiry

- To what extent does this site rely on trainees for its functioning, and (particularly for consortium sites) how consistent is this across rotation sites?
- How does this site decide whether interns are essential personnel?
- How do the rights, benefits, and obligations of interns reflect their status as trainees, versus their status as workers, in our system?
- How do the rights, benefits, and obligations of interns differ from those of clinical faculty and/ or trainees from other disciplines at our site (e.g., medical residents)?

2. Revisiting Training Benchmarks and Requirements: Hours vs. Competencies

Standards and requirements in HSP internship training help to ensure that trainees receive quality experiences and that future licensed psychologists have a high standard of clinical expertise. However, the ways in which these standards are set have varied. At the moment, in order for an internship to qualify for APPIC membership it must include a minimum of 1500 hours, with 25% of these hours being patient-facing. More consistent standards across internships have been called for, for example with 1800 hours recommended as an industry-wide standard (Tracy et al., 2011). However, the COVID-19 pandemic has made clear that current benchmarks for training completion—primarily based on a combination of hours in specific activities, as well as profession-wide and site-specific competencies—are due for reconsideration.

Especially during its earlier stages, the COVID-19 pandemic had sweeping impacts on trainees' ability to accumulate the clinical and supervision hours required by their programs. Trainees who experienced interruptions to clinical care for any reason confronted the prospect of an incomplete rotation. Many interns were ultimately offered an expanded set of clinical responsibilities or alternative clinical-adjacent learning opportunities (e.g., developing group protocols for future interns for inpatient care) to allow them to continue to fulfill training requirements. This decision was supported by guidance and statements from several training and accreditation agencies, including the APA CoA (2020), APPIC (2020a, 2020c), and the Council of Chairs of Training Councils (CCTC, 2020). Nevertheless, some interns who experienced lengthy interruptions to service provision were later encouraged to "make up" for lost clinical hours due to COVID-19 through non-clinical duties (e.g. making pamphlets, outreach to college students) or were encouraged to add additional clients to their caseload, adding additional responsibilities on top of existing clinical work. In contrast, other programs used competency-based approaches to guide their adjustments to training,

which helped them to successfully navigate some of the disruptions to training during the pandemic (Agazzi et al., 2021). Such shifts provide opportunities to embrace competency-based standards, which may be more conducive to ensuring quality HSP internship training, even outside of major public health emergencies. As a training requirement, raw numbers of clinical or supervised hours have long been regarded as a problematic metric (Fouad et al., 2009; Hatcher et al., 2013; Falender & Shafranske, 2012). Many clinical activities fit poorly into tracked hours logs (e.g., settings in which patient contact is unpredictable, home-based care models that necessitate long commute times between patient visits, environments in which patient visit lengths can vary widely, or work with underserved populations that may often require non-trackable hours of case management). The definition and justification of necessary hours has also historically been somewhat vague (Bell et al., 2020). It has been argued elsewhere (Fouad et al., 2009; Hatcher et al., 2013; Falendar & Shafranske, 2012; Stedman & Schoenfeld, 2011) that competency-based assessments are preferable to hours-based assessments because these allow programs to provide more specialized, flexible training and can be more resilient to externalities. Others have also noted that a focus on a raw quantity of hours confers unintended advantages to trainees from backgrounds of socioeconomic privilege and/or trainees without disabilities (Boggs & Douce, 2000; Lund, 2021; Pearlstein et al., 2021). Moreover, a departure from accumulating a specified *quantity of hours* enables a shift towards promoting *quality of training* in advancing clinical competencies in a way that is flexible to individual training contexts.

Toward Competency-Based Training—We therefore recommend that HSP training criteria shift further away from hours-based requirements and toward a stronger focus on competency (Recommendation 4). Current lack of consensus on competency evaluation is an obstacle to a systematic shift towards competency-based training and away from hours-based criteria. Such a shift would require substantial development and reflection on definitions of competency within clinical psychology, including special attention to implicit biases and equitable standardized assessment (Atkins et al., 2014; Casline et al., 2021; Humphreys et al., 2018; Lichtenberg et al., 2007).

Given that training programs responded to the COVID-19 outbreak in vastly different ways, APA and state licensing boards may find it necessary to offer some flexibility in appraising the clinical hours of 2019–2021 interns in the near term and, potentially, beyond (Recommendation 5). It is imperative for both APA and state licensing boards to ensure that trainees are not penalized for the response of their training programs to COVID-19 or future national emergencies, while still holding trainees and training programs to reasonable standards. Although our focus is on clinical psychology interns, trainees at all levels have been affected by the pandemic and will require consideration. For the next several years, incoming cohorts of internship trainees will have experienced interruptions to their graduate training caused by COVID-19 (King, 2020; Schneider et al., 2021), with variation in the nature of these disruptions across programs. It will be important to acknowledge the extent to which hours and other requirements are actually affected by contextual factors, as was especially evident during 2020–2021. Looking ahead, however, we advocate for a reconsideration and possible departure from hours as a core training benchmark. The

COVID-19 pandemic may present a timely opportunity to shift towards a more suitable system based on achieving competencies.

Questions for Collaborative Inquiry

- Are there hours-based requirements currently in place in this training setting? If so: (a) What provisions exist to balance quality of hours with quantity of hours? (b) Are there any trainees at a disadvantage for meeting these requirements?
- To what extent do we prioritize competency-based training?
- What are we doing to ensure that our definitions and measurement of competency are unbiased and support the growth of all trainees?

3. Training Aims

The training aims of internship programs are designed to meet profession-wide standards in the education of psychologists. Entities such as the APA, CoA, and APPIC also provide for flexibility in how programs establish and regulate their training aims (HSPE Collaborative, 2013; Stedman et al., 2005), which allows for variation and specialization among programs to meet specific needs (Boggs & Douce, 2000; Hafner, 1973). Although trainees have the opportunity to rank programs based on advertised training aims, once they have matched, trainees are typically in the position of adjusting to aims as they are designated by training programs, while providing relatively little input in the determination of these aims.

The COVID-19 pandemic required many interns and training programs to revisit the aims of training in light of disruptions to standard operating procedures, often while disruptions were already under way. These changes made it difficult to maintain fidelity to the training aims versus addressing other exigent pressures that required accommodation. For example, trainees who were removed from inpatient rotations due to the difficulty of providing telehealth in inpatient settings lost opportunities to receive in-depth training in high-acuity care. In college counseling settings, most clients moved home, resulting in loss of specific training experiences such as engaging in specialized outreach or clinical services. For some trainees, elective rotations that were interrupted due to not meeting the threshold of “essential care” represented the last opportunity to develop competency with specific populations or treatment modalities.

We observed that, especially during the tumultuous beginning of the COVID-19 pandemic, those programs and rotations that used a collaborative approach to revising training aims were better able to create plans that minimally detracted from training or trainees’ post-internship career prospects. In such cases, trainees and supervisors were often able to co-create training aims that not only facilitated new learning opportunities uniquely created by the COVID-19 pandemic (e.g., gaining experience in providing telehealth, supervision of graduate students in new clinical roles), but also allowed trainees to provide relevant psychological services during a time of unprecedented stress and patient need (e.g., running COVID-19 support groups, creating drafts of protocols adapted for telehealth). This collaborative approach to training aims was facilitated when committed advocates of

trainees were in positions of authority (e.g., training director), with the capacity to make systemic decisions that supported trainees.

Recommendations for Determining Training Aims—As the scope of training evolves after COVID-19, incorporating input from trainees themselves will be essential to ensuring that newly minted psychologists are well-equipped to serve the population in a variety of roles. We therefore recommend that programs identify and make explicit not only the established training aims developed by program leadership (e.g., acquiring competency in certain types of assessment), but also explicitly query trainees' aims for these rotations (Recommendation 6). Such inquiry could provide a mutual understanding of the goals of training, promote accountability when training aims shift, and introduce opportunities for changes in training aims to be collaborative when they do occur.

Trainees often rank internships based on advertised training aims, and they enter a bidirectional agreement with training sites to commit to internship (including abiding by the match and not leaving) based on these training goals. It was the authors' experience that program approval is typically required for a trainee to change previously agreed-upon training plans or aims. It is recommended that the opposite also be true - trainee approval should similarly be solicited if training goals change (Recommendation 7).

Recent work has also called for broader shifts in training aims, which would apply to all aspects of HSP training. Berenbaum et al., (2021) and Gee et al., (2021) point out that the psychological workforce has made limited headway in addressing the global disease burden of mental health challenges, and that alternate roles for psychologists—beyond either bench research or patient-facing service providers—may help better address these challenges (Berenbaum et al., 2021; Gee et al., 2021). Adopting these recommendations would mean substantive changes to the training focus of many trainees, with repercussions for their anticipated career trajectories. Especially for changes of this magnitude, we recommend the collaborative involvement of current, as well as past and future, trainees.

Questions for Collaborative Inquiry

- Who determines the training aims for this internship (or its rotations?)
- How are changes in training aims decided upon, and how much input do trainees have in these changes?
- When trainees' training aims change, what process do we have for evaluating how these changes may affect their future career aims?

4. Location and Locality for Trainees

Training sites have traditionally operated with assumptions of locality (e.g., trainees and supervisors are expected to be on site, especially at institutions like VAs). Statutes and billing procedures further regulate the provision of treatment across state lines (and whether trainees were able to provide services across states), restrictions on independent practice, and the allocation of space (e.g. offices) for treatment. Many of these expectations were no longer tenable during the COVID-19 pandemic and, when sites attempted to retain

them, many trainees and patients experienced unnecessary hardships. When constraints on locality were loosened, services and training were often facilitated with greater ease. This observation leads to the question: To what extent, and how many, of these restrictions were necessary to begin with?

Many restrictions on locality are predicated on state and regulatory requirements. For example, trainees have historically not been permitted to practice telehealth across state lines. During the COVID-19 pandemic, such guidance was occasionally subject to change. In VAs, top-down guidance from the VHA and at the local level initially maintained restrictions on trainees practicing telehealth across state lines. However, some VAs left such decisions up to trainees and supervisors in order to meet escalating mental health needs while protecting trainees and patients. Many college counseling center clients crossed state lines to return home, typically prompting referrals to providers in their communities. Finally, in some cases, trainees were strongly discouraged from traveling outside state lines by policies enforcing a mandatory 14-day quarantine without pay, regardless of capacity for working remotely. In the context of irregularly imposed bans on interstate travel, this policy meant that trainees who had previously traveled, or were required to travel for the sake of professional or personal need—a death in the family, for example—could be stranded out of state, or subjected to penalties for traveling. Such undesirable outcomes could have been easily avoided by embracing the added flexibility afforded by telehealth to participate in training and clinical activities remotely and from across state lines.

Moreover, working remotely was a hard-won, beneficial accommodation for people with disabilities and trainees who have children (Cokley, 2020). Concerns about productivity and ability to communicate with a team have led many companies to reject the idea of working from home (Abbot, 2020; Cirruzzo, 2020; Herbst, 2020). However, working from home is in many cases equally effective, and can promote diversity and inclusion by allowing more people to engage in work in a way that works for them (Allen et al., 2015; Golden & Gajendran, 2019; Golden & Eddleston, 2020). In a systematic review and series of interviews examining the advantages and disadvantages of remote work, Ferreira et al. (2021) developed a set of recommendations for its adoption. These readily apply to remote work for interns, and include a focus on strengthening team cohesion in the context of remote work, paying due attention to the limitations and restrictions imposed by workers' situations and remote work technology, and ensuring a sustainable work-life balance.

Expectations of locality also extended to the process of applying for internships. In past years, sites typically required prospective interns to attend in-person interviews, and few sites actively countered the expectation that remote interviews would diminish applicants' standing. This requirement contributed considerable expense to internship applications and exerted a stratifying force on the internship pipeline, with a median travel cost of $1000.00, excluding other application costs (APPIC, 2018). In 2020, remote interviews for internship were broadly adopted, which considerably reduced disruptions in domestic responsibilities (i.e., childcare), as well as financial costs (down 70% from 2018) and scheduling burdens for trainees and internship sites alike (APPIC, 2021a). Though analogous research with HSP trainees remains to be done, one study examining match interviews among cardiothoracic fellowship applicants and program directors found that after the suspension of in-person

interviews due to COVID-19, the majority recommended retaining remote interview options for future years, although most also did not support eliminating in-person options altogether (Robinson et al., 2021). In a comparison of in-person versus telephone and video interviews, Johnson et al. (2019) found that the quality of substantive material produced by different types of interviews was similar, although in-person interviews yielded richer opportunities for novel conversational turns, and might offer slight advantage. Thus, it will be important to understand and compensate for potential limitations of remote interviews in their adoption for future generations of interns.

Loosening Locality to Support Interns and Patients—The answer to our earlier question—"to what extent, and how many, of these restrictions were necessary to begin with?"—is made clear by the success with which interns were able to function when inter-state and locality restrictions were temporarily lifted during COVID-19. Although there is clear value to being on site for an internship, too-rigid restrictions on locality based solely on this value are unhelpful and sometimes harmful. The following section (*5. Fieldwide Adoption of Telehealth and Telesupervision*) addresses some of the opportunities and challenges presented by telehealth, which has rendered many of the pre-existing structures ripe for reconsideration. Opening up opportunities for interns to practice from remote locations would allow them to maintain their training even in the context of unexpected change, would help trainees endure family crises (e.g., being present with a sick relative) without foregoing their training obligations, and would provide more financial resilience to trainees by giving them greater geographical freedom in the event of financial disruptions or health need.

We therefore recommend that locality restrictions for interns be loosened (Recommendation 8). Hybrid models should be considered, in which interns have opportunities to work from home if their duties do not require them to work with patients or supervisors in-person. Although it can be important for interns to reside locally, requirements for on-site presence should be determined by patient and training needs, rather than remaining a universal mandate. Interns should also be allowed to participate in internship from across state lines for delimited periods of time (Recommendation 9). We recognize that state statutes may nevertheless restrict interns' ability to work across state lines, but we view changing site-side requirements as a vital step toward loosening these restrictions as well.

Support in the Midst of Relocation.—The experience of HSP training is bracketed by relocation for most trainees. Trainees who rank far-away programs can expect to move, but cannot necessarily expect to stay for over one year. Due to financial or pandemic-related constraints, many interns are unable to see their new residences in person prior to moving, and often move to new locations without the opportunity to meet anyone. This restriction not only leads interns to experience isolation but also curtails their capacity to advocate for themselves and receive support if their primary contacts are in supervisory roles. Programs are already encouraged to facilitate an inclusive and collegial culture by the APA CoA (2020). A further emphasis on mutual support (and mentorship from faculty who do not have evaluative roles for the trainee) can be helpful for interns, and should be facilitated through

programmatic adjustments that build opportunities for interns to form mutually supportive relationships with colleagues and staff at their new location (Recommendation 10).

We also unequivocally recommend that all internships adopt teleinterviews as a standard option for trainees, to be given equivalent weight as in-person interviews in applicant ranking (Recommendation 11). As part of this adoption, differences in applicants' resources (e.g., Internet quality) and characteristics (e.g., sensory disabilities) that might differentially impact success with teleinterviews should be considered and accounted for to ensure an equitable interview process.

Questions for Collaborative Inquiry

- To what extent is locality mandated by the training program, and what are the reasons for these mandates?
- How are these reasons balanced with the priorities of ensuring quality care delivery for patients, the safety and wellbeing of trainees, and the quality of training?
- Are there different policies for hybrid/remote work for trainees and clinicians at this site? If so, why?
- What does our program do to support trainees who have relocated from out of state and have few local connections?

5. Fieldwide Adoption of Telehealth and Telesupervision

The COVID-19 pandemic necessitated swift and abrupt adoptions of telehealth and telesupervision, often in settings in which these were not already used. Until recently considered a novel adjunct to clinical care, telehealth became standard in many treatment and training settings virtually overnight (see Cox et al., 2020; Hames et al., 2020; Mann et al., 2020, for general considerations). Interns suddenly found themselves calling into training activities from the kitchen table, a very different social context than typical training settings. It is unlikely that the transition to telehealth can be put back in the box, and it may become increasingly important for psychologists to work effectively on large, interdisciplinary treatment teams from afar. COVID-19 has made clear that through technology, the majority of training activities can be conducted remotely with appropriate adjustment.

In step with this expansion, between 2020 and 2021 twelve new states have enacted the Psychology Interjurisdictional Compact (PSYPACT)—an agreement that allows for the practice of psychology across signatory state lines via telehealth—with two additional states introducing reciprocity to legislation (*Map - PSYPACT*, n.d.). Remarks by policymakers suggest that after its meteoric rise, telehealth may be "here to stay" (Azar, 2020). Incorporating telehealth into clinical training confers numerous potential benefits, including expanding the diversity of care that the HSP workforce can provide, as well as the diversity of the HSP workforce itself. However, telehealth also generates new training concerns that warrant careful consideration. On balance, we believe that the expansion and adoption of telehealth is a net positive for HSP training, so long as relevant hurdles for trainees

are accounted for. We therefore offer trainee observations about the benefits as well as difficulties conferred to clinical training by the unexpected and rapid transition to telehealth and remote work.

Although new research will no doubt emerge in the wake of the COVID-19 pandemic (e.g., Monaghesh & Hajizadeh, 2020; Zhou et al., 2020), existing literature has found that teletherapy is effective for delivering evidence-based treatment for patients, with only small differences compared to in-person services (Gros et. al, 2011, Langarizadeh et al., 2017). Telehealth can also reduce accessibility barriers for patients across multiple facets of service delivery (Myers et al., 2010; Reay et al., 2020). The expansion of telehealth can provide many of the same benefits for trainees, for whom reduction in costs and time from commuting, as well as increased independence and autonomy, are noteworthy. If expanded, while keeping in mind and accounting for certain challenges that can accompany telehealth in training, telehealth can ease accessibility-induced bottlenecks and provide new and valuable opportunities in training.

Notably, trainee circumstances can affect the implementation of telehealth in training. During the rapid transition to telehealth that occurred during COVID-19, many trainees observed that well-meaning but differently situated supervisors were simply unaware of telehealth-specific challenges that trainees were experiencing. Unsurprisingly, wealth is a predictor of access to privacy and space available in one's home (Kasper, 2007). Because of comparatively lower pay grades, trainees may be likelier than other clinic staff to reside with non-relative roommates and lack separate space for an office, resulting in obstacles to confidentiality and privacy while working at home. They may also experience other obstacles to remote work. For example, low-cost housing is often in noisier neighborhoods (Casey et al., 2017), and affordable internet access packages may not be fast or reliable enough for conducting video therapy. For similar reasons, trainees may also not have access to appropriate technical equipment to engage in telehealth (e.g. a computer with a working camera and microphone), in which case training sites may need to provide such equipment.

The transition to telehealth often entails a corresponding transition to telesupervision, with thus-far unclear impacts on clinical training. During the COVID-19 pandemic, in contexts where video recordings were central to supervision but were no longer possible, live supervision opportunities decreased without a viable alternative (Scharff et al., 2020). On the other hand, for some supervisors, telehealth provided new opportunities for "live" supervision over phone and video platforms. By lifting the ordinary constraints of locality, technology can enable the provision of quality training and supervision to trainees by supervisors who are far removed from the practice site (e.g., through opportunities to observe supervisors' sessions or have trainees' sessions observed by supervisors through HIPAA-compliant phone and video platforms). Preliminary research suggests that telesupervision is not inferior to in-person supervision (Inman et al., 2019; Wood et al., 2005). However, given the paucity of available literature on best practices for telesupervision (Inman et al., 2019), further research and consideration by training leadership are warranted. Bernhard and Camins (2020) provide two practicum trainees' first-person accounts of receiving telesupervision, which may be useful as a case study of good practices in telesupervision from trainees' perspectives.

Relatedly, in the early stages of the COVID-19 pandemic, many trainees did not have specialized skills for telehealth and found that their skills did not always generalize from face-to-face to telehealth modalities. A survey of neuropsychology trainees (which included graduate students and postdoctoral residents) found that most trainees did not have prior training or experience in telehealth as of April 2020 (Breting et al., 2020). Although these numbers are likely to have shifted dramatically since then due to COVID-19 related accommodations, concerted training for telehealth would be a valuable addition to supervision and didactics. Several recommendations for teletherapy and teleassessment training have recently been issued, although these have primarily focused on pre-doctoral practicum training rather than internship. Casline et al. (2021) provide recommendations for training clinics to enact didactic, procedural, and evaluative changes to support students practicing teletherapy, with attention to some of the same issues we discuss in this article, such as competency-based training and acknowledgment of power differentials between faculty and trainees. Patel et al. (2021) provide further practicum trainee perspectives on supervision for teleassessment in an article that carefully weighs multiple considerations for supervision prior to, during, and after a teleassessment.

Recommendations for Embracing the Potential of Telehealth—Looking forward, as decisions are made about what components of telehealth are to be retained beyond the COVID-19 pandemic, it will be important to develop telehealth-specific training strategies, and to include competencies for telehealth and telesupervision in training (Recommendation 12). Depending on the advancement of clear guidelines, proactive clinical innovations, and provision of technical support, programmatic transitions to telehealth have the potential to expand and improve training aims and outcomes. Training programs can leverage the expansion of telehealth as a new path for developing the competence and independence of trainees. As with all new frontiers in training and in practice, identifying the best practices for remote training—including aspects of training that do not translate well to remote options (e.g., informal peer support and relationship building)—requires forethought, creativity, and research. We therefore also suggest that best practices for effective “teletraining” are an urgent target for further research, ideally through study designs that incorporate trainee stakeholder perspectives.

Telehealth and telesupervision options should be made available, though with due consideration of trainee circumstances, as well as patient needs and quality of training and service delivery (Recommendation 13). When trainees are asked or provided the option to work remotely, we recommend that programs open a collaborative dialogue about any challenges in the trainees’ remote work environment and work with trainees to identify possible solutions to issues that arise. Problem-solving from the outset avoids miscommunication, helps ensure that trainees have the resources to meet programmatic expectations, and is an essential step to protecting patient privacy.

Questions for Collaborative Inquiry

- What is the culture around telework in this internship environment? What are implicit or explicit biases and norms concerning remote telework?

- How does this site make use of competencies focused on telehealth provision for trainees, and on telesupervision for supervisors?
- Are trainees with different personal circumstances afforded equivalent opportunities for participating in telehealth and, if not, what barriers do they experience?

6. Economic Security

Training interns is undoubtedly costly to training sites and programs, and internships must be financially sustainable in order for the field to succeed (Rosenberg et al., 1985). However, there is a significant financial burden of training that is also placed on the trainee, who may already be financially vulnerable as a result of years of doctoral training prior to internship. The average debt incurred from pre-internship psychology doctoral training in the US is $91,750 (SD = $103,937, median = $60,000), as reported by the 2018–2019 internship cohort, 61% of whom were PhD students (APPIC, 2018), though even higher debt numbers were reported by Wilcox, et al., (2021). Prior to internship, doctoral students have historically paid to apply and travel for internship interviews, with costs averaging $2,323.00 (SD = $1,804; APPIC, 2018). In 2020, the mean stipend for APPIC-accredited internships was $31,100 (APPIC, 2021b)[1].

The financial costs of pursuing doctoral studies and internship are particularly challenging for those supporting families or dependents. Based on the Center on Budget Policy Priorities' guidelines (2020), for a family of three (e.g., an intern with a spouse and one dependent) the median internship salary barely exceeds (by $771.00 annually) the cut-off for qualifying for the supplemental nutrition assistance program (SNAP). Given that 13% of 2018 internship applicants resided with at least one dependent child, a non-trivial proportion of interns, especially those who support dependent family members, are in a state of financial precarity throughout their internship if they do not have additional sources of income. For example, one of this article's authors worked two additional jobs during a full-time internship to support their family; other trainees were not permitted to take on additional jobs without site approval. Racial and ethnic minority trainees are at greater risk of financial instability due to existing racial differences in family wealth (Campbell & Kaufman, 2006), and marginalized trainees are more likely to accumulate debt than their more privileged peers (Lantz & Davis, 2017; Wilcox et al., 2021), adding to the stratifying influences of HSP training.

To "raise the bar in this area," APPIC requires that internship training sites provide adequate pay to interns (*FAQ: Stipend Req for Interns and Postdoc Fellows*, n.d.[2]). However, the primary standard for adequate pay currently hinges on regional parity (i.e., consistency with pay rates at other internship sites in the region), rather than comparison with cost of living in the area or average pay among US adults generally. Not all sites provide health insurance, and not all that provide insurance extend those benefits to trainees' dependents.

[1]Medians have historically been lower than means given the higher pay of military internships (2021 mean = $77,600), but because means are not reported for 2021 we base subsequent calculations on reported medians from 2018: $27,000).
[2]We observed that "raise the bar" was excised from the language of the 12/2020 update, so the quoted phrase will not be found on current versions of the page.

Per the APPIC directory, internships vary in the benefits that they provide, including stipend, sick leave, vacation, dental insurance, health insurance, disability insurance, life insurance, and paid time off or professional development days. Although one cannot directly search the website by benefits, sites are asked to self-report these benefits in the “fringe benefits” section. Of the 19 sites that provide a stipend of $20,000 or less, only nine noted that they provide health insurance as a benefit (*APPIC Directory Search*, 2021). Lack of access to health insurance during internship creates further challenges in accessing care for trainees with disabilities, or those with young families, for whom regular access to medical care is essential.

Such problems have led at least one elite program to suggest that “asking for financial help from your family can be a solution” to financial strain (Yale School of Medicine, 2021). This proposed recourse further disadvantages marginalized, first generation, and immigrant students, who are less likely to have easy access to additional money (Fairlie, 2013; Hernandez Kent & Ricketts, 2020). The financial costs of applying for and completing internship (and, inseparably, doctoral training) are a powerful stratifying force, which exacerbates disparities between trainees who come into their training with multiple forms of privilege and those who do not. They also make it very costly for those interns who are most likely to experience hardships (e.g., members of historically marginalized groups) to dissent from policies set by their internship, given that any disruption of their stipend can mean financial insolvency.

Unlike other professionals, trainees are often unable to supplement their income with other work due to widespread “moonlighting” clauses in training agreements, which forbid compensated work outside of the internship. Lifting such clauses may offer a stopgap. However, we also emphasize that secure stipends that adequately cover cost of living offer a better solution than income supplementation, which may not be possible for interns with disabilities and interns with family obligations, and may undermine the training emphasis of the training year. In addition, relative to most employees, interns lack employment freedom, as they are bound to complete the internship year at their matched site. If they require higher income than their site offers, interns are not free to seek a raise or discontinue internship and seek another job. On the contrary, they risk forfeiting their degrees unless they complete internship as stipulated at their matched site. It is noteworthy that interns are not always considered employees, and are therefore not always eligible for some of the labor protections afforded to workers (Bruch, n.d.). There is no union or labor organization among interns, likely due in part to the brevity of training, and trainees at many sites did not have pathways to join existing labor organizations open to staff.

These pre-existing economic pressures were further worsened during COVID-19. Trainees who were members of households where others lost work faced increased financial responsibility. In cases when trainees were required to remove themselves from work (e.g., if they were exposed to COVID-19), some were required to take unpaid leave if this period exceeded allotted leave times. One author had a COVID-19 scare and was not paid for two weeks of work due to changing regulations governing who was eligible for COVID-19 specific leave. As discussed earlier, such disruptions placed some affected interns in financial precarity. Some internship programs enacted new policies as a result

of the pandemic that adjusted annual leave and remuneration, providing a crucial safety net for interns. Low income may have also exposed trainees to risks that are not directly related to their training. For example, many trainees share living quarters (often with other healthcare providers), use public transportation and/or rideshare services, and restrict their use of premium services (e.g., grocery delivery) that can mitigate exposure to COVID-19.

Economic Sustainability for HSP Internship Trainees—It is the strong opinion of all authors that internship sites should be required by accrediting bodies to provide health insurance coverage, with options to cover dependents (Recommendation 14). Further, it would be beneficial for internships to extend benefits usually given to full time employees, such as short-term disability, family or parental leave, and workers compensation, so that interns have the ability to support themselves and weather unexpected events (Recommendation 15). It is also important to recognize that accrual-based sick leave or vacation policies make trainees more vulnerable to difficulties at the beginning of internship. Providing interns with access to annual leave from the start of internship can offset this challenge. These steps offer vital protection to trainees in the event of unanticipated disasters and are critical to addressing current inequities in training.

Intern salaries must also be raised in order to provide adequate financial stability for individuals enacting professional roles on par with staff clinicians (Recommendation 16) – a call that has been made in other recent commentaries on the state of training in our field (Gee et al., 2021). Rather than parity with nearby internship sites, we recommend that internship salaries be based on median incomes for the location where the internship sites are located. It is important to recognize that at this point the VA is the largest internship provider in the US. VAs have the opportunity to shape the market forces that govern internship pay rates and lead the field by setting a higher standard for economic compensation of trainees in order to make the work sustainable and feasible for aspiring psychologists.

Finding funding is challenging in contemporary healthcare environments. However, because of the transient nature of internship, we contend that interns have occupied an underprivileged bargaining position compared with other demands and stakeholders. Our earlier recommendations of considering a switch to postdoctoral internship, as well as a recommendation we discuss below—affording interns the opportunity to switch internships—may provide greater bargaining power. Another alternative option is reducing the number of weekly expected hours on internship (without a reduction in salary), such that interns could remotely teach courses at their home institutions in order to supplement their salaries. The need to raise salaries and benefits for interns will require considerable effort on the part of the many interlocking systems within which internship training is situated (e.g., as adjunct labor becomes more prevalent, opportunities for interns to teach courses at their home institutions remotely are diminished). However, these issues must be addressed before a funding crisis renders internship tenable only for more privileged applicants, which would exacerbate the existing shortage of psychologists, and especially psychologists from disadvantaged backgrounds.

Questions for Collaborative Inquiry

- How do trainee salaries compare to the median income for the internship site's location?
- What kind of safety net is available to trainees who experience sudden life disruptions (e.g., illness, disability, death of a loved one)?
- Are interns treated as employees, entitled to workers' compensation and leave benefits? Why or why not?

7. The Need to Support a Diverse Body of HSP Trainees

Internship year presents a unique constellation of stressors, each of which is softened by privilege and exacerbated by systemic inequities. COVID-19 and world events such as protests against race-related violence placed a spotlight on issues of diversity, equity, and inclusion in clinical training. These events often amplified existing disparities in clinical training, and increased the urgency of taking action to address them.

Health risks are not equally distributed during public health crises or other national emergencies. Segments of the U.S population that are already marginalized experience greater burdens from large-scale disasters and infectious diseases (Bambra et al., 2020; Blumenshine et al., 2008; Curran, 2013, Yancy, 2020), and trainees from marginalized backgrounds were unduly affected by COVID-19. The spread, severity, and consequences of COVID-19 disproportionately affected Black, Asian, Indigenous, and Latinx individuals (Burton et al., 2020; Webb Hooper et al., 2020; Haynes, et al. 2020). Trainees who belong to these communities, already at higher risk of health problems because of compounded forms of marginalization and inequity, also faced the possibility of transmitting the illness to loved ones or other members of already disproportionately affected communities, contributing to both systemic and personal burden.

Trainees with disabilities, chronic health conditions, and/or compromised immune systems, including those with heart disease, diabetes, and pulmonary illness, were also at elevated risk for COVID-19 related adverse outcomes (Grasselli et al., 2020; Jordan et al., 2020; Yancy, 2020; Zhou et al., 2020). Although the number of trainees experiencing health problems during the COVID-19 pandemic is not clear, 4% of APPIC internship applicants reported experiencing a chronic medical condition in a 2018 survey (APPIC, 2018; however, this survey is limited by a 58% response rate, and not all reported conditions entailed an increased risk of COVID-19 related complications). The proportion of trainees with disabilities has increased over time, and these individuals continue to experience considerable barriers in their training (Lund, 2021). COVID-19 appears to be especially risky for older adults (Gardner et al., 2020), resulting in a disproportionate burden to older trainees (approximately 4%; APPIC, 2018) and an unknown number of trainees who care for dependent adults. Trainees in high-risk categories, or who cared for others in high-risk categories, were burdened by the consequences of shelter-in-place policies (e.g., by losing childcare, Bayham & Fenichel, 2020), loss of compensated leave/sick time, lost wages or partners' income, lack of public transportation, changes in training plans, and microaggressions in the workplace.

In addition to the economic and health risks associated with COVID-19, discrimination against people of Asian descent increased in the context of the pandemic (Devakumar et al., 2020), adding risks to wellbeing and safety. The spring of 2020 has also informally been called a "double pandemic" for individuals who are Black, Indigenous, and/or People of Color (BIPOC), referring to both the COVID-19 pandemic and the police brutality and killings of unarmed Black and Indigenous people (Novacek et al., 2020). Compounding the stress of training during a public health crisis, minority status can add additional burden (Assari & Bazargan, 2019) to trainees who are attempting to navigate the power dynamics of negotiating safety and training needs with supervisors and institutions in the context of a national emergency. In addition, international trainees faced difficulties with traveling home, visa processes, and notable delays or disruptions to typical immigration services during this time.

These challenges prompt scrutiny of how HSP training handles the diversity, and marginalization, of trainees. When disadvantaged trainees—whether due to racial, cultural, disability, socioeconomic, mental health, or other disparities—attempt to navigate training, do they find themselves negotiating a system that disadvantages people with their backgrounds? Are there resources in place to counteract existing inequities and give these trainees an even footing? The combined stressors of systemic inequality and COVID-19 easily exacerbate other challenges related to the role of the psychology trainee. We have emphasized several backgrounds and identities particularly affected by the pandemic, including people who are marginalized along the lines of race, disability, and socioeconomic status. However, there exist other groups who have been disproportionately affected by the pandemic (e.g., women, sexual minorities, Peterson et al., 2021) and it is important to address the specific, intersectional circumstances relevant to each trainee in order to ensure equity. Strategies to address longstanding issues in training that have been illuminated by COVID-19 must include equity for people from diverse racial, ethnic, immigration, disability, age, and other backgrounds, who are still often disadvantaged within the structures of HSP training.

Supporting Diversity, Equity, Inclusion, and Belonging in HSP Training—Efforts must be made by training programs to safeguard and advocate for (and with) their trainees, prioritizing those most vulnerable, so that emergencies do not exacerbate existing barriers to training for marginalized communities (Hammond & Yung, 1993; Turpin & Coleman, 2010). Such actions would contribute needed improvements in the overall training environment. Although a full examination of the structural and pragmatic changes necessary to support diverse trainees exceeds the scope of this paper, readers are further referred to two excellent sources: In an article composed by graduate students and postdoctoral trainees, Galán et al. (2021) offer a careful analysis and list of recommendations for an antiracist clinical science; Pearlstein, et al. (2021) offer a set of guidelines for supporting trainees with sensory disabilities. We also emphasize several recommendations aimed at supporting a diverse population of trainees and addressing inequities in HSP training.

We recommend that programs proactively address inequitable supervision, training, and human resources policies and praxes (Recommendation 17). Although many programs made antiracist and affirming statements during the crises, it is vital to close the "principle-

implementation gap" (Dixon et al., 2017), sometimes known as "bait and switch" (Slay et al. 2019), so that these statements do not ring hollow. Meaningful actions that training programs can take include creating effective and safe systems for amplifying the voices of those experiencing minority stress, engaging in individual work to minimize privilege-related defensiveness when responding to the experiences of marginalized trainees, implementing and sharing the results of cultural climate assessments, facilitating programmatic introspection, and enacting evidence-informed change in economic, logistic, and other training policy domains. Crucially, trainees must have a safe, equitable process for making diversity-related complaints that are valued and integrated.

As numerous programs have begun to do, it is important to make both antiracist and BIPOC-centered healing resources (e.g., mentors, therapists, affinity and ally groups, confidential reporting processes, ombudspersons) available to trainees (Recommendation 18), as well as to explore additional policies and systemic changes (Galán et al. 2021). There is evidence that non-evaluative diversity-focused mentoring programs may be an efficacious support mechanism (Burney et al., 2009; Johnson & Gandhi, 2015; Mangione et al., 2018). Leadership and training staff may also model valuing diversity by attending diversity events and committees, by consistently raising opportunities for engagement with meaningful diversity initiatives and discussions, and by ensuring they possess relevant knowledge of local resources.

To recapitulate arguments made by others in the field (Mustapha & Eyssallenne, 2020), this use of time should be valued on par with other time use, and accordingly remunerated and considered in evaluations for tenure, promotion, compensation, and accolades (Recommendation 19). Such recognition is particularly important given many marginalized training faculty's experience of cultural taxation, where diversity-related responsibilities are disproportionately placed on diverse faculty, leading to higher levels of stress and a more difficult path to milestones such as tenure (Padilla, 1994; Joseph & Hirschfield, 2011).

Questions for Collaborative Inquiry

- What opportunities exist for trainees from underprivileged backgrounds to voice concerns about inequities in a way that is heard and responded to by the training program?
- In what ways does our training program model a commitment to equity, beyond statements and advertisement? What concrete actions are being taken to increase equity in the program?
- What resources, supportive spaces, systems, and staff facilitate antiracist action within the organizational culture and policies, and among interns and faculty?

8. Trainee Roles in Decision-Making and Policy

Ordinarily, policy decisions on internship flow from the top down. For instance, internship training programs make decisions guided by accreditation agencies, government policy, training staff expertise and experiences, and other corporate institutions such as hospitals, with opportunities for feedback and adjustment when necessary. The traditional top-down

structure can be well-suited to the brevity of the training year and the desirability of stability from one year to the next. However, there is also a need for greater collaborative decision-making and trainee stakeholder involvement in HSP training. During COVID-19, several factors interfered with present decision-making procedures and structures, including the unequal power structures of internship training, as well as inefficiencies in the communication between interns and internship programs. These point to a need for clearer pathways to incorporate trainee input in internship programs' decision-making.

The inevitable power differential between trainees and other members of training institutions affects interns' decision-making capacity about aspects of their own training. As Watson and Foster-Fishman (2013) observe, differentials in power accompany any collaborative decision-making endeavor. These differentials in power are instantiated through unequal access to resources (e.g., finances, accreditation) and norms (e.g., which voices carry the most weight). For example, in the spring of 2020, some training programs offered their trainees the option of either discontinuing or continuing on-site work as usual. However, some trainees wishing to eschew on-site activities faced barriers to making that choice, such as when the supervisor with whom they were negotiating a change in the training plan was also in an evaluative position or stood to influence their career prospects. At some training sites, when interns advocated for themselves, they faced judgments about their level of interest in providing services, supervisors' pushback, or other retributive acts. Other factors that can constrain interns' choices may include a lack of alternative activities that would provide full-time compensation, a path to graduation, and timely eligibility for desirable professional positions. In some cases, such as for international students whose legal residency depends on a visa, these limitations could lead to especially negative consequences.

Relatedly, top-down decision-making may place too much decision-making burden on too small a part of the training system. In the spring of 2020, some training directors communicated to training sites that trainees were to be removed from face-to-face service provision by default. Such top-down decisions, although well-intentioned, were often fraught. If not conservative enough, trainees may be exposed to excessive risk, the program may contribute to the spread of contagions, and dissatisfaction or burnout may grow among trainees. If too conservative, trainees may be denied opportunities to receive important training and to serve communities and patients to whom they are committed. Moreover, care teams may be left suddenly understaffed, potentially harming the relationship between the training program and training site or adversely affecting patient care. In a top-down system, discrete decisions can have far-reaching consequences; making these decisions collaborative can distribute the work required to carefully think through their impacts, thereby improving equity and sustainability and avoiding unintended negative consequences (Laverack & Labonte, 2000).

Importantly, many changes affecting trainees are also observed initially by the trainees themselves. For example, consider the intersection of two reasonable policies from different entities at the beginning of the COVID-19 pandemic: (1) An internship program elects to discontinue face-to-face contact for interns, and (2) a hospital stipulates that absenteeism in excess of allotted sick leave will not be compensated. Interns may be the first to realize (as

several of the authors did) that the combination of these two policies will mean that they are subject to extended uncompensated time during internship. These types of predicaments may also have differential impact on interns from disadvantaged backgrounds, such that interns with less financial or social capital, or those with existing health conditions, may experience greater impact from such disruptions compared with other interns, thereby increasing disparities. As noted by others (e.g., Bell et al., 2020), guidance from accrediting and government agencies underwent continual change and frequent updates during the early stages of the pandemic, sometimes resulting in contradictory instructions from different regulatory bodies. Amid ever-changing expectations and recommendations, structures where trainees are "recipients" of policies without a forum for voicing concerns may leave training programs under-informed about the real-world impact of their policies. Soliciting trainee experiences and input could have presented a crucial touchstone in the absence of other information, helping to maintain commitments to training and patient care.

However, existing systems for obtaining trainee feedback have limitations. Some training programs emphasize the involvement of interns by inviting them on training or other special committees (although some other programs' training committees do not have intern members). These authors' experiences suggest that, even when included in such committees, trainees are often hesitant to share their concerns and when they do, their perspectives are accorded less weight than faculty and leadership opinions. In settings that do not include trainee members on committees, trainees may only learn of implemented policies after the fact. In more extreme cases, as in the experience of several authors, interns were not informed of emerging COVID-19 policies at all. Although internships sometimes utilize trainee feedback sessions at the end of the year to gather information, not all internship sites have protocols for integrating this feedback. When such protocols exist, their details are often not communicated to trainees. Finally, given that interns leave at the end of the year, it is not always clear to what extent any given cohort of interns is able to influence training at their location. Without clear structures for integrating feedback in place, there may be little accountability for doing so.

Although the CoA is required to have one graduate student member (nominated by APAGS: APA, n.d.-b), there is presently no requirement that this graduate student be an intern. In fact, at the time of writing this article, neither APPIC nor the APA-CoA have interns as members of their committees or boards. Both APPIC and the CCTC have recommended a "trainee focus" in response to the identified power, resource, and risk imbalances experienced by trainees. Similarly, Bell and colleagues (2020) also noted that training programs should advocate for trainees who are vulnerable or who are unable to advocate for themselves.

However, a trainee *focus* is insufficient. A more equitable model should feature stakeholder (trainee) *involvement* in decision-making. We concur with Bell et al.'s (2020) recommendation, and add that training programs should engage in advocacy in a way that includes interns as stakeholders. As previously described, collaborative inclusion of trainees in the development of COVID-19 training policies was essential to preventing inequitable risks and mitigating training challenges. This collaborative inclusion should henceforth be an essential part of decision-making in training. Not only can stakeholder involvement

bolster the effectiveness of HSP training entities' responses to unforeseen events, it is needed in standard training policies as we enter a new status quo.

Recommendations for a Trainee Stakeholder Model—We argue that a trainee stakeholder model is necessary for addressing many of the concerns outlined throughout this article. A collaborative model of training invites trainees to have equity in the training system and participate in decision-making. Given that internship is the final training stage prior to a clinical doctorate degree, interns are well-equipped to engage in this type of process. Moreover, this could serve as a valuable training opportunity for psychologists to act as responsible stakeholders in their field.

In contrast to a trainee stakeholder model, the top-down structures of HSP internship training currently resemble a "banking model" of education (Freire, 1996), where training sites are assumed to provide knowledge—a type of capital—to trainees who are without it. This assumption underlies the representation of the economic sacrifices of training as "an investment," without due attention to the differences in resources that people can invest. It also helps to explain how, even when trainee involvement in decision-making is advertised in brochures and manuals, this involvement is constrained through rigid imposition of rules and norms (i.e., trainees are there to acquire intellectual capital, and not to influence the system that distributes it). On the other hand, a trainee stakeholder model is more closely aligned with a "pedagogy of solidarity" (Freire et al., 2014), which entails equal participation and mutual advancement for the purpose of ultimately providing good psychological care to those who need it. For this to occur, the educator must endeavor to know the pressing concerns of those being educated. It also entails an understanding of the structures and norms that interfere with stakeholder equity in a collaborative process.

Collaborative decision-making models have been employed effectively across various fields and settings and may benefit HSP training as well (Coury & Terranova, 1991; Higgs et al., 2008; Panzarasa et al., 2002). The Exchange Boundary Framework for collaborative decision-making (Watson & Foster-Fishman, 2013) identifies challenges and opportunities for increasing disadvantaged stakeholder equity by analyzing the exchange of resources and the establishment of norms among stakeholders. This framework enables a productive analysis of HSP internship training and its contingencies. Resources in HSP training include time, money, expertise, training, and accreditation; norms include the expectations from, and perceived legitimacy of, the various stakeholders involved. Watson and Foster-Fishman (2013) observe that for disadvantaged stakeholders to increase their influence in collaborative decision-making without tokenization or cooptation of their interests, several conditions must obtain. Each of these conditions can be tied to specific recommendations for HSP training.

First, dependency on resources cannot flow only in one direction. Advantaged stakeholders must also depend on the resources of disadvantaged stakeholders, and disadvantaged stakeholders "must have access to multiple sources for their desired resources (so as to avoid becoming dependent on any one agent)" (Watson and Foster-Fishman, 2013, p. 153). One way to increase mutual dependency is to enable interns to provide publicly available feedback on internships, with real impact on internships' standing and future

interns' choices in selecting internships (Recommendation 20). The forum for where such feedback is made public (in anonymized, and possibly aggregate, form in order to prevent identification) should be endorsed by organizations such as APPIC, the APA CoA, and the Council of University Directors of Clinical Psychology (CUDCP), and may be integrated with the process of APPIC accreditation. This would create a real stake for internships to prioritize intern input, as they would have a resource (public feedback) that internships value and cannot themselves provide. Another consequence of such a feedback system would be to provide a valuable data stream about internship training, which may help remedy Gee et al.'s (2021) observation that available data about clinical training are "not sufficient for recursive refinement of training practices" (p. 35).

Watson and Foster-Fishman (2013) also recommend that no party be the sole arbiter of a valued resource. Currently, the advantaged party (an internship program) is the only source of a valued resource (credentialing), and disadvantaged parties (interns) cannot go elsewhere. We therefore recommend that interns be able to switch internships if necessary (Recommendation 21). If interns were not a captive workforce, they would have greater agency and ability to advocate for themselves. Present requirements stipulate that interns must finish a complete year in the internship assigned by the match process. However, it is possible to find other ways to ensure that interns acquire the training expected from internship. For example, in accord with current time-based standards, it might be required that interns finish a year's *worth* of internship, as is the case for postdoctoral licensure requirements. We do not anticipate that this would make changing internships common, just as changing postdoctoral programs midway is relatively uncommon. After all, many internship sites present terrific training and environments, and changing sites is costly, inconvenient, and difficult. We recognize that this shift would be monumental for training, and would likely interact with our other recommendations. For example, does requiring a year's worth of internship, rather than a one-year internship, align with a shift toward competencies versus hours? And, would such a shift be easier to facilitate if internship training were post-rather than pre-doctoral? These questions require careful thought and input from multiple parties including graduate students, interns, graduate training programs, internship faculty and supervisors, accreditation agencies, and patient advocates.

Applying the Exchange Boundary Framework to HSP training also indicates that trainees should be active participants across the HSP system. Watson and Foster-Fishman (2013) observe that equitable collaborative exchange is facilitated when additional stakeholders (e.g., patients, credentialing bodies, and external organizations) can benefit from (and therefore value) the resources of disadvantaged stakeholders (interns). To support trainees' involvement with additional stakeholders, trainees should have representation in the accrediting agencies and bodies that determine the standards for their own training (Recommendation 22). Establishing a rotating, year-long position to be filled by at least one intern within the CoA, CCTC, and APPIC would ensure intern representation. We also suggest that APA accreditation criteria be extended to include a stipulation that trainees are actively involved in decision-making processes within the internship (APA CoA, 2020). This is a natural extension of current accreditation criteria, which require that programs foster a supportive learning environment, have policies that support cultural and individual differences and diversity, and involve trainees in their own program evaluation and program

improvement efforts, including the evaluation of training structures and aims. Trainee involvement in decision-making processes puts them in contact with other stakeholders, including patients, administration, and external organizations.

Finally, the norms of institutions must change such that legitimacy is accorded to disadvantaged stakeholders (Watson & Foster-Fishman, 2013). At present, it is often normative for trainees to be regarded as recipients of policy who do not occupy "expert" roles in training; expectations from trainees are commensurate, with little involvement or influence in institutional decision-making anticipated from interns. Shifting this status quo in the culture of training requires multifaceted action along multiple fronts. For example, in many training environments, trainees are often relegated to participating in activities that are deemed trainee-relevant (e.g., serving on a training committee), consistent with norms that limit trainees' ability to contribute their voices to broader issues within an institution. Instead, including trainees in essential and valued activities such as grand rounds, mandatory didactics for training faculty, or setting the agenda and methods for meeting institutional growth goals, is a vital and achievable way to legitimize trainees (Recommendation 23).

Interns are stakeholders in training strategy selection—usually a top-down process in healthcare policy (Laverack & Labonte, 2000)—and must be legitimate collaborators. Toward this end, when trainee feedback is formally solicited through surveys or discussions, we recommend that trainees inform the evaluation process itself, with input into the domains being evaluated (Recommendation 24). For example, a program at which trainees are experiencing undue financial hardships may not receive feedback about these if it queries only supervisor quality, but these kinds of gaps can be filled by soliciting trainee input on the questions being asked of trainees. As trainees are present for only one year at their site, suggestions made by trainees are often not integrated until several trainee cohorts later (if they are integrated at all). To truly work with trainee stakeholders, we suggest that feedback should be solicited regularly and suggested changes addressed in an expedient timeline when possible. Ideally, current trainees who provide feedback would have the opportunity to see action taken during their internship year. Iterative integration of feedback would help trainees meaningfully contribute to their programs.

Questions for Collaborative Inquiry

- In the culture of the internship training program, what are the norms and expectations about trainees' inclusion, valuation, and involvement in decision-making?
- What are the barriers to including interns as collaborators in making decisions that have impacts on training or clinical care?
- To what extent is the internship receiving and integrating feedback from interns about topics that matter for interns?

Calling the Whole Field In: Invitations to Dialogue and Action

Addressing the challenges in HSP training discussed in this article will require action across different parts of our field. It is therefore important to acknowledge the complexity of

the systems within which HSP training takes place, involve the stakeholders within these systems in a productive dialogue, and take meaningful action to address these pressing concerns. This article identifies a set of recommendations based on observations by trainee stakeholders, which we hope can serve as an invitation to dialogue and a catalyst for action. In discussions about addressing systemic barriers to equity and diversity, action is often stymied by allusions to the amount of time, effort, and resources that such tremendous change would take. However, the pandemic demonstrated that our field is capable of dramatically changing complex systems and integrating vast technological change in a matter of weeks. Thus, a lesson learned from COVID-19 is that the programmatic barriers to sustainable, quality HSP training could likely be targeted and changed in reasonable timeframes.

Some of our recommendations, such as those concerned with addressing economic security for trainees, have a financial cost. It is to be anticipated that many of these will be met with a financial litmus test: Where would the money come from, and would there be financial incentives for institutions to adopt these changes? In informal conversations with training faculty, administrators, and other supportive members of our training environment, a recurrent theme was that many of the institutions involved in HSP training must make a profit, and that some may be unwilling or unable to undertake costly change. These fiscal realities must be confronted soberly. However, we argue that limited input from trainees, their subordinate and transient positions, and the policies that govern training (e.g., the match process), have enabled a disproportionate under-resourcing of HSP internship training, which is now due for a correction. The authors also note that HSP is a profession with ethical commitments, which must sometimes serve as a counterweight to financial pressures. With appropriate action, such as ongoing efforts to secure funding for internship training through U.S. Health Resources and Services Administration (HRSA) Bureau of Health Professions (APA, 2020), our field can move in the right direction.

It is also important to recognize that HSP internships exist within the broader continuum of graduate training and professional development. Because the scope of this paper has been restricted to internship, the role of graduate programs—and graduate training in general—in the issues we have identified has been accorded less attention. However, it must be borne in mind that at present, interns are technically students. They typically continue paying a fee to their graduate programs while on internship and are required to complete internship to earn their doctorates. However, graduate programs have little-to-no oversight of the quality of training interns receive once they have matched. This extends to less-scrupulous, for-profit doctoral training sites that obtain revenue by training a high volume of doctoral students without taking responsibility for their training on internship. HSP internship training is primarily in the hands of the training institution or hospital (Frank et al., 2004), and communication between graduate programs and training institutions is typically with the training office, rather than site administration, when these are separate entities. Ponce, Aosved, and Hill (2021) provide guidance for using APPIC's Informal Problem Consultation process to facilitate communication between graduate programs and internships. However, as the name of the process suggests, it is largely undertaken responsively rather than proactively. We believe that our recommendations would help address some of these issues, although they will also require a broader response by key

groups and leadership in our field. Combining the insights of the lived experience of trainee stakeholders with that of long-standing trainers and administrators can create pioneering solutions to the complex problems outlined above.

Finally, the interlocking nature of the systems around internship training contributes to entrenchment of the present status quo. Many of our recommendations involve shifts in graduate training, licensure, accreditation, and federal policy—each of which is subject to unique circumstances. As an example, one of our potentially more controversial recommendations is to explore whether making internships postdoctoral would be an improvement to the current system, as suggested by Berenbaum et al., (2021). However, effecting this change through a unilateral pivot in APA requirements could also cause serious problems (Gee et al., 2021), including under-qualified practitioners in states that do not require postdoctoral hours for licensure, as well as potential exploitation of PhD-level clinicians who have not yet completed their postdoctoral internships. It could also lead to the collapse of internship programs that rely on federal funding because—as federal policies are presently written—they would no longer be eligible without internship being a graduation requirement. However, it is also possible to imagine an alternative scenario where postdoctoral internships enable Graduate Medical Education funding to support internship training, with PhDs moving toward a trajectory more similar to MDs. Licensing boards can adopt standards that address the need for postdoctoral hours from a licensing perspective. Because the status quo surrounding internship training is maintained by a regulatory gridlock, with no entity being able to make meaningful change without accommodation from other entities, solutions must be carried out with involvement from multi-sector stakeholders.

We also believe it is possible to find movable points in this gridlock where change can be effected first, and which can facilitate change in other parts of the system. For example, institutions that train large numbers of interns are in positions to take impactful steps toward addressing some of the concerns raised in this paper. Given that VAs are by far the largest provider of internship training, changes in VA policy (such as an increase in intern salaries) are likely to have standard-setting and system-wide repercussions. Entities such as accreditation bodies can also have important impacts. For example, APPIC and other agencies issued position statements and recommendations in response to COVID-19 (see Bell et al., 2020 for a summary). Notably, these included acknowledging disparities in trainee resources, increasing training in disaster psychology, and shifting the focus of training away from specific goalposts such as clinical hours and toward competency-based training models. Many of these recommendations are appropriate for training outside the specific context of COVID-19 and should be retained. Similarly, instituting a transparent and publicly available feedback system for internships (which may include feedback from graduate programs, involving them more closely as stakeholders in HSP training) can be instituted and supported by APPIC, through which the majority of interns find their training sites.

In 2007, after 25% of applicants did not match with training sites, a system-wide self-study was launched, leading to important changes in training structures. As we have discussed, these changes did not address many of the long-standing challenges in internship training,

which have only been exacerbated during COVID-19. We propose that now, 14 years later, another self-study followed by concrete action to address these issues is warranted—a "Boulder 2.0", as referred to by Gee et al. (2021). What is clear to us is that the status quo is no longer tenable, and the field must begin to actively find ways to shift these interlocking systems before another training crisis takes place.

Conclusion

COVID-19 has had an undeniable impact on psychology training. The pandemic and its sequelae revealed dilemmas in clinical training that impact trainees and training programs, as well as patients and the institutions involved in training, such as hospitals, universities, and accreditation agencies. Many of the issues in training illuminated by the COVID-19 outbreak, however, are not in themselves novel: The ambiguity of trainee roles, the presence of social and economic inequities within clinical training, and the need for a collaborative approach to decision-making among trainees and training institutions have been there all along. If incorporated, these stakeholder observations and recommendations can contribute to long-needed improvements in the state of HSP training and practice.

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References

Abbott I (2020, April 10). A Letter to My Abled Friends. Medium https://medium.com/@isabelfaithabbott/a-letter-to-my-abled-friends-e37e55c1517.

Agazzi H, Najmabadi S, Flood J, Cimorelli D, & Chenneville T (2021). COVID-19 Adaptations for Health Service Psychology Internship Training in a Medical School. Journal of Clinical Psychology in Medical Settings 10.1007/s10880-021-09784-2

Allen TD, Golden TD, & Shockley KM (2015). How effective is telecommuting? Assessing the status of our scientific findings. Psychological Science in the Public Interest, 16(2), 40–68 [PubMed: 26403188]

Ameen E, Bergner C, Berry S, & El-Ghoroury NH (2016). Medicaid Reimbursement for Interns' Services: We Need You To Advocate (In Your State) https://www.appic.org/Portals/0/2016%20Conference/Medicaid_APPIC_2016_Presentation.pdf

American Psychological Association (n.d.-a). 2022 Self-Study Narrative Preparation Sheets-INTERNSHIP Retrieved from APA Self-Study Information website: https://www.accreditation.apa.org/accreditation-process/self-study on October 12, 2021.

American Psychological Association. (n.d.-b). About the APA Commission on Accreditation Retrieved October 14, 2021, from https://www.accreditation.apa.org/about-coa

American Psychological Association (2020). Securing increased funding for psychology workforce training programs Retrieved October 9, 2021, from https://www.apaservices.org/advocacy/news/workforce-program-funding

American Psychological Association Commission on Accreditation (2020). APA Accreditation COVID-19 Updates and Information, updated March 23, 2020. Retrieved from https://www.accreditation.apa.org/covid-19

Assari S, & Bazargan M (2019). Unequal Associations between Educational Attainment and Occupational Stress across Racial and Ethnic Groups. International Journal of Environmental Research and Public Health, 16(19), 3539. 10.3390/ijerph16193539 [PubMed: 31546681]

Association of Psychology Postdoctoral and Internship Centers (2018). 2018 APPIC Match: Survey of Internship Applicants. Part 1: Summary of Survey Results https://www.appic.org/Internships/Match/Match-Statistics/Applicant-Survey-2018-Part-1

Association of Psychology Postdoctoral and Internship Centers (2020a, March 31). COVID-19 Statement #2 https://www.appic.org/News-Articles/ArtMID/1931/ArticleID/7/APPIC-Board-of-Directors-COVID-19

Association of Psychology Postdoctoral and Internship Centers (2020b). APPIC membership criteria: Doctoral psychology internship programs Association of Psychology Postdoctoral and Internship Centers. https://www.appic.org/Internships/Internship-Membership-Criteria

Association of Psychology Postdoctoral and Internship Centers (2020c, March 21). APPIC Board of Directors: COVID-19 statement to education and training community https://www.appic.org/News-Articles/ArtMID/1931/ArticleID/7/APPIC-Board-of-Directors-COVID-19

Association of Psychological Postdoctoral and Internship Centers (2021a). 2021: APPIC Match: Survey of Internship Applicants https://appic.org/Internships/Match/Match-Statistics/Applicant-Survey-2021-Part-1

Association of Psychology Postdoctoral and Internship Centers (2021b). Directory Statistics & Trainee Stipends Retrieved October 13, 2021, from https://www.appic.org/Directory/Directory-Statistics-Trainee-Stipends

Association of Psychology Postdoctoral and Internship Centers Directory Search. (2021). Retrieved February 7, 2021, from https://membership.appic.org/directory/search

Atkins MS, Strauman TJ, Cyranowski JM, & Kolden GG (2014). Reconceptualizing Internship Training Within the Evolving Clinical Science Training Model. Clinical Psychological Science, 2(1), 46–57. 10.1177/2167702613501308

Ayanian JZ, & Weissman JS (2002). Teaching hospitals and quality of care: A review of the literature. The Milbank Quarterly, 80(3), 569–593, v. 10.1111/1468-0009.00023 [PubMed: 12233250]

Azar AM (2020, July). Trump administration aims to keep telehealth revolution here to stay USA TODAY. https://www.usatoday.com/story/opinion/2020/07/31/covid-19-brought-telehealth-revolution-now-trump-wants-stay-column/5556733002/

Bambra C, Riordan R, Ford J, & Matthews F (2020). The COVID-19 pandemic and health inequalities. J Epidemiol Community Health, 74(11), 964–968. 10.1136/jech-2020-214401 [PubMed: 32535550]

Bayham J, & Fenichel EP (2020). Impact of school closures for COVID-19 on the US health-care workforce and net mortality: A modelling study. The Lancet Public Health, 5(5), e271–e278. 10.1016/S2468-2667(20)30082-7 [PubMed: 32251626]

Bell DJ, Self MM, Conway F, Washburn JJ, & Crepeau-Hobson F (2020). Health service psychology education and training in the time of COVID-19: Challenges and opportunities. American Psychologist, advance online publication.

Berenbaum H, Washburn JJ, Sbarra D, Reardon KW, Schuler T, Teachman BA, Hollon SD, Atkins MS, Hamilton JL, Hetrick WP, Tackett JL, Cody MW, Klepac RK, & Lee SS (2021). Accelerating the rate of progress in reducing mental health burdens: Recommendations for training the next generation of clinical psychologists. Clinical Psychology: Science and Practice, 28(2), 107–123. 10.1037/cps0000007

Bernhard PA, & Camins JS (2020). Supervision from Afar: Trainees' perspectives on telesupervision. Counselling Psychology Quarterly, 0(0), 1–10. 10.1080/09515070.2020.1770697

Blumenshine P, Reingold A, Egerter S, Mockenhaupt R, Braveman P, & Marks J (2008). Pandemic influenza planning in the United States from a health disparities perspective. Emerging Infectious Diseases, 14(5), 709–715. 10.3201/eid1405.071301 [PubMed: 18439350]

Bodin D, Schmidt JP, Lemle RB, Roper BL, Goldberg RW, Hill KR, Perry-Parrish C, Williams SE, Kuemmel A, & Siegel W (2018). Recruitment and selection in health service psychology postdoctoral training: A review of the history and current issues. Training and Education in Professional Psychology, 12(2), 74–81. 10.1037/tep0000181

Boggs KR, & Douce LA (2000). Current status and anticipated changes in psychology internships: Effects on counseling psychology training. The Counseling Psychologist, 28(5), 672–686. 10.1177/0011000000285005

Bolin B, & Kurtz LC (2018). Race, Class, Ethnicity, and Disaster Vulnerability. In Rodríguez H, Donner W, & Trainor JE (Eds.), Handbook of Disaster Research (pp. 181–203). Springer International Publishing. 10.1007/978-3-319-63254-4_10

Breting LMG, Towns SJ, Butts AM, Brett BL, Leaffer EB, & Whiteside DM (2020). 2020 COVID-19 American Academy of Clinical Neuropsychology (AACN) Student Affairs Committee survey of neuropsychology trainees. The Clinical Neuropsychologist, 34(7–8), 1284–1313. 10.1080/13854046.2020.1809712 [PubMed: 32842877]

Bruch RR (n.d.) Doctoral Psychology Interns: Are They Employees Under The FLSA? APA Resources. https://www.apa.org/ed/resources/labor-regulations.pdf

Burney JP, Celeste BL, Johnson JD, Klein NC, Nordal KC, & Portnoy SM (2009). Mentoring professional psychologists: Programs for career development, advocacy, and diversity. Professional Psychology: Research and Practice, 40(3), 292.

Burton ÉC, Bennett DH, & Burton LM (2020). COVID-19: Health disparities and social determinants of health. International Social Work, 63(6), 771–776. 10.1177/0020872820944985

Callahan JL, Smotherman JM, Dziurzynski KE, Love PK, Kilmer ED, Niemann YF, & Ruggero CJ (2018). Diversity in the professional psychology training-to-workforce pipeline: Results from doctoral psychology student population data. Training and Education in Professional Psychology, 12(4), 273–285. 10.1037/tep0000203

Campbell LA, & Kaufman RL (2006). Racial differences in household wealth: Beyond Black and White. Research in Social Stratification and Mobility, 24(2), 131–152. 10.1016/j.rssm.2005.06.001

Caplan P (2000). Risk Revisited Pluto Press.

Casey JA, Morello-Frosch R, Mennitt DJ, Fristrup K, Ogburn EL, & James P (2017). Race/Ethnicity, Socioeconomic Status, Residential Segregation, and Spatial Variation in Noise Exposure in the Contiguous United States. Environmental Health Perspectives, 125(7), 077017. 10.1289/EHP898 [PubMed: 28749369]

Casline E, Tawfik SH, Brodar KE, Patel ZS, & Tarlow N (2021). Considerations for assessment training competencies in health service psychology programs in the age of COVID-19. Training and Education in Professional Psychology Advance online publication. 10.1037/tep0000360

Center on Budget and Policy Priorities (2020, September 1). A Quick Guide to SNAP Eligibility and Benefits Retrieved March 21, 2021, from https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits

Cirruzzo C (2020, April 22). Disabled people have worked remotely for years, and they've got advice for you and your bosses. The Washington Post https://www.washingtonpost.com/lifestyle/wellness/disabled-people-have-worked-remotely-for-years-and-theyve-got-advice-for-you-and-your-bosses-/2020/03/17/f99dfd54-67d1-11ea-b313-df458622c2cc_story.html.

Cokley R (2020, March 29). Disabled Community: We've Always Needed Today's Flexible Work Arrangements. So Make Them Stick OZY. https://www.ozy.com/news-and-politics/disabled-americans-need-flexible-work-coronavirus-proves-it-can-be-done/293004/.

Council of Chairs of Training Councils (2020, May 8). CCTC guidance statement on resumption of in-person psychological services and training [Guidance statement]. https://cudcp.org/resources/Documents/CCTC%20Statement%20on%20Return%20to%20In-Person%20Services%20and%20Training%20May%202020.pdf

Cox DJ, Plavnick JB, & Brodhead MT (2020). A Proposed Process for Risk Mitigation During the COVID-19 Pandemic. Behavior Analysis in Practice, 1–7. 10.1007/s40617-020-00430-1

Coury BG, & Terranova M (1991). Collaborative Decision Making in Dynamic Systems. Proceedings of the Human Factors Society Annual Meeting, 35(13), 944–948. 10.1177/154193129103501311

Curran D (2013). Risk society and the distribution of bads: Theorizing class in the risk society. The British Journal of Sociology, 64(1), 44–62. 10.1111/1468-4446.12004 [PubMed: 23488699]

D'Angelo EJ (2014). Blueprint for professional development: The role of the psychology internship. Training and Education in Professional Psychology, 8(1), 34–37. 10.1037/tep0000033

DeHay TL, Ross SG, & McFaul MB (2014). Accreditation Readiness and Barriers Survey: United States Version, Technical Report Western Interstate Commission for Higher Education (WICHE).

Devakumar D, Shannon G, Bhopal SS, & Abubakar I (2020). Racism and discrimination in COVID-19 responses. The Lancet, 395(10231), 1194.

Dixon J, Durrheim K, & Thomae M (2017). The Principle-Implementation Gap in Attitudes Towards Racial Equality (and How to Close It). Political Psychology, 38(S1), 91–126. 10.1111/pops.12393

Fairlie RW (2013). Minority and immigrant entrepreneurs: Access to financial capital. International Handbook on the Economics of Migration https://www.elgaronline.com/view/edcoll/9781845426293/9781845426293.00016.xml

Falender CA, & Shafranske EP (2012). The importance of competency-based clinical supervision and training in the twenty-first century: Why bother? Journal of Contemporary Psychotherapy: On the Cutting Edge of Modern Developments in Psychotherapy, 42(3), 129–137. 10.1007/s10879-011-9198-9

FAQ: Stipend Req for Interns and Postdoc Fellows (n.d.). Retrieved February 7, 2021, from https://www.appic.org/About-APPIC/APPIC-Policies/FAQ-Stipend-Req-for-Interns-and-Postdoc-Fellows

Ferreira R, Pereira R, Bianchi IS, & da Silva MM (2021). Decision Factors for Remote Work Adoption: Advantages, Disadvantages, Driving Forces and Challenges. Journal of Open Innovation: Technology, Market, and Complexity, 7(1), 70. 10.3390/joitmc7010070

Fouad NA, Grus CL, Hatcher RL, Kaslow NJ, Hutchings PS, Madson MB, Collins FL Jr., & Crossman RE (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. Training and Education in Professional Psychology, 3(4, Suppl), S5–S26. 10.1037/a0015832

Frank G (1984). The Boulder Model: History, rationale, and critique. Professional Psychology: Research and Practice, 15(3), 417–435. 10.1037/0735-7028.15.3.417

Frank RG, Blevins NC, & Dimoulas E (2004). Policy and financing of the professional psychology workforce. Journal of Clinical Psychology in Medical Settings, 11(2), 119–125. 10.1023/B:JOCS.0000025723.42145.6c

Freire P (1996). Pedagogy of the Oppressed (2nd ed.). Penguin.

Freire P, Freire AMA, & Oliveira WF de. (2014). Pedagogy of Solidarity Left Coast Press.

Galán Chardée, Bekele B, Boness CL, Bowdring M, Call C, Hails K, McPhee J, Mendes S, Moses J, Northrup J, Rupert P, Savell S, Sequeira S, Brenden Tervo-Clemmens, Tung I, Vanwoerden S, Womack S, & Yilmaz B (2020). A Call to Action for an Antiracist Clinical Science. PsyArXiv 10.31234/osf.io/xqwr4

Gardner W, States D, & Bagley N (2020). The Coronavirus and the Risks to the Elderly in Long-Term Care. Journal of Aging & Social Policy, 0(0), 1–6. 10.1080/08959420.2020.1750543

Gee D, DeYoung KA, McLaughlin KA, Tillman RM, Barch D, Forbes EE, Krueger R, Strauman TJ, Weierich MR, & Shackman AJ (2021). Training the next generation of clinical psychological scientists: A data-driven call to action. PsyArXiv 10.31234/osf.io/xq538

Grasselli G, Zangrillo A, Zanella A, Antonelli M, Cabrini L, Castelli A, Cereda D, Coluccello A, Foti G, Fumagalli R, Iotti G, Latronico N, Lorini L, Merler S, Natalini G, Piatti A, Ranieri MV, Scandroglio AM, Storti E, Pesenti A (2020). Baseline Characteristics and Outcomes of 1591 Patients Infected With SARS-CoV-2 Admitted to ICUs of the Lombardy Region, Italy. JAMA, 323(16), 1574–1581. 10.1001/jama.2020.5394 [PubMed: 32250385]

Gros DF, Yoder M, Tuerk PW, Lozano BE, & Acierno R (2011). Exposure therapy for PTSD delivered to veterans via telehealth: Predictors of treatment completion and outcome and comparison to treatment delivered in person. Behavior Therapy, 42(2), 276–283. [PubMed: 21496512]

Gruber J, Prinstein MJ, Abramovitz JS, Albano AM, Aldao A, Borelli JL, Chung T, Clark LA, Davila J, Forbes EE, Gee DG, Nagayama Hall GC, Hallion LS, Hinshaw SP, Hofmann SG, Hollon SD, Joormann J, Kazdin AE, Klein DN, Weinstock LM (2020). Flattening the mental health curve in the time of COVID-19: A call to action for clinical psychological science. American Psychologist, advance online publication.

Grus CL, McCutcheon SR, & Berry SL (2011). Actions by professional psychology education and training groups to mitigate the internship imbalance. Training and Education in Professional Psychology, 5(4), 193–201. 10.1037/a0026101

Golden TD, & Eddleston KA (2020). Is there a price telecommuters pay? Examining the relationship between telecommuting and objective career success. Journal of Vocational Behavior, 116, 103348.

Golden TD, & Gajendran RS (2019). Unpacking the role of a telecommuter's job in their performance: examining job complexity, problem solving, interdependence, and social support. Journal of Business and Psychology, 34(1), 55–69

Hafner AJ (1973). Internship Training: Innovations in Clinical Psychology Internship Training. Professional Psychology, 4(1), 111–118. 10.1037/h0020889

Hames JL, Bell DJ, Perez-Lima LM, Holm-Denoma JM, Rooney T, Charles NE, Thompson SM, Mehlenbeck RS, Tawfik SH, Fondacaro KM, Simmons KT, & Hoersting RC (2020). Navigating uncharted waters: Considerations for training clinics in the rapid transition to telepsychology and telesupervision during COVID-19. Journal of Psychotherapy Integration, 30(2), 348–365. doi:10.1037/int0000224

Hammond WR, & Yung B (1993). Minority student recruitment and retention practices among schools of professional psychology: A national survey and analysis. Professional Psychology: Research and Practice, 24(1), 3–12. 10.1037/0735-7028.24.1.3

Hatcher RL, Fouad NA, Campbell LF, McCutcheon SR, Grus CL, & Leahy KL (2013). Competency-based education for professional psychology: Moving from concept to practice. Training and Education in Professional Psychology, 7(4), 225–234. 10.1037/a0033765

Haynes N, Cooper LA, & Albert MA (2020). At the heart of the matter: unmasking and addressing COVID-19's toll on diverse populations. Circulation

Health Service Psychology Education Collaborative. (2013). Professional psychology in health care services: A blueprint for education and training. The American Psychologist, 68(6), 411–426. 10.1037/a0033265 [PubMed: 23915400]

Herbst J (2020, March 31). I've asked to work remotely for years. It's painful to watch companies finally comply. Fast Company https://www.fastcompany.com/90484423/ive-asked-to-work-remotely-for-years-its-painful-to-watch-companies-finally-comply

Hernandez Kent A, & Ricketts LR (2020). Wealth Inequality in America over Time: Key Statistics | St. Louis Fed https://www.stlouisfed.org/open-vault/2020/december/has-wealth-inequality-changed-over-time-key-statistics

Higgs J, Jones MA, Loftus S, & Christensen N (2008). Clinical Reasoning in the Health Professions E-Book Elsevier Health Sciences.

Hoch EL, Ross AO, & Winder CL (1966). Conference on the professional preparation of clinical psychologists: A summary. American Psychologist, 21(1), 42–51. 10.1037/h0021107

Humphreys L, Crino R, & Wilson I (2018). The competencies movement: Origins, limitations, and future directions. Clinical Psychologist, 22(3), 290–299. 10.1111/cp.12143

Inman AG, Soheilian SS, & Luu LP (2019). Telesupervision: Building bridges in a digitalera. Journal of Clinical Psychology, 75(2), 292–301. 10.1002/jclp.22722 [PubMed: 30589439]

Johnson DR, Scheitle CP, & Ecklund EH (2019). Beyond the In-Person Interview? How Interview Quality Varies Across In-person, Telephone, and Skype Interviews. Social Science Computer Review, 0894439319893612. 10.1177/0894439319893612

Johnson MO, & Gandhi M (2015). A mentor training program improves mentoring competency for researchers working with early-career investigators from underrepresented backgrounds. Advances in Health Sciences Education, 20(3), 683–689. [PubMed: 25274417]

Jordan RE, Adab P, & Cheng KK (2020). Covid-19: Risk factors for severe disease and death. BMJ, 368. 10.1136/bmj.m1198

Joseph TD, & Hirshfield LE (2011). 'Why don't you get somebody new to do it?'Race and cultural taxation in the academy. Ethnic and racial studies, 34(1), 121–141.

Kainz K (2002). Barriers and enhancements to physician-psychologist collaboration. Professional Psychology: Research and Practice, 33(2), 169–175. 10.1037/0735-7028.33.2.169

Kaslow NJ, & Rice DG (1985). Developmental stresses of psychology internship training: What training staff can do to help. Professional Psychology: Research and Practice, 16(2), 253–261. 10.1037/0735-7028.16.2.253

Kasper DVS (2007). Privacy as a Social Good. Social Thought & Research, 28, 165–189.

King BR (2020). “The remainder of your practicum training has been terminated”: A unique challenge faced by trainees during the COVID-19 pandemic. Counselling Psychology Quarterly, 0(0), 1–7. 10.1080/09515070.2020.1796593

Kohout JL, Pate II WE, & Maton KI (2014). An updated profile of ethnic minority psychology: A pipeline perspective. In APA handbook of multicultural psychology, Vol. 1: Theory and research (pp. 19–42). American Psychological Association. 10.1037/14189-002

Langarizadeh M, Tabatabaei MS, Tavakol K, Naghipour M, Rostami A, & Moghbeli F (2017). Telemental Health Care, an Effective Alternative to Conventional Mental Care: A Systematic Review. Acta Informatica Medica, 25(4), 240–246. 10.5455/aim.2017.25.240-246 [PubMed: 29284913]

Lantz MM, & Davis BL (2017). For whom the bills pile: An equity frame for an equity problem. Training and Education in Professional Psychology, 11(3), 166–173. 10.1037/tep0000162

Laverack G, & Labonte R (2000). A planning framework for community empowerment goals within health promotion. Health Policy and Planning, 15(3), 255–262. 10.1093/heapol/15.3.255 [PubMed: 11012399]

Lichtenberg JW, Portnoy SM, Bebeau MJ, Leigh IW, Nelson PD, Rubin NJ, Smith IL, & Kaslow NJ (2007). Challenges to the assessment of competence and competencies. Professional Psychology: Research and Practice, 38(5), 474–478. 10.1037/0735-7028.38.5.474

Loucks S, Burstein AG, Schoenfeld LS, & Stedman JM (1980). The real cost of psychology intern services: Are they a good buy? Professional Psychology, 11(6), 898–900. 10.1037/0735-7028.11.6.898

Lund EM (2021). We must do better: Trends in disability representation among pre-doctoral internship applicants. Training and Education in Professional Psychology, No Pagination Specified-No Pagination Specified. 10.1037/tep0000361

Mangione L, Borden KA, Nadkarni L, Evarts K, & Hyde K (2018). Mentoring in clinical psychology programs: Broadening and deepening. Training and Education in Professional Psychology, 12(1), 4.

Mann DM, Chen J, Chunara R, Testa PA, & Nov O (2020). COVID-19 transforms health care through telemedicine: Evidence from the field. Journal of the American Medical Informatics Association, 27(7), 1132–1135. 10.1093/jamia/ocaa072 [PubMed: 32324855]

Map—Psychology Interjurisdictional Compact (PSYPACT) (n.d.). Retrieved February 7, 2021, from https://psypact.site-ym.com/page/psypactmap

McFall RM (2006). Doctoral Training in Clinical Psychology. Annual Review of Clinical Psychology, 2(1), 21–49. 10.1146/annurev.clinpsy.2.022305.095245

Menon A, Klein EJ, Kollars K, & Kleinhenz ALW (2020). Medical Students Are Not Essential Workers: Examining Institutional Responsibility During the COVID-19 Pandemic. Academic Medicine 10.1097/ACM.0000000000003478

Miller DG, Pierson L, & Doernberg S (2020). The Role of Medical Students During the COVID-19 Pandemic. Annals of Internal Medicine, 173(2), 145–146. 10.7326/M20-1281 [PubMed: 32259194]

Miller IF, Becker AD, Grenfell BT, & Metcalf CJE (2020). Disease and healthcare burden of COVID-19 in the United States. Nature Medicine, 26(8), 1212–1217. 10.1038/s41591-020-0952-y

Monaghesh E, & Hajizadeh A (2020). The role of telehealth during COVID-19 outbreak: A systematic review based on current evidence. BMC Public Health, 20(1), 1193. 10.1186/s12889-020-09301-4 [PubMed: 32738884]

Morrow WR (1946). The development of psychological internship training. Journal of Consulting Psychology, 10(4), 165–183. 10.1037/h0053807 [PubMed: 21002979]

Mustapha T, & Eyssallenne T (2020). Paying a Penny for Our Thoughts and Then Asking for Our 2 Cents. Academic Medicine, 95(12), 1788. 10.1097/ACM.0000000000003721

Myers KM, Vander Stoep A, McCarty CA, Klein JB, Palmer NB, Geyer JR, & Melzer SM (2010). Child and adolescent telepsychiatry: Variations in utilization, referral patterns and practice trends. Journal of Telemedicine and Telecare, 16(3), 128–133. 10.1258/jtt.2009.090712 [PubMed: 20197356]

Novacek DM, Hampton-Anderson JN, Ebor MT, Loeb TB, & Wyatt GE (2020). Mental health ramifications of the COVID-19 pandemic for Black Americans: Clinical and research recommendations. Psychological Trauma: Theory, Research, Practice, and Policy, 12(5), 449–451. 10.1037/tra0000796 [PubMed: 32525370]

Olk ME, & Friedlander ML (1992). Trainees' experiences of role conflict and role ambiguity in supervisory relationships. Journal of Counseling Psychology, 39(3), 389–397. 10.1037/0022-0167.39.3.389

Padilla AM (1994). Research news and comment: Ethnic minority scholars; research, and mentoring: Current and future issues. Educational Researcher, 23(4), 24–27.

Panzarasa P, Jennings NR, & Norman TJ (2002). Formalizing Collaborative Decision-making and Practical Reasoning in Multi-agent Systems. Journal of Logic and Computation, 12(1), 55–117. 10.1093/logcom/12.1.55

Patel ZS, Tarlow N, & Tawfik SH (2021). Assessment supervision during COVID-19 and beyond: Trainee perspectives on the supervision of teleassessment. Training and Education in Professional Psychology 10.1037/tep0000342

Pearlstein JG, Schmidt AT, Lund EM, Khazem LR, & Liu NH (2021). Guidelines to address barriers in clinical training for trainees with sensory disabilities. Training and Education in Professional Psychology 10.1037/tep0000367

Peterson ZD, Vaughan EL, & Carver DN (2021). Sexual identity and psychological reactions to COVID-19. Traumatology, 27(1), 6–13. 10.1037/trm0000283

Pinals DA, Hepburn B, Parks J, & Stephenson AH (2020). The Behavioral Health System and Its Response to COVID-19: A Snapshot Perspective. Psychiatric Services, 71(10), 1070–1074. 10.1176/appi.ps.202000264 [PubMed: 32781926]

Ponce AN, Aosved AC, & Hill K (2021). Facilitation of consultation and communication between psychology doctoral programs and internships. Training and Education in Professional Psychology, 15(3), 189–194. 10.1037/tep0000313

Reay RE, Looi JC, & Keightley P (2020). Telehealth mental health services during COVID-19: Summary of evidence and clinical practice. Australasian Psychiatry 10.1177/1039856220943032

Robinson KA, Shin B, & Gangadharan SP (2021). A Comparison Between In-Person and Virtual Fellowship Interviews During the COVID-19 Pandemic. Journal of Surgical Education, 78(4), 1175–1181. 10.1016/j.jsurg.2020.11.006 [PubMed: 33250429]

Rosenberg H, Bernstein AD, & Murray L (1985). Cost-efficiency of psychology internship programs: Another look at the monetary and nonmonetary considerations. Professional Psychology: Research and Practice, 16(1), 17–21. 10.1037/0735-7028.16.1.17

Schauble PG, Murphy MC, Cover-Paterson CE, & Archer J (1989). Cost effectiveness of internship training programs: Clinical service delivery through training. Professional Psychology: Research and Practice, 20(1), 17–22. 10.1037/0735-7028.20.1.17

Scharff A, Breiner CE, Ueno LF, Underwood SB, Merritt EC, Welch LM, Fonda C, Malatras JW, Lin B, Hormes JM, Pieterse AL, Gordis EB, Halpern LF, Pazienza R, & Litchford GB (2020). Shifting a training clinic to teletherapy during the COVID-19 pandemic: A trainee perspective. Counselling Psychology Quarterly, 0(0), 1–11. 10.1080/09515070.2020.1786668

Schneider MB, Greif TR, Galsky AP, Gomez D, Anderson C, Edwards DS, Cherry AS, & Mehari K (2021). Giving psychology trainees a voice during the COVID-19 pandemic: Trainee mental health, perceived safety, and support. Training and Education in Professional Psychology, 15(1), 76–85. 10.1037/tep0000343

Shakow D, Brotemarkle RA, Doll EA, Kinder EF, Moore BV, & Smith S (1945). Graduate internship training in psychology. A report by the Subcommittee on Graduate Internship Training to the Committees on Graduate and Professional Training of the American Psychological Association and the American Association for Applied Psychology. Journal of Consulting Psychology, 9(5), 243–266. 10.1037/h0058618 [PubMed: 21005121]

Shapiro MA (2020). Competence vs. Identity, Trainees vs. Physicians: How COVID-19 Has Highlighted Role Confusion in Residency Training. Academic Psychiatry, 1–4. 10.1007/s40596-020-01346-2 [PubMed: 31873922]

Sheridan EP (1981). Advantages of a clinical psychology residency program in a medical center. Professional Psychology, 12(4), 456–460. 10.1037/0735-7028.12.4.456

Slay KE, Reyes KA, & Posselt JR (2019). Bait and switch: Representation, climate, and tensions of diversity work in graduate education. The Review of Higher Education, 42(5), 255–286.

Stedman JM, Hatch JP, Schoenfeld LS, & Keilin WG (2005). The Structure of Internship Training: Current Patterns and Implications for the Future of Clinical and Counseling Psychologists. Professional Psychology: Research and Practice, 36(1), 3–8. 10.1037/0735-7028.36.1.3

Stedman JM, & Schoenfeld LS (2011). Knowledge competence in clinical and counseling training and readiness for internship. Journal of Clinical Psychology, 67(1), 1–5. 10.1002/jclp.20740 [PubMed: 21046645]

Stewart AE, & Stewart EA (1996). Personal and practical considerations in selecting a psychology internship. Professional Psychology: Research and Practice, 27(3), 295–303. 10.1037/0735-7028.27.3.295

Tanne JH, Hayasaki E, Zastrow M, Pulla P, Smith P, & Rada AG (2020). Covid-19: How doctors and healthcare systems are tackling coronavirus worldwide. BMJ, 368, m1090. 10.1136/bmj.m1090 [PubMed: 32188598]

Tracy EN, Bucchianeri MM, & Rodolfa ER (2011). Internship hours revisited: Further evidence for a national standard. Training and Education in Professional Psychology, 5(2), 97–101. 10.1037/a0023294

Turpin G, & Coleman G (2010). Clinical Psychology and Diversity: Progress and Continuing Challenges: Psychology Learning & Teaching 10.2304/plat.2010.9.2.17

Veterans Health Administration – Office of Emergency Management (2020). COVID-19 Response Plan Available at: https://www.va.gov/opa/docs/VHA_COVID_19_03232020_vF_1.pdf

Veteran Affairs/Department of Defense VA/DoD (1982) Health Resources Sharing and Emergency Operation Act, Pub L. No. 97–174

Wang SC, Hubbard RR, & Dorazio C (2020). Overcoming racial battle fatigue through dialogue: Voices of three counseling psychologist trainees. Training and Education in Professional Psychology, 14(4), 285–292. 10.1037/tep0000283

Watson ER, & Foster-Fishman PG (2013). The Exchange Boundary Framework: Understanding the Evolution of Power within Collaborative Decision-Making Settings. American Journal of Community Psychology, 51(1/2), 151–163. 10.1007/s10464-012-9540-8 [PubMed: 22760794]

Webb Hooper M, Nápoles AM, & Pérez-Stable EJ (2020). COVID-19 and Racial/Ethnic Disparities. JAMA, 323(24), 2466–2467. 10.1001/jama.2020.8598 [PubMed: 32391864]

Weiskopf R, & Newman JP (1982). Redesigning internship training programs: A cost-efficient point of view. Professional Psychology, 13(4), 571–576. 10.1037/0735-7028.13.4.571

Wells SR, Herbst RB, Parent MC, Ameen EJ, El-Ghoroury NH, Mattu AM, Wilson GA, Mereish EH, & FitzGerald ME (2014). The internship crisis: Graduate students look back and plan ahead. Training and Education in Professional Psychology, 8(2), 112–118. 10.1037/tep0000042

Wilcox MM, Barbaro-Kukade L, Pietrantonio KR, Franks DN, & Davis BL (2021). It takes money to make money: Inequity in psychology graduate student borrowing and financial stressors. Training and Education in Professional Psychology Advance online publication. 10.1037/tep0000294

Wood JAV, Miller TW, & Hargrove DS (2005). Clinical Supervision in Rural Settings: A Telehealth Model. Professional Psychology: Research and Practice, 36(2), 173–179. 10.1037/0735-7028.36.2.173

Yale School of Medicine (2021) Doctoral Internship in Clinical & Community Psychology New Haven, CT

Yancy CW (2020). COVID-19 and African Americans. JAMA, 323(19), 1891–1892. 10.1001/jama.2020.6548 [PubMed: 32293639]

Zhou F, Yu T, Du R, Fan G, Liu Y, Liu Z, Xiang J, Wang Y, Song B, Gu X, Guan L, Wei Y, Li H, Wu X, Xu J, Tu S, Zhang Y, Chen H, & Cao B (2020). Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: A retrospective cohort study. The Lancet, 395(10229), 1054–1062. 10.1016/S0140-6736(20)30566-3

Table 1.

Recommendations associated with challenges in HSP training

Trainee Roles
1. Make definition of trainee roles consistent, transparent, and collaborative with trainees.
2. Consider proposals to make internship postdoctoral.
3. Trainee roles should be consistent with their rights, benefits, and obligations.
Standards and Requirements
4. Shift away from hours and toward competency-based requirements for internship. Consider implicit biases in measurement and evaluation of competency.
5. Licensure and accreditation boards should retain flexible standards for hours, especially in the wake of crises like COVID-19.
Training Aims
6. Internships should query and incorporate trainee input into determining training aims.
7. In the event that training aims change, trainee approval should be solicited for these changes.
Locality
8. Allow interns to work from off-site when their duties do not require face-to-face patient or supervisor interaction.
9. Sites should allow interns to work across state lines for delimited periods of time, while adhering to applicable statutes.
10. Build opportunities for interns to form mutually supportive relationships with colleagues and staff at their new location.
11. Teleinterview options for internship should be adopted as a standard. Inequitable access to resources in conducted teleinterview should be considered.
Telehealth
12. Develop telehealth-specific training strategies, with competencies for telehealth and telesupervision included in training.
13. Telehealth and telesupervision should be available options when feasible, with due consideration of trainee circumstances, as well as patient needs and quality of training and service delivery.
Economic Security
14. Internship sites should be required by accrediting bodies to provide health insurance coverage, with options to cover dependents.
15. Internships should extend benefits usually given to full time employees to their interns, such as short-term disability, family or parental leave, and workers compensation.
16. Raise intern salaries, with reference to median income for training site location rather than neighboring training sites.
Supporting Diverse Trainees
17. Internship programs should proactively address inequitable supervision, training, and human resources policies and praxes.
18. Make antiracist and affirming resources (e.g., mentors, therapists, groups, confidential reporting processes, ombudspersons) available to trainees.
19. Diversity-related activities should be valued and remunerated on par with other clinical and administrative work for trainees and staff, including consideration in evaluations for tenure, promotion, compensation, and accolades.
Collaborative Decision Making
20. Interns should be able to provide publicly available feedback on internships, in a public forum with endorsement from organizations such as CoA, APPIC, and CUDCP.
21. Interns should be able to switch internships if necessary.
22. Interns should have representation in the accrediting agencies and bodies that determine the standards for their own training.
23. Interns should be involved in essential and valued activities at their training site, including providing mandatory didactics for faculty, grand rounds, and aspects of institutional decision-making.
24. When trainee feedback is formally solicited through surveys or discussions, trainees should inform the evaluation process itself, with input into the domains being evaluated

Table 2.

Questions for Collaborative Inquiry

Trainee roles
➢ To what extent does this site rely on trainees for its functioning, and (particularly for consortiums) how consistent is this across rotation sites?
➢ How does this site decide whether interns are essential personnel?
➢ How do the rights, benefits, and obligations of interns reflect their status as trainees, versus their status as workers, in our system?
➢ How do the rights, benefits, and obligations of interns differ from those of clinical faculty and/or trainees from other disciplines at our site (e.g., medical residents)?
Requirements
➢ Are there hours-based requirements currently in place in this training setting? If so: (a) What provisions exist to balance quality of hours with quantity of hours? (b) Are there any trainees at a disadvantage for meeting these requirements?
➢ To what extent do we prioritize competency-based training?
➢ What are we doing to ensure that our definitions and measurement of competency are unbiased and support the growth of all trainees?
Aims
➢ Who determines the training aims for this internship (or its rotations?)
➢ How are changes in training aims decided upon, and how much input do trainees have in these changes?
➢ When trainees' training aims change, what process do we have for evaluating how these changes may impact their future career aims?
Locality
➢ To what extent is locality mandated by the training program, and what are the reasons for these mandates?
➢ How are these reasons balanced with the priorities of ensuring quality care delivery for patients, the safety and wellbeing of trainees, and the quality of training?
➢ Are there different policies for hybrid/remote work for trainees and clinicians at this site? If so, why?
➢ What does our program do to support trainees who have relocated from out of state and have few local connections?
Telehealth
➢ What is the culture around telework in this internship environment? What are implicit or explicit biases surrounding remote telework?
➢ How does this site make use of competencies focused on telehealth provision for trainees, and on telesupervision for supervisors?
➢ Are trainees with different personal circumstances afforded equivalent opportunities for participating in telehealth and, if not, what barriers do they experience?
Economic Security
➢ How do trainee salaries compare to the median income for the internship site's location?
➢ What kind of safety net is available to trainees who experience sudden life disruptions (e.g., illness, disability, death of a loved one)?
➢ Are interns treated as employees, entitled to workers' compensation and leave benefits? Why or why not?
Supporting Diverse Trainees
➢ What opportunities exist for trainees from under privileged backgrounds to voice concerns about inequities in a way that is heard and responded to by the training program?
➢ In what ways does our training program model a commitment to equity, beyond statements and advertisement? What concrete actions are being taken to increase equity in the program?
➢ What resources, supportive spaces, systems, and staff facilitate antiracist action within the organizational culture and policies, and among interns and faculty?
Collaborative Decision-Making
➢ In the culture of the internship training program, what are the norms and expectations about trainees' inclusion, valuation, and involvement in decision-making?
➢ What are the barriers to including interns as collaborators in making decisions that have impacts on training or clinical care?
➢ How does the internship ensure that it is receiving and integrating feedback from interns about topics that matter for interns?