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Reforming Clinical Psychological Science Training: The Importance of Collaborative Decision-Making With Trainees

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Abstract
To effectively address the staggering burden of mental illness, clinical psychological science will need to face some uncomfortable truths about current training practices. In a commentary authored by 23 current or recent trainees, Palitsky and colleagues (2022) highlighted a number of urgent challenges facing today’s clinical interns. They provide a thoughtful framework for reform with specific recommendations and guiding questions for a broad spectrum of stakeholders. Key suggestions are applicable to the entire sequence of clinical training, including doctoral studies that occur prior to internship. Although there is cause for cautious optimism, overcoming these systemic barriers will require a coordinated, all-hands approach and a more collaborative approach to policymaking.

Keywords
clinical psychology training, graduate education, mental health

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We cannot perpetuate the status quo in clinical training simply because it is familiar and comfortable. . . . If evolving circumstances render past approaches no longer defensible or sustainable, then we must face this reality and deal with it forthrightly.


The status quo is no longer tenable, and the field must begin to actively find ways to shift these interlocking systems.

—Palitsky and colleagues (2022, p. 839)

The fundamental goal of clinical psychological science is to reduce the immense suffering caused by mental illness. Tackling this challenge will require new etiological insights and the development and dissemination of intervention strategies that are more effective, sustainable, and equitable. Clinical psychological science is uniquely poised to serve as a transdisciplinary hub for this work (Gee et al., 2022; Teachman et al., 2019). Rising to this challenge also requires the field to carefully consider the strengths and weaknesses of current training practices, which are typically more anchored in anecdote and historical practices than evidence (Levenson, 2017). Clinical internship is a core component of clinical psychological science training, an opportunity for trainees to deeply immerse themselves in the practical realities of clinical assessment and treatment.

In this issue, Palitsky and colleagues (2022) delineated some of the most urgent concerns facing today’s interns, including

- ambiguous professional status (students vs. employees);
- arbitrary training benchmarks (hours) and inadequate assessments of clinical skills;
- adverse consequences of making the internship a predoctoral requirement

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• challenges and opportunities of telehealth and remote work
• economic insecurity
• diversity, equity, and inclusion
• power sharing and collaborative decision-making

Three features of the article make it an especially valuable addition to the training literature. First, all 23 authors are current or recent interns, and their grassroots perspective reflects a thoughtful synthesis of new data and their own experiences as trainees, something that has been largely absent from other high-profile calls for reform (Baker et al., 2008; Berenbaum et al., 2021; Levenson, 2017; McFall, 2006; for exceptions, see Galán et al., 2021; Gee et al., 2022; Victor, Devendorf, et al., 2022; Victor, Schleider, et al., 2022). Critically, trainees have a unique vantage point that allows them to offer practical suggestions and novel insights—about both challenges and solutions—that are not available from other sources in the training ecosystem. Attempts to change the system without trainee input are more likely to fail or to create “knock-on” problems (Palitsky et al., 2022).

Second, Palitsky and colleagues (2022) provide a thoughtful framework for reform with specific and highly actionable recommendations for a broad spectrum of stakeholders—from funders and accreditors to program directors and trainees—and an emphasis on sustainable solutions that have the potential to foster clinical rigor and enhance the health and well-being of trainees and clients alike. We encourage programs to creatively experiment and empirically test the impact of modifying local training models. Implementing the recommendations outlined by Palitsky and colleagues—from more closely aligning trainee compensation with local living costs to strengthening diversity and inclusion efforts—would go a long way to creating a more rigorous and humane training environment with the potential to enhance quality of care and patient satisfaction. As Palitsky and colleagues noted, focusing reform efforts on the Veterans Administration and other large internship sites that serve as de facto national or regional benchmarks is likely to be especially fruitful both in terms of the number of interns impacted and the possibility of nudging smaller programs to adopt similar policies.

Third, recognizing that there is no straightforward or universal answer to the systemic challenges besetting the field, Palitsky et al. (2022) organized much of the article around a series of questions. For example,

• What provisions exist to balance quality of training hours with quantity?
• How can we ensure that competency assessments are unbiased?
• What mechanisms exist for trainees from underrepresented backgrounds to voice concerns about inequities, and how can we ensure that their concerns are addressed?
• How can we support trainees who experience sudden life disruptions? What can be done to include interns as genuine collaborators in policymaking?

Palitsky and colleagues’ questions are aimed at sparking honest conversations between trainers, trainees, and other stakeholders (e.g., institutional leadership, patients) and have the potential to provide a framework for collaborative problem-solving at both the local and national levels.

Palitsky and colleagues’ (2022) article is squarely focused on the challenges of clinical internship. Backed by new data and the authors’ “in-the-trenches” experience, they make it clear that there are enormous opportunities for improving internship norms and training practices, which currently run the gamut from suboptimal to downright inequitable and unsustainable. Of course, internship is just one stage of doctoral training in clinical psychological science, and many of their concerns and suggestions for improvement are broadly applicable to the entire sequence of graduate training. In the sections that follow, we expand on three recommendations that cut across specific challenges, all focused on the process of enacting constructive change.

Developing New Data Streams for Recursive Refinement

[Contemporary clinical psychology training is] based on a patchwork of accumulated wisdom, historical practices, observation of past successes and failures, and feedback from past trainees. It is particularly seductive . . . to enumerate the students . . . who have gone on to do great things . . . and to conclude that we must be doing something (probably a lot of things) right. However, we all know that good intentions, anecdotal outcomes, and personal endorsements are a weak basis for making important decisions. (Levenson, 2017, p. 18).

When given voice, trainees have spoken to problems often sidelined in the broader training literature. . . . Without a forum for voicing [trainee] concerns, training programs [often remain] underinformed about the real-world impact of their policies.
Soliciting trainee experiences and input...[is] a crucial touchstone. (Palitsky et al., 2022, p. 836)

Palitsky and colleagues (2022) remind the field that existing data streams are not sufficient for recursive refinement of training practices at either the local or national levels (Gee et al., 2022; Victor, Devendorf, et al., 2022). For example, financial and occupational surveys administered by the Association of Psychology Postdoctoral and Internship Centers (APPIC) and American Psychological Association are aggregated across degrees and programs. Accreditor surveys lack detailed assessments of workload, climate, mental health, financial strain, discrimination, and other key challenges highlighted by Palitsky et al.

To clearly understand the challenges facing today’s trainers and trainees and determine whether revised practices are having the intended consequences, the field urgently needs new data streams. Ultimately, these can inform the development of evidence-based standards for training (Gee et al., 2022; Levenson, 2017), including the kinds of competency standards recommended by Palitsky and colleagues (2022). At the local level, we encourage programs to collect anonymous surveys of trainees and trainers on an annual or more frequent basis. As Palitsky and colleagues emphasized, trainees should be involved in the development of such surveys to ensure adequate coverage of grassroots concerns. Naturally, survey developers, respondents, and data users must remain mindful of potential confidentiality concerns. Survey data should be carefully screened and, in the case of open-ended narrative responses, censored or aggregated before dissemination. Longitudinal data collection will be particularly useful. In some cases, it may be possible to conduct randomized trials of specific interventions, potentially using patient-reported experience as a complementary outcome. At the national level, we recommend that accreditors harmonize and institutionalize these efforts. As noted by Palitsky et al., this has the potential to serve as an institutional incentive to invest the resources necessary to foster more equitable and sustainable training environments. Although they are often less actionable at the local level, anonymous surveys conducted by accreditors or other national organizations have the potential to encourage more open and honest reporting. We urge professional groups to advocate for these changes, accreditors to facilitate them, and funders to invest the modest level of support necessary to enact them.

**Power Sharing and Collaborative Policymaking**

Without clear structures for integrating [trainee] feedback...there may be little accountability. A more equitable model...[would] feature stakeholder (trainee) involvement in decision-making. (Palitsky et al., 2022, p. 836)

More and better data are important, but in the absence of meaningful power sharing, trainee concerns and suggestions can easily be ignored. Palitsky and colleagues (2022) underscore the value of collaborative policymaking for driving positive changes in the training environment. We strongly endorse their recommendation that trainees be formally involved in policymaking at both the program and national levels. As Palitsky and colleagues note, to be effective, this must be a genuine collaboration. Student representatives must be granted appropriate decision-making power (e.g., voting rights), respect, and recognition. Of course, privacy and other practical concerns will somewhat limit the extent of power sharing at the local level—particularly at sites with small cohorts of trainees—but a number of institutions have demonstrated that these challenges can be overcome and trainee representatives can be fruitfully involved in policy development and other aspects of governance (e.g., hiring) at the department and program levels. Many of the challenges inherent to shared policymaking can be best addressed through actively involving trainees in the process of shaping practices (e.g., opportunities to inform how trainees are involved in program discussions and decision-making). We urge professional groups and accreditors (e.g., Commission on Accreditation and APPIC) to nurture these changes (for broader discussions of specific ways in which national stakeholders can facilitate positive change, see Berenbaum et al., 2021; Gee et al., 2022).

**Boulder Revisions**

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 multisector stakeholders. (Palitsky et al., 2022, p. 839)

To have the best chance of tackling the immense burden of mental illness, clinical psychological science needs to face some uncomfortable realities about the current state of training norms and practices. Fully addressing the challenges identified by Palitsky and colleagues and other recent commentators will require an all-hands approach and bolder kinds of systemic change (Berenbaum et al., 2021; Gee et al., 2022; Strauman, 2021). These changes are necessary and in
many cases, long overdue. Some of these changes will be difficult to implement and disruptive in the near term. In short, they need to be made with the greatest care, transparency, and attention to potential “off-target” effects. This will require debate, advocacy, and action at the local and national levels. We strongly endorse Palitsky and colleagues’ call for professional organizations, accreditors, and funders to organize and invest in the necessary meetings (“Boulder 2.0”). The first such meeting, organized by the Academy of Psychological Clinical Science, is scheduled to take place at Washington University in St. Louis in May 2023 (APCS, 2023). It is essential that clinical interns and other kinds of pre- and postdoctoral trainees have a robust voice in these discussions. Of course, discussion alone will not be adequate to overcome the urgent challenges in clinical psychological science training. Bold thinking, creative partnerships, novel incentives, and new institutional investments will be necessary to create sustainable training environments in which trainees and trainers can focus their efforts on understanding and reducing the suffering caused by mental illness.

Concluding Thoughts—A Cause for Cautious Optimism

Palitsky and colleagues (2022) highlight the many barriers to reforming clinical-science training. Yet they also provide a rationale for hope, reminding the field that radical shifts in training practices are not only possible but are in fact a recurring theme in the history of clinical psychological science training and service provision, beginning with the rapid implementation of current norms in the aftermath of World War II and culminating in the warp-speed adoption of digital tools for mental-health-care delivery (“telehealthcare”) in response to the global COVID-19 pandemic.

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Dylan G. Gee: Conceptualization; Writing – original draft; Writing – review & editing.
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References


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


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Abstract
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 article written by 23 trainees across different sites and training specializations, we 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 long-standing dilemmas in HSP training that were exacerbated by the pandemic and will continue to require resolution after the pandemic has subsided. We 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 training, diversity equity and inclusion

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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, p. 243)

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, Becker, et al., 2020). As health-care 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 such as 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, which illuminates and deepens 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 (referred to hereafter 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., 2021; 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 (for an autoethnography of three counseling-psychology trainees addressing racial battle fatigue in training, see Wang et al., 2020). We draw on the lessons learned from COVID-19 as a touchstone for a position article from trainee stakeholders and argue 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: (a) ambiguity in the status of trainees, including essential versus nonessential status; (b) training benchmarks and competencies; (c) training aims; (d) location and locality of trainees; (e) the broad adoption of telehealth during 2020–2021; (f) economic security of trainees; (g) challenges pertaining to diversity, equity, and inclusion; and (h) 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, health-care systems, patients), 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 [APA], 2021), 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 discuss in this article. 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 article 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.

As is the case with any position article, not all clinical settings and perspectives can be represented. For
Table 1. Recommendations Associated With Challenges in Health-Service-Psychology 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 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, including competencies for telehealth and telesupervision included in training.
13. Telehealth and telesupervision should be available options when feasible, including due consideration of trainee circumstances, 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 APA 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, having input into the domains being evaluated.

Note: CoA = American Psychological Association Commission on Accreditation; APPIC = Association for Psychology Postdoctoral and Internship Centers; CUDCP = Council of University Directors of Clinical Psychology.

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., Gruber et al., 2021; Hames 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 preexisted 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 and highlight areas in need of
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 the system?
- How do the rights, benefits, and obligations of interns differ from those of clinical faculty and/or trainees from other disciplines at the 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? and (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 the site’s 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 on, and how much input do trainees have in these changes?
- When trainees’ training aims change, what process is there for evaluating how these changes may affect 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 well-being 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 the 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 with 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 underprivileged backgrounds to voice concerns about inequities in a way that is heard and responded to by the training program?
- In what ways does the 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?
improvement. As the opening quotation to this article suggests, an emergency provides the opportunity to evaluate pressing challenges 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-20th 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 (G. Frank, 1984). Internship training was established on the blueprint of the medical-residency model, including enough flexibility to enable the emergence of additional models for training such as 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 people 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); corresponding attention has been given to developing equitable and fair practices that do not discriminate against marginalized individuals and communities. Throughout these transitions, 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 predominate 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, which has led to 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 coauthors. They were unique in raising a range of issues that deserve but have not received greater attention. They described challenges that included (a) role confusion for trainees, (b) the difficulties of juggling multiple responsibilities between life and internship, (c) the importance of bonding among intern cohorts and between interns and supervisors, (d) the challenges of relocation for trainees, (e) the role of training staff in mitigating the novelty of training experiences, (f) the tacit pressure for trainees to “prove” themselves, (g) the unique workplace politics of internship, and (h) concerns about parity with medical residents. Note that 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 [HSPE] Collaborative, 2013). In many ways, the COVID-19 crisis brought preexisting core issues in HSP training to the fore because they were exacerbated or made especially salient during the pandemic.

Challenges in HSP Training

Trainee status: Are trainees essential or nonessential 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 long-standing challenge in training related to how trainees are regarded within the health-care system, the rights and privileges they are accorded, and their agency as both providers and students. Thus, 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 was 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), and APA Commission on Accreditation (APA 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, 2021). 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-versus-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, and more service hours contribute 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 nonaccredited 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-versus-training priorities.

In the received (although 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, and 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, which leaves trainees potentially subject to both sets of expectations—that they should be workers first and (also) trainees first. This preexisting 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 nonessential 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, 2020c); eventually, guidelines (sometimes conflicting) came from accreditation agencies (for an extended discussion of the initial adjustment period, see Bell et al., 2020). Essential/nonessential designations were influenced by training programs and institutional considerations. For example, the Fourth Mission of the U.S. Department of Veteran Affairs states that VA hospitals strive to provide reserve medical care for civilian populations during national emergencies (Veteran Affairs/Department of Defense Health Resources Sharing and Emergency Operation Act, 1981; Veterans Health Administration Office of Emergency Management, 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/nonessential designations were also influenced by the type of service the trainee was providing. For example, inpatient psychiatric services were deemed essential at some sites, which confers 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 health-care system’s response during a national emergency, when increased demand for on-site mental-health professionals is to be expected (Gruber et al., 2021). On the other hand, psychology trainees have less autonomy and remuneration and 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 articles written by medical students offered 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 article also authored by medical students deemed it important for medical schools to offer students opportunities for service and training during the pandemic (Miller, Pierson, & Doernberg, 2020).

In a statement on training adjustments during COVID-19, APPIC (2020b) reiterated its position that the primary focus of the internship year is training “in contrast to supervised experience or on-the-job training.” 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 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, according to 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, which has impacts for the ethical obligations both of, and to, trainees. Furthermore, role confusion contributes added distress for trainees (Olk & Friedlander, 1992; Shapiro, 2021) 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-versus-nonessential status.**

This article does not advocate for the ubiquitous adoption of either essential or nonessential 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 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. Note that Berenbaum et al. (2021) 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. 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 versus nonessential 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). Furthermore, 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 personal protective equipment, 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 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, compared with their status as workers, in the system?
- How do the rights, benefits, and obligations of interns differ from those of clinical faculty and/or trainees from other disciplines at the site (e.g., medical residents)?

Revisiting training benchmarks and requirements: hours versus 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, for an internship to qualify for APPIC membership, it must include a minimum of 1,500 hr, and 25% of these hours must be patient-facing. More consistent standards across internships have been called for, for example with 1,800 hr recommended as an industry-wide standard (Tracy et al., 2011). However, the COVID-19 pandemic has made clear that current benchmarks for training completion—based primarily on a combination of hours in specific activities and 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 in 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 because of 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 (Falender & Shafranske, 2012; Fouad et al., 2009; Hatcher et al., 2013). 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 nontrackable 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 (Falender & Shafranske, 2012; Fouad et al., 2009; Hatcher et al., 2013; 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 toward 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 toward 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, 2021; 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 toward 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? and (b) Are there any trainees at a disadvantage for meeting these requirements?
- To what extent does the site prioritize competency-based training?
- What is being done to ensure that the site’s definitions and measurement of competency are unbiased and support the growth of all trainees?

**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, 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, 1975). Although trainees have the opportunity to rank programs according to 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 because of 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, which resulted in the loss of specific training experiences such as engaging in specialized outreach or clinical services. For some trainees, elective rotations that were interrupted because they did not meet 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-locate 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) and had 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 not only identify and make explicit 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 on the basis of advertised training aims, and they enter a bidirectional
agreement with training sites to commit to internship (including abiding by the match and not leaving) on the basis of these training goals. It was the authors’ experience that program approval is typically required for a trainee to change previously agreed-on 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) pointed 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, which would have repercussions for their anticipated career trajectories. Especially for changes of this magnitude, we recommend the collaborative involvement of current, 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 on, and how much input do trainees have in these changes?
- When trainees’ training aims change, what process is there for evaluating how these changes may affect their future career aims?

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 are 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 this question: To what extent were these restrictions—and how many of them—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, which typically prompted 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 (Abbott, 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 & Eddleston, 2020; Golden & Gajendran, 2019). 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 exerted a stratifying force on the internship pipeline by contributing considerable expense to the application process, including $1,000 in median travel costs without factoring in additional application fees (APPIC, 2018). In 2020, remote interviews for internship were broadly adopted, which considerably reduced disruptions in domestic responsibilities.
We recognize that state statutes may nevertheless allow interns to participate in internship from across state lines for delimited periods of time (Recommendation 9). Although 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 because of 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 interviews and telephone and video interviews, D. R. Johnson et al. (2021) 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 about the necessity for these restrictions is made clear by the success with which interns were able to function when interstate 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. In the following section (“Field-Wide Adoption of Telehealth and Telesupervision”), we address some of the opportunities and challenges presented by telehealth, which has rendered many of the preexisting 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 faraway programs can expect to move but cannot necessarily expect to stay for more than 1 year. Because of financial or pandemic-related constraints, many interns are unable to see their new residences in person before 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 and that they be weighted the same 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 affect 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 well-being 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 the program do to support trainees who have relocated from out of state and have few local connections?

**Field-wide 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 (for general considerations, see Cox et al., 2020; Hames et al., 2020; Mann et al., 2020). 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, 12 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 (Psychology Interjurisdictional Compact, 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 and 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 and 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 research has found that teletherapy is effective for delivering evidence-based treatment for patients, and there are only small differences compared with 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 and 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 nonrelative roommates and lack separate space for an office, which results 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.

It is unclear how the transition to telehealth, and the corresponding transition to telesupervision, will affect clinical training. During the COVID-19 pandemic, in contexts in which video recordings were central to supervision but were no longer possible, live supervision opportunities decreased without a viable alternative (Scharff et al., 2021). 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) provided 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 because of COVID-19-related accommodations, concerted training for telehealth would be a valuable addition to supervision and didactics. Several recommendations for teletherapy and telesessment training have recently been issued, although these have primarily focused on predoctoral practicum training rather than internship. Casline et al. (2021) provided recommendations for training clinics to enact didactic, procedural, and evaluative changes to support students practicing telesessment. Their work attends to many of the issues we discuss in this article, such as competency-based training and acknowledgments of power differentials between faculty and trainees. Patel et al. (2021) provided further practicum trainee perspectives on supervision for telesessment in an article that carefully weighs multiple considerations for supervision before, during, and after a telesessment.

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, although with due consideration of trainee circumstances, 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?

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 before internship. The average debt incurred from preinternship psychology doctoral training in the United States is $91,750 (SD = $103,937, Mdn = $60,000), as reported by the 2018–2019 internship cohort, 61% of whom were PhD students (APPIC, 2018), although even higher debt numbers were reported by Wilcox et al. (2021). Before internship, doctoral students have historically paid to apply and travel for internship interviews, incurring 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 interns supporting families or dependents. According to guidelines from the Center on Budget Policy Priorities (2022), for a family of three (e.g., an intern with a spouse and one dependent), the median internship salary barely exceeds (by $450.00 annually) the cutoff for qualifying for the supplemental nutrition assistance program. Given that 13% of 2018 internship applicants resided with at least one dependent child, a nontrivial proportion of interns, especially ones 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 because of existing racial differences in family wealth (Campbell & Kaufman, 2006), and marginalized trainees are more likely to accumulate debt than their more privileged
Centers, 2020d). 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 U.S. adults generally. Not all sites provide health insurance, and not all that provide insurance extend those benefits to trainees’ dependents. 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 provided a stipend of $20,000 or less in 2021, only nine noted that they provided health insurance as a benefit (APPIC Directory Search: https://membership.appic.org/directory/search). Lack of access to health insurance during internship creates further challenges in accessing care for trainees with disabilities or interns 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 trainees 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 because of 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 internship year. In addition, relative to most employees, interns lack employment freedom because 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, 2016). 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 preexisting economic pressures were further worsened during COVID-19. Trainees who were members of households in which others lost work faced increased financial responsibility. In cases in which 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 2 weeks of work because of 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, which provided 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 health-care 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). Furthermore, 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 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 United States. 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 health-care environments. However, because of the transient nature of internship, we contend that internships have occupied an underprivileged bargaining position compared with other demands and stakeholders. Our earlier recommendations of considering a switch to postdoctoral internship and 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 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, especially psychologists from disadvantaged backgrounds.

**Questions for collaborative inquiry.**

- How do trainee salaries compare with 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?

**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; Haynes et al., 2020; Webb Hooper 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, which contributed to both systemic and personal burden.

Trainees with disabilities, chronic health conditions, and/or compromised immune systems, including people 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), which results 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 other people in high-risk categories were burdened by the consequences of shelter-in-place policies (e.g., by losing child care; 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), which added risks to well-being 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, we note that 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 because of 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 to ensure equity. Strategies to address long-standing 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 article, readers are further referred to two excellent sources: In an article composed by graduate students and postdoctoral trainees, Galán et al. (2020) offered a careful analysis and list of recommendations for an antiracist clinical science; Pearlstein et al. (2021) offered 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 people 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) and to explore additional policies and systemic changes (Galán et al. 2020). There is evidence that nonevaluative diversity-focused mentoring programs may be an efficacious support mechanism (Burney et al., 2009; M. O. Johnson & Gandhi, 2015; Mangione et al., 2018). Leadership and training staff may also model valuing diversity by attending diversity events and committees, consistently raising opportunities for engagement with meaningful diversity initiatives and discussions, and 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, in which 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 (Joseph & Hirshfield, 2011; Padilla, 1994).
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 the 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?

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, providing 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 and 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) observed, 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 spring 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 when 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 spring 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, which could potentially harm the relationship between the training program and training site or adversely affect 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).

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: (a) An internship program elects to discontinue face-to-face contact for interns, and (b) 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 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 in which trainees are “recipients” of policies without a
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 before 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), in which 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 people who need it. For this to occur, the educator must endeavor to know the pressing concerns of the people 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) observed that for
disadvantaged stakeholders to increase their influence in collaborative decision-making without tokenization or co-optation 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 & Foster-Fishman, 2013, p. 153). One way to increase mutual dependency is to enable interns to provide publicly available feedback on internships, such that there is real impact on internships’ standing and future interns’ choices in selecting internships (Recommendation 20). The forum in which such feedback is made public (in anonymized and possibly aggregate form to prevent identification) should be endorsed by organizations such as APPIC, the APA CoA, and the Council of University Directors of Clinical Psychology and may be integrated with the process of APPIC accreditation. This would create a real stake for internships to prioritize intern input because 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 recommended 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 1-year internship, align with a shift toward competencies versus hours? And would such a shift be easier to facilitate if internship training were postdoctoral rather than predoctoral? 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) observed 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 APA 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, such that little involvement or influence in institutional decision-making is 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 health-care 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 by having 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. Because trainees are present for only 1 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 the 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. In this article, we identify 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 the 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 time frames.

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 underresourcing of HSP internship training, which is now due for a correction. We 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 the U.S. Health Resources and Services Administration Bureau of Health Professions (APA, 2020), the 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 article 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 (R. G. Frank et al., 2004), and communication between graduate programs and training institutions is typically with the internship’s training office rather than site administration when these are separate entities. Ponce et al. (2021) provided 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 the 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 underqualified 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 for support without internship being a graduation requirement. However, it is also possible to imagine an alternative scenario in which adoption of postdoctoral internships enables Graduate Medical Education funding to support internship training, so that PhDs move toward a trajectory more similar to that of 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, and no entity is able to make meaningful change without accommodation from other entities, solutions must be carried out with involvement from multisector stakeholders.

We also believe it is possible to find movable points in this gridlock in which 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 meaningful steps toward addressing some of the concerns raised in this article. Given that VAs are by far the largest provider of internship training, changes in VA policy (e.g., 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 (for a summary, see Bell et al., 2020). 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. Likewise, 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, which led 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 COIVD-19. We propose that now, 15 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 affect 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. Incorporating stakeholder observations and recommendations can contribute to long-needed improvements in the state of HSP training and practice.

**Transparency**

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**Author Contributions**

R. Paltisky organized and wrote the primary drafts and revised drafts of the manuscript. D. M. Kaplan wrote sections of the manuscript and contributed to the content and structure of the manuscript and revisions. M. A. Brodt
contributed to revisions of the original manuscript and the revised manuscript and contributed expertise in issues of diversity, equity, and inclusion. The rest of the manuscript authors contributed equally and share equal authorship on this article. M. R. Anderson, A. Athey, J. A. Coffino, A. Egbert, E. S. Hallowell, G. T. Han, M.-A. Hartmann, C. Herbitter, M. Herrera Legon, C. D. Hughes, N. C. Jao, M. T. Kassel, T.-A. P. Le, H. F. Levin-Aspenson, G. López, M. R. Maroney, M. Medrano, S. J. Reznik, M. L. Rogers, and B. Stevenson contributed written sections, content based on their experiences, read and revised the manuscript, and share equivalent credit. All of the authors approved the final manuscript for submission.

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Notes
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 December 2020 update, so the quoted phrase will not be found on current versions of the page.

References


Mustapha, T., & Eysallenne, T. (2020). Paying a penny for our thoughts and then asking for our 2 cents. Academic Medicine, 95(12), 1788. https://doi.org/10.1097/ACM.000000000003721


Will this finally be the impetus to substantive change? Will this inspiring article push the field to address longstanding inequities in internship training? In a manner both thorough and eloquent, this talented group of 23 recent psychology interns documented the history of concerns with the health-service psychology internship and provided no less than 24 specific recommendations for reform. It is hard to read this and not be enraged and disappointed by the inaction of the field amid a plethora of inequities. A few examples:

- A recent survey of 400 interns during the pandemic found that 43% felt unsafe at work.
- Average debt following internship is over $91,000.
- An intern was required to work two additional jobs while on internship to support their family, whereas others struggling to live on an intern’s salary are unable to supplement their income because of program restrictions.
- An “elite program” responds to financial concerns noted by students by telling them to “ask for financial help from their families.”
- Interns required to stay home due to COVID restrictions are docked their pay and denied opportunities to make up their hours, thereby putting them at risk of not completing the required number of hours for internship.

Written during the height of COVID, the problems they described were exacerbated by COVID, but the problems themselves are hardly new given that concerns for the quality of internship training have been prominent at least since the Gainesville Report of 1989 (Belar et al., 1989), more than 30 years ago! Clearly, the field has recognized the need for structural change but failed to act. Furthermore, there have been no lack of ideas for how to improve the system, as Palitsky et al. (2022) reviewed. Yet we know of no other article that has itemized these concerns with such precision and thoughtfulness. For example, their discussion of diversity issues is compelling—most notably the lack of accommodations for marginalized students, including a shameful lack of concern for students without financial resources—in part because of the credibility of their very personal examples. In addition, they offered constructive solutions and associated “questions for collaborative inquiry” that are impressive in scope and thoughtfulness. We do not have the space to review them all, but we do want to emphasize a few key points.

First, this entire article and its quality make the case for the importance of including the voice and perspective of interns, a major point of the article. As with all activists, they asked that people stop talking about them without them. They also pointed out that the inclusion of interns’ voices and perspectives can provide a self-corrective on the top-down approach that has too long dominated psychology training. What they described as collaborative inquiry is an opportunity to engage in a serious discussion of seemingly intractable problems to arrive at solutions that will promote equity and high-quality training. As noted, these issues are not new, and many of the solutions have been proposed previously. Where this article differs dramatically from most prior efforts is its sense of urgency.

A second point to highlight is their careful description of the complex net of systems and structures that maintain the status quo. Graduate programs have delegated authority of the internship experiences of their students to nonaffiliated hospitals and agencies, which leaves interns in what Palitsky et al. (2022) noted as an “underprivileged bargaining position” (p. 833), an obvious understatement. With few guardrails on a cottage
industry of cheap and high-quality labor and few restrictions on their employment, the economic incentives for internship-training sites promote more service and less training. Furthermore, whereas the American Psychological Association (APA) Office of Accreditation and the Association of Psychology Postdoctoral and Internship Centers (APPIC) provide guidelines to promote quality over quantity, the guidelines are only broad strokes with little enforcement (as is apparent from the descriptions of interns’ experiences). We also note that the Association for Psychological Science-affiliated Psychological Clinical Science Accreditation System (PCSAS) has yet to identify internship standards after more than a decade into its formation. This is despite proposals outlined in a 2014 article written by three current and one former internship director in which they described variations on a new model for clinical internship addressed specifically to the then newly developed PCSAS “to reconceptualize internship training within clinical science” (Atkins et al., 2014, p. 50). Perhaps now, with the impetus of this cogent article, graduate-training programs—that is, people who hold the most power and authority over training—will embrace this opportunity to be at the forefront of shaping an equitable system to train the next generation of clinical psychologists.

We note that an alignment of graduate programs and internships reflects some of the initial recommendations in the middle of the 20th century when internship experiences were first formalized: “Increasing emphasis has been given to the need of close affiliations between university and clinical institution, and to the necessity for initiative to rest with the university in this matter” (Morrow, 1946, p. 179). This is not to take the onus off internships to improve working standards, but if aligned, graduate programs and internships could work collaboratively to define the experiences and needs of the interns, providing interns the guidance and support of their graduate-training directors, presumably knowledgeable of their unique training and educational needs and therefore able to help advocate for them. This is relevant to the discussion regarding the status of interns as essential versus nonessential workers—again, brought to the fore by COVID but exposing the long-standing precarious position of interns in these organizations.

Palitsky et al. (2022) offered several opportunities for immediate action. We especially appreciate the idea of public ratings of internships to provide information to applicants and serve as a quality-control mechanism to programs. Our program, as do many others, provides applicants a confidential lunch with our current interns to allow an honest discussion of our program without concern for how it might affect their status. We have found that our interns take this responsibility quite seriously and maintain these discussions in strictest confidence. That this can serve as a built-in corrective to ensure that current and past interns’ concerns are acknowledged is an added bonus. Having a national rating review would be a welcome addition to provide feedback regarding relative program strengths and deficits. But one addition we would recommend is to link these ratings directly to students’ graduate programs and perhaps even include these ratings in their program’s accreditation review. After all, is there another profession that requires an experience for the degree but takes no responsibility for its availability or quality, an issue medical education addressed over a century ago (Flexner, 1910)?

We also greatly appreciated the case for interns having a voice in policy issues related to internship training and, relatedly, being allowed discretion over the content of their training. However, for the former, given the limitation of their (typically) 1-year status, we suggest consideration of some safeguards to encourage an honest appraisal of programs. For example, we wonder how comfortable an intern would be, new to the organization and to the internship faculty who are in an evaluative role, to address issues of fairness and equity. Perhaps this would best be implemented at a regional level with graduate students and interns serving in an advisory capacity protected from the judgment of specific program and faculty. For the second feature in which interns are given voice over their training, we wholeheartedly concur because this has been a core feature of our internship for more than 2 decades. Two aspects of our process are especially relevant to this review.

First, in our program, no faculty are guaranteed an intern; faculty members are allotted time to present their program to the interns as a group, and interns then decide whether they are interested in that experience. This avoids assigning interns to experiences that are not in line with their training goals. Second, interns are provided the nine competencies required by the APA Commission on Accreditation (CoA) and, with guidance from our director of training, decide how they will acquire those experiences. This produces a set of experiences uniquely tailored to each intern’s training needs while acknowledging their advanced status as early career professionals—an example of collaborative decision-making as Palitsky et al. (2022) described it. We note that our internship is specifically designed for academically oriented interns, but we suggest that this model would be appropriate for interns with other career aspirations as well.

Individualizing training goals in this way works especially well in our setting because our internship is
entirely funded by a line item on our department’s state budget. No clinical revenue is allocated to the internship, and therefore there is no incentive to require one or another clinical experience. However, although this offers an advantage of flexibility that internships funded by fee-for-service models may not be able to replicate, it is not without fault. Specifically, this line item is a fixed sum, and therefore increases in stipends are generated through our department’s general fund. And although we have been able to advocate successfully to have our stipend raised to meet regional standards, it is still below the minimum salary for a full-time employee at our university, an issue correctly noted as problematic by this article. In addition, state-budget shortfalls have seriously affected the viability of the program at times, which led to the loss of several positions that we are just now beginning to recoup. These exigencies may be specific to our program, but they represent the larger issue of the vulnerability of internship programs and trainees in a volatile health-care environment as noted eloquently by Palitsky et al. (2022).

Related to salaries, we suggest the solution will again require an alignment of graduate programs and internships because it is unlikely that improving interns’ salaries can be accomplished by internships alone. For one, internship programs run on tight budgets, often funded through clinical revenue or, as with our program, department or university resources. Without a formal affiliation with a graduate program, their stake in training is influenced by the benefits their setting would derive from the interns' activities. As noted, these incentives, without additional support, will work against providing interns many of the rights and high-quality training that they deserve even despite the best efforts of the internship-training faculty who must answer to their respective department leadership. Ideally, therefore, if the internship was jointly funded by the graduate program as an affiliated program, as long recommended, it would balance these incentives and allow for some of the innovations recommended in this article, including (and especially) a livable wage.

Obviously, this is not an easy fix because funding in graduate training also has many limitations. But as Palitsky et al. (2022) noted, there are several options, including collaborative grants and shared clinical reimbursement. In our case, we have a formal agreement, negotiated with APPIC and APA CoA, for the Northwestern University clinical-psychology graduate program to fund one dedicated position in our internship for a graduate student from their program, assuming that student meets our program-selection criteria. Because our respective programs are aligned philosophically in a clinical-science model, this has been a fruitful collaboration. Although limited to only one student, it is an example of one way to align graduate programs and internships.

In closing, we offer the experience of Big Pharma and medical education for some perspective and foretelling. In 2009, concerned with the cavalier attitude of his pharmacology professor on the side effects of cholesterol drugs, a Harvard medical student searched this faculty member online and found that he was a consultant to 10 pharmaceutical companies, including several that sold cholesterol drugs. He shared this information with his classmates and faculty, and more than 200 people signed a petition to follow the lead of other medical schools and eliminate the influence of Big Pharma on their training. The issue was picked up by the American Medical Student Association, and before long, the policy of restricting drug-company influence on medical training was a national debate (Magee, 2019; Wilson, 2009) and is now almost universal policy.

We offer this historical precedent both to encourage students to continue to speak out and as advance notice to clinical-science faculty that students have waited long enough and that now is the time to push these ideas forward. We congratulate our colleagues for what we believe will be a seminal article on psychology training and, we hope, an impetus for graduate-training programs and internships to accept the invitation to engage in much needed discussion and change. After all, sweeping these issues back under the rug will be so much harder now.

**Transparency**

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*Marc S. Atkins:* Conceptualization; Writing – original draft; Writing – review & editing.  
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Palitsky et al. (2022) wrote a timely article that highlights long-standing issues in health service psychology (HSP) internship training and offers concrete recommendations for addressing these challenges. The authors offer suggestions for HSP internship-training reform and recommendations that may be feasible in the confines of current internship models including accreditation requirements. Their article focuses specifically on problematic practices that predated—and have been exacerbated by—the COVID-19 pandemic. These issues have disproportionately affected trainees who face marginalization because of race, ethnicity, socioeconomic status, disability, and other aspects of their social identity. We highlight four issues worth further discussion: (a) the integration of trainee perspectives, (b) the need for additional data to guide decisions about best training practices, (c) the importance of considering both trainees and clients when making decisions about whether to allow remote-internship options, and (d) the consideration of how discussions about internship training fit into conversations about larger HSP-training reform.

Integration of Trainees’ Voices

Written by 23 doctoral psychology trainees in HSP, all of whom completed their predoctoral internship during the first 2 years of the pandemic (i.e., 2019–2020 or 2020–2021), Palitsky et al. (2022) reflects an often-neglected perspective on HSP-internship issues—that of trainees. As the authors note, decisions concerning HSP-internship training have historically been made by individuals in leadership positions (i.e., from the top-down), including training directors, accreditation agencies, and corporate institutions such as hospitals. Note that individuals in these positions are often White, cis-gender, heterosexual, able-bodied individuals from higher socioeconomic backgrounds. These individuals, in part because of the considerable amount of privilege they experience in society, may have a limited understanding of how their decisions about training and related issues (e.g., economic considerations, relocating) may cause undue stress and harm to interns with less privileged identities. Furthermore, given the historical lack of attention to cultural-humility training in HSP programs, many clinical supervisors are not equipped to support trainees in their capacity to deliver culturally humble services (Galán et al., in press). Yet anecdotally, the field is seeing a new generation of graduate trainees who are deeply committed to social justice and are proactive in seeking out training in cultural humility and multiculturalism, particularly given the proliferation of virtual trainings on these topics offered through several organizations. Thus, in some internship programs, trainees may actually have more up-to-date training in things such as cultural humility than some of their supervisors, particularly in programs with more diverse trainees but less diverse supervisors. This highlights why the trainee perspective, a group that tends to be
more diverse than individuals in HSP leadership positions, is vital to ensuring that training practices are contextually grounded and designed to respond flexibly and sustainably to diverse needs (Brown et al., 2022).

Including trainees’ voices at all levels of the field requires a shift in the way we (as a field) define the relationship between “trainer/supervisor/teacher” and “trainee/student.” It means moving away from a hierarchical top-down approach to a more collective community approach in which trainers share power with trainees and value them as stakeholders with unique values, needs, and priorities. Examples could include having an intern representative be involved in the internship-training committee and attend ongoing meetings throughout the year, ensuring that interns are able to provide anonymous feedback at multiple points throughout the year, and involving current interns in the application-review process for the incoming class. Centering interns in these ways will shift the status quo by meaningfully embedding interns in internship leadership, providing unique training opportunities for interns, and allowing ongoing integration of feedback.

**Need for More Data to Test Assumptions About What Constitutes “Good Clinical Training”**

As we consider how to translate Palitsky et al.’s (2022) recommendations into practice, it is critical to consider barriers to enacting the changes recommended by the authors. We expect that there may be resistance to some of the suggestions recommended by the authors, such as remote-work and hybrid-training options (see Palitsky et al., 2022, Table 1). Such resistance may be related to specific assumptions or beliefs about what constitutes “good clinical training” and optimal methods for learning. However, many of these beliefs may actually represent speculation from more privileged individuals who are drawing from their own prior experiences and what worked for them in the past. These assumptions and insistence on traditional methods may not fit with the rapidly changing landscape of mental-health treatment (e.g., rise of telehealth) and are clearly contributing to inequities in training and trainee well-being (Buchanan & Wiklund, 2020; Galán et al., 2021). Collecting data to empirically test these assumptions is an important next step. On a program level, this means developing standardized systems for assessing internship-training outcomes. A multimethod, multiinformant approach should be used when operationalizing good clinical training, including but not limited to a combination of intern self-assessments, intern satisfaction with training, supervisor ratings of intern outcomes and growth during internship, client/patient outcome data, measures of therapeutic alliance, and standardized performance ratings of live or recorded clinical sessions (Sharpless & Barber, 2009). Specific strengths, limitations, and applications of each of these methods are outlined in resources such as the Council of Training Council’s “Benchmarks document” (Fouad et al., 2009) and “Competency Assessment Toolkit” (Kaslow et al., 2009).

Research on internship training can play a pivotal role in fueling large-scale systemic changes, helping to dispel erroneous assumptions about the necessity or superiority of certain training practices and providing a way to measure the risks and benefits of certain methods and policies for trainees. For instance, a study conducted with psychology doctoral students found that there were no differences between in-person supervision and telesupervision on supervisee-reported outcomes, including supervision satisfaction and supervisory working alliance (Tarlow et al., 2020). Although these findings tentatively suggest that telesupervision may be a viable alternative to in-person supervision, the study employed a multiple-baseline experimental design and involved only three trainees. Before the field can make definitive conclusions regarding the effects of supervision modality on training outcomes, researchers need additional research comparing telesupervision with in-person supervision, especially studies using larger samples and randomized trials. These recommendations echo those of others in the field who have called for more data to guide the design and refinement of training programs and accreditation systems (Gee et al., 2022; Levenson, 2017). As noted by Gee and colleagues (2022),

> Longitudinal data collection will be particularly important for understanding the consequences of local innovations. To enhance efficiency and rigor, survey design should be coordinated across institutions via Academy of Psychological Clinical Science (APCS) or Council of University Directors of Clinical Psychology (CUDCP) workgroups. In some cases, it may be possible to organize randomized trials of particular training or climate interventions. (p. 63)

Such data will enable the field to anchor decisions about training and accreditation requirements in evidence rather than intuition. On a practical level, this also requires the field to generate more accessible tools and models for how to build sustainable systems of obtaining and integrating trainee feedback and other training outcome measures and considering who may not be reflected in any given set of findings (e.g., as a result of marginalization and/or exclusion).
Need for More Data on Client Outcomes When Evaluating Telehealth Options

An additional area in which more data are needed regards the efficacy of telehealth interventions and the barriers to engaging in such services. The COVID-19 pandemic catalyzed the rapid adoption of telehealth services because of social-distancing guidelines, stay-at-home orders, and increased psychological distress (Wosik et al., 2020). Palitsky et al. (2022) advocated for “embracing the added flexibility afforded by telehealth to participate in training and clinical activities remotely and from across state lines” (p. 828). Although the authors acknowledge some of the challenges that trainees have faced with the transition to telehealth and telesupervision, such as the lack of privacy and lack of access to affordable, high-speed Internet, missing from this discussion is a consideration of how the adoption of telehealth has affected clients. On the one hand, teletherapy has the potential to reduce barriers to mental-health access by increasing flexibility and reducing challenges associated with scheduling and transportation (e.g., for clients of lower socioeconomic status who do not have access to reliable transportation or childcare). However, it is also possible that because of inequalities in access to technology and the Internet (i.e., the “digital divide”), families of low socioeconomic status and individuals of color have faced the greatest disruptions in access to mental-health services, further amplifying inequities. Better understanding of whom we are reaching and who is being left out as a result of the transition to telehealth is essential (Willis et al., 2022).

In addition, although telehealth has been shown to be effective for delivering both individual- and group-level interventions (e.g., Hollis et al., 2017; Nelson & Sharp, 2016), most of this work has been conducted in non-Hispanic, White individuals, raising questions about whether these interventions are equally effective for people of color. Although models exist for adapting in-person services to telehealth and for adapting evidence-based treatments to be culturally responsive, research on how to tailor interventions to be culturally responsive and appropriate for telehealth platforms is lacking (Willis et al., 2022). Thus, although we agree with Palitsky et al. (2022) that telehealth may help to advance equity and improve sustainability in HSP training, better understanding of how telehealth can be adapted to meet the specific needs of historically marginalized populations is critical before the field can draw definitive conclusions about the circumstances under which trainees should be allowed to provide telehealth services.

Connecting Discussions About HSP Internship Training Within Broader Discussions of Reform

Discussions about HSP-internship training should be situated within discussions regarding larger HSP-training-model reform. Although Palitsky et al. (2022) emphasized the importance of integrating trainees’ voices during the internship year, it is also important that trainees have a voice in shaping other aspects of their training, including whether they complete an internship or receive training in other professional activities likely to reduce mental-health burdens (e.g., training prevention, mobile mental health). This article is largely predicated on the assumption that completing a predoctoral internship should continue to be a graduation requirement for HSP trainees and that all doctoral-level HSP-training programs are responsible for ensuring that their students are eligible for licensure after graduating. Berenbaum and colleagues (2021) challenge this dominant approach to training and advocating instead for a flexible two-phase model for clinical-psychology training. In Phase I (the “Foundational Knowledge and Competency Phase”), graduate students would develop foundational knowledge of psychopathology, assessment, and intervention and basic competency in the provision of clinical services. In Phase II (the “Focused Competency Phase”), students would receive advanced training and develop expertise in a subset of topics relevant to the professional roles they wish to pursue, such as research, public policy, or direct client care. Under this modular approach, internship would be part of postdoctoral, rather than predoctoral, training, empowering students to make their own decisions about what they want next in their training based on their personal values, goals, interests, and personal life circumstances (e.g., economic security, caregiving responsibilities). Although concerns about the two-phase model have been raised (e.g., Gee et al., 2022), we posit that several of the training issues raised by Palitsky and colleagues (2022) could be addressed by making internships part of postdoctoral training.

As an example, take the issue raised by Palitsky and colleagues (2022) regarding whether HSP trainees should be considered essential or nonessential personnel. Under the current training model, the goal of the HSP internship is to continue the development of clinical skills in the pursuit of degree completion. If training were to shift to a two-phase model as described by Berenbaum and colleagues (2021), internship would be a postdoctoral experience. The goals of the postdoctoral clinical internship may therefore differ from the goals of the current predoctoral-internship experience.
Although internship would remain a training experience, it would occur after degree completion, similar to the current medical-school and residency-training sequence. This may shift the primary goal away from training and toward gaining experience through service activities and revenue generation, thus tipping their role toward that of essential personnel. Under a two-phase model, interns may also be afforded appropriate salaries and additional rights and protections as a result of being essential personnel, which may ultimately be in better alignment with their training and responsibilities compared with the current predoctoral-internship approach, which does not guarantee that interns are considered nonessential personnel. Furthermore, if internship became postdoctoral, there would be a stronger rationale for the importance of trainee voices/shared power. As postdoctoral fellows, interns could play a critical role in the evolution of internships. Interns’ proximity to changing career landscapes and opportunities (e.g., the inability to support ever-growing numbers of principal investigators or the rise of mHealth companies) best position them to be drivers of change and consultants to internship programs. This would facilitate the evolution of internships to best prepare future HSPs. Thus, it is key to consider how recently proposed changes to the HSP-training model, including internship training, interface with the internship challenges raised by Palitsky and colleagues.

Conclusion

Palitsky et al. (2022) offered a much-needed critique of the current HSP-internship-training model and raised several critical issues for stakeholders to consider moving forward. Although we share the sentiment that there is a critical need for the continued amplification of trainee voices and needs, we are also cognizant of the constraints that internship sites face because of factors such as funding and accreditation requirements and ongoing discussions regarding HSP-training reform more broadly. Thus, conversations regarding HSP-internship training must be situated within discussions regarding larger HSP-training-model reform. Any changes to training should be data-driven and evidence-based and consider diverse stakeholder perspectives, including not only those of trainees themselves but also those of the trainers, organizations, and the people HSP serves. Individuals leading these efforts must also critically consider which voices may be excluded from the data, keeping in mind how current systems are influenced by and uphold the perspectives of privileged groups.

Transparency

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References


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Toward a Postdoctoral-Residency Training Model

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We applaud Palitsky and colleagues (2022) for their efforts to include trainee stakeholders in the conversation about changes to the health-service-psychology (HSP) training model. Although we support many of the suggestions offered, present inequities in training may be maintained if institutions variably “pick and choose” which suggestions to adopt. Instead, we suggest that a more parsimonious approach is a universal shift to internship as a postdoctoral milestone, akin to medical residency. We believe that a postdoctoral-residency model directly addresses the problems that underpin many of the serious and legitimate concerns raised by Palitsky and colleagues about the current internship model.¹ The proposal for postdoctoral internship/residency is not new. In their recent article, Berenbaum and colleagues (2021) also suggested a move to a postdoctoral internship, which was first discussed by the Association of Psychology Postdoctoral and Internship Centers (APPIC) in 1997 (Boggs & Douce, 2000; Christiansen, 1997). Although APPIC ultimately voted to keep internship as a predoctoral training experience, the Council of University Directors of Clinical Psychology voted in favor of changing the training experience to postdoctoral. To clarify trainee roles and improve economic equity without negatively affecting competency standards, we believe that now is the time for the transition to a postdoctoral residency. We propose that shifting internship to a postdoctoral milestone will resolve the concerns articulated by Palitsky and colleagues regarding trainee roles and equity and will promote training trajectories consistent with trainee goals.

The Role of the Postdoctoral Resident

Palitsky and colleagues (2022) highlighted how role confusion contributed to inequitable treatment of interns during the COVID-19 pandemic. In the current predoctoral internship, the intern role is ambiguous given interns’ simultaneous status as students and employees. A common point of confusion, especially within multidisciplinary and medical settings such as hospitals and Veterans Affairs Medical Centers, is the HSP intern’s level of experience and training. The term “intern,” as noted by Palitsky and colleagues, can suggest a more junior status akin to a “medical student” or “undergraduate student observer.” Indeed, we and other interns have experienced instances of being given less responsibility and independence on internship compared with our experiences at practicum sites because of supervisors misunderstanding our training level. Relatedly, the ambiguous classification of interns in larger institutions is a frequent source of confusion for onboarding (e.g., being added to the electronic medical record system, setting up accounts), and such problems frequently reemerge throughout the year for sites with multiple rotation options. Addressing these issues can waste valuable training time and institutional resources. Postdoctoral trainees will be better situated to take on clinical opportunities consistent with their experience level and training needs, thereby enhancing training outcomes.

Some programs have adopted the term “psychology resident” to convey a similar status to that of a medical resident with multiple years of clinical training in practice settings. The transition to a postdoctoral residency would make the status of HSP trainees even more clear. Similar to our physician colleagues, postdoctoral residents could use the title “Doctor” with colleagues and patients, conferring an additional level of respect and...
clarity in multidisciplinary teams. Likewise, using the title “Doctor” may facilitate building rapport with clients, who we have found are often confused by explanations of interns’ training status, and contribute to more positive treatment expectancies. Current and former interns have remarked that transitioning to internship is a substantial shift from student to a more independent professional. Postdoctoral residents would still hold training status, because the position requires supervision and is a requirement of licensure, but with a more clearly delineated level of experience and associated expectations.

**Trainee Trajectories**

A shift toward postdoctoral residency will also provide a valuable opportunity for the field to reevaluate what is being taught during internship and how this facilitates the desired trajectories of trainees. For example, what is the relationship between the current training structure and projected workforce needs? As noted by Berenbaum and colleagues (2021), the role of the clinical psychologist extends far beyond providing direct clinical service, including but not limited to research, program development, consultation, training and supervision, teaching, management, public-facing communication, policy development, and advocacy. In many cases, the predoctoral internship is a year of more dense, graduate-level clinical experiences. Given that “the primary focus and purpose [of internship] is assuring breadth and quality of training” (APPIC, 2020) and the empirical evidence that years of training is unrelated to therapeutic outcomes (e.g., Christensen & Jacobson, 1994; Stein & Lambert, 1984; Tracey et al., 2014), the postdoctoral residency could capitalize on trainee’s doctoral status to move beyond an accumulation of clinical hours to include richer opportunities for training in these crucial roles. Indeed, it may be beneficial to shift perspectives on clinical training to view the hours of direct clinical service obtained during graduate school as sufficient for clinical practice and to view the goals of the postdoctoral residency as specialization and higher-level training (e.g., supervision, program development). Such a paradigm shift would require advocacy and policy change regarding state-level licensure requirements.

In addition to breadth, quality of training is paramount. A postdoctoral-residency model must build on foundational competencies to promote a training structure that focuses training on evidence-based practice. Indeed, substantive training in evidence-based approaches is limited at many internship sites (Hays et al., 2002). Note that evidence-based practice does not mean that training should be limited to empirically supported treatments but should, rather, incorporate the best available research evidence, the expertise of supervisors, and patients’ preferences and values (Hollon et al., 2014; Spring et al., 2009). Beyond training in evidence-based practice, HSP trainees should also be trained in how to disseminate these approaches throughout the various systems in which they work. To address the treatment gap between individuals who need mental-health treatment and individuals who actually receive evidence-based, quality mental-health care (e.g., Kazdin, 2017), HSP trainees could serve a unique role in providing training in evidence-based practice to lay counselors or peer supports.

As in the present predoctoral model, postdoctoral residency would require only 1 year of full-time clinical training but would allow for additional opportunities for residents to remain at their institutions; subsequent training years could contain research and clinical time consistent with the training goals of the institution and the resident (similar to current postdoctoral positions). A postdoctoral residency also allows for increased flexibility among research-focused PhDs who do not intend to pursue licensure. These trainees could choose to forgo the clinical training year without having to sacrifice a “clinical psychology” degree. Such flexibility would also open spaces in postdoctoral residency for clinically oriented trainees, although consideration will need to be given to whether trainees who do not complete a clinically focused postdoctoral residency immediately after graduation could opt to do so at a future point. Moving forward, postdoctoral-residency programs must balance training in core competencies, foundational to any work in the field, with opportunities to specialize and participate in multiple facets of the roles of HSP professionals.

**Economic Equity**

Palitsky and colleagues (2022) also characterized the economic burden of predoctoral internship, particularly in cases in which interns are considered essential workers but not afforded salaries and benefits commensurate with this designation (e.g., living wages, health insurance). As a full-time employee, the postdoctoral resident would be eligible for employee benefits. To ensure that postdoctoral-resident salary is commensurate with doctoral-level experience and education, we suggest widespread adoption of the National Institutes of Health (NIH) stipend levels for postdoctoral trainees such that the postdoctoral-residency year is NIH postdoctoral Year 0. Postdoctoral residents could then be reasonably considered an essential worker given that their pay and benefits more equitably balance such risk. To enact these changes, we support continued advocacy for
Medicare and Medicaid reimbursement for psychology-trainee services, which may be strengthened by the transition to a postdoctoral-residency model (American Psychological Association, 2014). As of 2019, 25 states permit Medicaid reimbursement for supervised trainees (Ashton et al., 2019). It is our hope that billable postdoctoral hours (at a prelicensed or provisional license rate) would generate revenue for the institution to help offset the increased cost of higher salaries and benefits. However, we also acknowledge that additional advocacy and policy change may be required for this goal to be realized. Likewise, careful consideration will need to be given to ensure that achieving equitable resident salaries does not result in inequity elsewhere, for example by reducing the number of internship positions available.

Postdoctoral residency also reduces internship-associated costs. Presently, many interns move to a new locality for internship and a second new locality for postdoctoral training. The costs associated with moving to two new localities in as many years is disproportionate relative to the average graduate-level and predoctoral-internship stipends, which were well described by Palitsky and colleagues (2022). A postdoctoral model would also eliminate the unnecessary expenses associated with interns paying tuition and fees to their graduate institution as well as the travel costs associated with returning to the graduate institution to defend the dissertation, as required by some programs. Reducing the economic burden of internship is crucial to diversity, equity, and inclusion initiatives.

Conclusion: The Time Is Now

The clinical internship was implemented because graduate students often acquired minimal clinical experience during graduate school, which became evident with rising demand for mental-health services during and following World War II (Thorpe et al., 2005). However, modern graduate training involves extensive supervised direct clinical service that is often redundant with internship training (Thorpe et al., 2005), and the available evidence suggests that years of experience is not predictive of treatment outcomes (e.g., Christensen & Jacobson, 1994), making the necessity of a predoctoral, clinically focused internship questionable. Making clinical internship postdoctoral capitalizes on an opportunity to facilitate more specialized training that is aligned with trainees’ goals and interests, which for many, extends beyond the acquisition of clinical hours. We recognize that the shift to a postdoctoral-training model is substantial and will require significant institutional efforts. A change of this scope will require a fundamental shift by accrediting bodies (i.e., American Psychological Association, Psychological Clinical Science Accreditation System) that will need to be coordinated with various clinical-training stakeholders (i.e., APPIC) to inform state- regulatory boards in revising requirements for licensure. Yet, as noted by Palitsky and colleagues (2022), COVID-19 has demonstrated how flexible training programs can be in exceptional circumstances. The benefits of a postdoctoral-residency model outweigh potential costs and would address a number of concerns raised by both trainee stakeholders and other professionals (Gee et al., 2022). Although small changes in the training model would likely lead to modest improvements, an overhaul of the system toward a postdoctoral-training model will have the broadest impact on both trainees and the HSP field as a whole.

Transparency

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Note
1. Our commentary is limited to the perspectives of clinical psychology trainees; undoubtedly, a shift to a postdoctoral residency will affect trainees from the school-psychology and counseling-psychology fields, whose perspectives should be incorporated into this important conversation.

References


Inclusion of Trainee Stakeholders Is Necessary for Effective Change in Health-Service-Psychology Internship Training


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Abstract

In a recent call to action, we described pressing issues in the health-service-psychology (HSP) internship from the perspective of interns. In our article, we sought to initiate a dialogue that would include trainees and bring about concrete changes. The commentaries on our article are a testament to the readiness of the field to engage in such a dialogue, and we applaud the actionable recommendations that they make. In our response to these commentaries, we seek to move the conversation further forward. We observe two themes that cut across these responses: the impetus to gather novel data on training (the “need to know”) and the importance of taking action (the “need to act”). We emphasize that in new efforts to gather data and take policy-level action, the inclusion of trainee stakeholders (as well as others involved in and affected by HSP training) is a crucial ingredient for sustainable and equitable change.

Keywords

professional standards, public mental-health systems, health-service-psychology training, diversity, equity, inclusion

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In 2022, Clinical Psychological Science published our article, “Systemic Challenges in Internship Training for Health-Service Psychology: A Call to Action From Trainee Stakeholders” (Palitsky et al., 2022). As a group

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of 23 interns, we sought to add previously absent trainee perspectives to the ongoing, field-wide discussions about the future of the health-service-psychology (HSP) internship. The central argument of our article was that trainee stakeholders needed to be included in decision-making about the HSP internship to identify and address systemic problems in HSP training. We made 24 recommendations on the basis of the challenges that we observed and suggested a set of “questions for collaborative inquiry” that training programs might use, together with trainees, to navigate their responses to these challenges. The publication and reception of our article and the four thoughtful commentaries published in response are clear indicators of the readiness to include trainees in conversations about the future of training in the field.

Each of the four commentaries (Atkins & Mehta, 2023; Galán et al., 2023; Gee & Shackman, 2023; Knowles et al., 2023) addressed the interconnected and multifaceted challenges in HSP training, providing valuable insights and actionable strategies for change. Although we cannot respond to each point raised in the commentaries here, we focus on two overarching themes relevant to the larger discussions on HSP training that we consistently observed in the commentaries. We label the first theme the “need to know,” which reflects the many calls for additional data on HSP training to produce evidence-informed changes in the field. Then, we address the second theme—the “need to act”—which reflects the mounting, field-wide impetus to begin materially addressing the challenges in the field. Across both themes, trainee inclusion remains critical for ensuring that the next actions we take as a field support equitable and sustainable HSP training.

Given that the original authors are no longer interners (importantly, some of us are new clinical training faculty), we are joined by two current interns who have added important perspectives on current experiences of internship. Nevertheless, as Galán et al. (2023) noted, it is important to bear in mind the broader communities and still-unrepresented individuals affected by HSP and to strive to include them in ongoing work.

**Need to Know: Calls for More and Better Data in HSP Training**

Resistance [to making changes in HSP training] may be related to specific assumptions or beliefs about what constitutes “good clinical training” and optimal methods for learning. However, many of these beliefs may actually represent speculation from more privileged individuals who are drawing from their own prior experiences and what worked for them in the past. (Galán et al., 2023, p. x)

Several commentaries urged for quality data in the field of HSP training, and we strongly support these calls. Our original article’s discussion of data collection was primarily restricted to recommending (a) feedback solicitation from trainees and (b) a forum for trainees to hold internships accountable through publicly available ratings (Recommendations 20 and 24; Palitsky et al., 2022). The commentaries made meaningful additions over and above our initial recommendations. HSP is an evidence-based discipline; accordingly, data should inform the design and implementation of HSP training. Galán et al. (2023) noted that embedded practices in HSP internship are often based on assumptions about training in the absence of data. Such tacit and unfounded beliefs (e.g., that difficult training means rigorous training) can be offset by “new data streams for recursive refinement” (Gee & Shackman, 2023, p. xx) in clinical training.

Gee and Shackman’s (2023) commentary provides a well-rounded account of ways to enhance the data-collection streams in HSP training. They highlighted the importance of trainee anonymity, of collecting (and acting on) data at local and national levels, and of including trainees in the development of feedback mechanisms. Furthermore, they pointed to the importance of longitudinal data collection, a recommendation also made by Galán et al. (2023), which can help to answer quality and equity questions (e.g., In what ways are characteristics such as gender, race, number of dependents, or financial savings during internship linked with the career trajectories of trainees?). Galán et al. also emphasized that patients and other consumers of HSP must figure prominently in the research that informs training recommendations, a suggestion with which we concur. For instance, they expanded on our recommendations for improving telehealth (and tele-health access) in training: “Better understanding how telehealth can be adapted to meet the specific needs of historically marginalized populations is critical before we can draw definitive conclusions about the circumstances under which trainees should be allowed to provide telehealth services” (Galán et al., 2023, p. xx). These recommendations provide excellent starting points for collecting information about HSP training that equitably reflects the needs and experiences of all major stakeholders in training: training programs, trainees, and the individuals whom health-service training systems aspire to serve.

**Balancing Knowledge With Action**

Given the emergent emphasis on collecting new data about clinical training, we highlight two priorities that we hope will be considered in discussions about the need for more data. First, it is crucial to ensure that
newly collected data are actually representative of trainees with diverse experiences. Disparities in data often reflect societal gradients in privilege (Diebold, 2022), potentially skewing representation toward better-resourced programs and trainees (e.g., Which institutions are designing the studies on HSP training?). “Certain data are also difficult to obtain or interpret accurately, whether because of the positionality and power dynamics inherent to research with trainees, or because of imprecise fits between units of analysis and the problems we are attempting to solve” (p. 3). Lived experiences, such as ones we described (Palitsky et al., 2022), can nevertheless signal the existence of urgent issues. In one example from our article, also noted by Atkins and Mehta (2023), an intern coauthor had to take multiple jobs during internship to support their family, a situation that is disturbing but not shocking in light of already available information about internship salaries. The question remains, however: Whose lived experiences inform the narratives of clinical training?

Therefore, the second priority is that the improved collection of data should be part of a broader response that includes prompt and attentive alleviation of known problems rather than deferring action on the basis of needing more data. Although a new study about the prevalence of intern moonlighting may be illuminating, it would be misguided to wait for such a study before increasing interns’ salaries. The field knows this problem is occurring (without formal data collection), and it should act now.1 When collection of novel empirical data is not practical or expedient, we also suggest that turning to established theoretical frameworks may help guide effective action locally and field-wide. For example, in our call to action (Palitsky et al., 2022), we applied the exchange-boundary framework (Watson & Foster-Fishman, 2013)2 to understand the barriers and possible solutions to collaborative decision-making in HSP training. Interdisciplinary analyses grounded in feminist theory (Sharma, 2019), anti-racism (Diffey & Mignone, 2017), and decolonial theory (Cullen et al., 2020), which have been developed through decades of rigorous research on difficult-to-address problems, can be vital frameworks for action. Critically, nonaction in and of itself constitutes a response. The rationale for such a response is not based on data but, rather, on entrenched structures that constitute the training environment. When invited to the table, trainees have voiced that waiting for action is untenable.

Need to Act: The Time for Change Is Now

The field is in a moment of unique opportunity to consider changes—large and small—to the HSP internship. If interns are included as stakeholders in these efforts, the primary aim of our article (Palitsky et al., 2022) will have been achieved. The commentaries also provide many important proposals for concrete change, which we examine in this section.

One eminently actionable step is to make feedback count more for training programs. As we mentioned in our article and as emphasized by Gee and Shackman (2023), publicly visible feedback that is recognized by training institutions (and perhaps even included in their directory listings) can provide a powerful incentive for training sites and a direct way to include interns in power-sharing. Just as interns should be involved in the development of feedback mechanisms, they should also influence the interpretation and dissemination of the feedback results (providing a crucial and context-sensitive way of protecting them from the repercussions of negative feedback). As noted by Gee and Shackman, inviting trainees to serve and vote as members of accreditation, guideline-setting agencies, and professional organizations is a very important and achievable step. Feedback from trainees is not only a data-collection strategy but also a way to empower interns.

Importantly, strategies for involving trainees in HSP-training decisions do not need to be led by training programs and can be enacted by clinical-science forums and organizations. For example, academic journals may add weight to trainee perspectives by soliciting special issues on training that include trainee coauthors (a practice exemplified by the journal Translational Issues in Psychological Science, published in collaboration with the American Psychological Association of Graduate Students [APAGS]; Weiss, 2021). Organizations such as the Association for Psychological Science (APS) can also ensure the involvement of trainees in different aspects of HSP training by codifying collaborative trainee-stakeholder models into their standards. As Atkins and Mehta (2023) noted, “[APS-affiliated] Psychological Clinical Science Accreditation System (PCSAS) has yet to identify internship standards after more than a decade into its formation” (p. xx) despite early calls to do so (Atkins et al., 2014). Establishing such standards is imperative.

Balancing Action With Knowledge: Reflections on a Postdoctoral Internship

A core issue noted by all commentaries is that although internship is a required part of doctoral training, it is only loosely connected with interns’ doctoral programs. Perhaps the most prominent large-scale solution recommended in the commentaries was a transition to a postdoctoral internship (i.e., internship would begin after completion of the doctorate). This idea has been raised...
recurringly over the years (Berenbaum et al., 2021) and was advocated by Knowles et al. (2023), Galán et al. (2023), and Gee and Shackman (2023). On the other hand, Atkins and Mehta (2023) recommended strengthening ties between internships and graduate programs. We, much like the authors of the commentaries, are not uniformly in opposition or in favor of a shift toward postdoctoral internships. Although Galán et al. interpreted our article as "predicated on" a predoctoral model of internship (p. xx), we wish to clarify that we wrote about internship in the only way we have experienced it and not as an argument for retaining the predoctoral model.

Advocates of the postdoctoral internship anticipate many potential benefits of its adoption. Knowles et al. (2023) recommended a transition to postdoctoral internship as a high-impact initiative that would prevent programs from selectively deciding which recommendations for action in HSP training to take up. If its proponents' best intentions are realized, these benefits would indeed address a number of our recommendations (Palitsky et al., 2022), including improved understanding of the status and roles of interns (Recommendations 1–3), elimination of redundant training, excessive focus on training hours and improved choice in training (Recommendations 4, 6), improved pay and benefits for interns (Recommendations 14–16), elimination of tuition and fees for interns still in their graduate programs, and greater parity with the physician model of training (e.g., formalizing “interns/internship” as “residents/residency”). However, these are potential strengths, and—as with the other recommended changes—a shift as large as a transition to postdoctoral internship should be carefully evaluated to constitute a real improvement for trainees.

We emphasize that each of the recommendations we made in the initial article (Palitsky et al., 2022) remains relevant, and if a transition to postdoctoral internship occurs, sustained quality-improvement initiatives aligned with our recommendations are still needed. It remains unclear to what extent these recommendations would be effected in a transition to postdoctoral internship. For example, it is not guaranteed that a postdoctoral internship would shift training benchmarks from clinical hours to competencies (Recommendation 4), that trainee approval would be sought when training aims change (Recommendation 7), or that trainees would have broad representation in the infrastructure of training (Recommendations 20–24). These recommendations would still need to be pursued, and we do not believe that the only choice is between cherry-picking solutions or adopting one singular, sweeping change. To address the many issues that require consensus, we recommend dedicated forums for discussion and dialogue to identify criteria that would need to be met to justify such a change, which should meaningfully include trainee stakeholders.

If we are to achieve a trainee-stakeholder model in HSP training, perhaps the most integral question is whether postdoctoral interns would, in fact, have more voice in training. Galán et al. (2023) stated that “As postdoctoral fellows, interns could play a critical role in the evolution of internships.” (p. xx). However, the postdoctoral role is notoriously exploitative (Greenberg, 2003), particularly of women, BIPOC (Black, Indigenous, and other people of color) individuals, international workers, and underserved populations (Ålund et al., 2020; Bodin et al., 2018; Ding, 2021; Karalis Noel et al., 2022). Many of this article’s authors have now completed postdoctoral fellowships, and we cannot in confidence state that we have had greater opportunities for input into our own training during our fellowships than we had during internship (some authors have; some have not). Postdoctoral internship may be a deferral, rather than a solution, to solving the existing problems with the HSP internship as long as postdoctoral fellows also lack real influence on training.

**Discussion**

More and better data are important, but in the absence of meaningful power-sharing, trainee concerns and suggestions can easily be ignored. (Gee & Shackman, 2023, p. xx)

There are clear tensions in our responses to these commentaries: We urge for better data on HSP training, but we also advocate against waiting for the data to come in. We call for action now, yet we hesitate at big changes such as postdoctoral internship. To help manage these tensions, we return to the trainee-stakeholder and collaborative approaches that we advocated in our article (Palitsky et al., 2022) and this commentary. We introduce a simple heuristic: Are trainees included or excluded? The application of this heuristic to the need to know and the need to act is illustrated in Figure 1. For example, data collection is an important tool for representing the impacts of policies on trainees, clients, and others with a stake in HSP training as long as the data reflect and represent their experiences. Importantly, data should not be made to stand in the place of trainees or act as a barrier to their inclusion. Specific kinds of data gathered on behalf of trainees should not be required to legitimate trainee concerns. Likewise, concerted action is needed in response to the serious challenges of HSP internship. When trainees are included collaboratively, the field begins to directly address problems in training. However, when
large-scale changes are made on the administrative level on behalf of trainees without including them, it is easy to make oversights, even with the best of intentions. In the impetus for greater knowledge and effective action to improve HSP training, trainee inclusion is key.

In that spirit, we recapitulate that deliberate efforts to develop new policies that support trainees across the field are needed now. We concur with Atkins and Mehta (2023) that guidelines for internship from APS are long past due. Even provisional guidelines, perhaps published as the summary statement from a nationwide meeting, would represent a visible benchmark that can be followed with action from PCSAS and other training entities. Training agencies and entities in clinical, counseling, and school psychology, including PhD and PsyD programs, would be important collaborator-stakeholders in such an effort. There are already existing initiatives moving in this direction in HSP, such as recent efforts by the Coalition for Advancement and Application of Psychological Science, which includes members of many professional societies and organizations instrumental in training (e.g., Park & Stewart, 2022). “Boulder 2.0” has also become an increasingly popular idea, which may be realized in planned meetings such as the Summit on Clinical Science Training (Academy of Psychological Clinical Science, 2023). We call for trainees, including especially trainees of historically marginalized positionalities, to be included as partners in these next steps for training reform. In addition to these top-down change strategies, individual programs can make meaningful changes that are locally responsive while advocating for larger systematic national changes rather than waiting for them to occur from the top-down, as exemplified by Atkins and Mehta (2023).

Note that articles such as ours (Palitsky et al., 2022) may be helpful for beginning to explore issues relevant to interns, but reading the experiences of a group of interns who are not local stakeholders to a given program is not a suitable substitute for including local interns. We do not write on behalf of all trainees in this commentary and speak only from our own experiences and understandings of clinical training. Although there were many voices included in our initial article (Palitsky et al., 2022) and the commentary responses, many perspectives remain unrepresented. At the same time, our assessment points to the importance of action because the cost of inaction is an untenable status quo. In the responses the field takes to the many calls for action in HSP training, including trainees as stakeholders will be vital for an equitable and sustainable future.

**Transparency**

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Notes

1. The data on interns’ salaries are in Hood et al. (2022) and have been available on public databases (e.g., APPIC Directory Search: https://membership.apppic.org/directory/search) for some time. As an important step in the right direction for our field, the Veterans Administration (VA) recently announced an increase in intern salaries by 27% (G. Keillin, listserv communication, January 10, 2023). We hope, as we suggested in our (Palitsky et al., 2022) article, that non-VA internships will follow the lead of the largest entity in HSP internship.

2. We became aware of this framework because one of our article’s reviewers invited a current intern to contribute to the review, for which we are grateful. This experience illustrates the importance of including trainees in efforts to improve HSP training and the unfortunate reliance on conscientious faculty to ensure their inclusion.

References


