APTC BULLETIN

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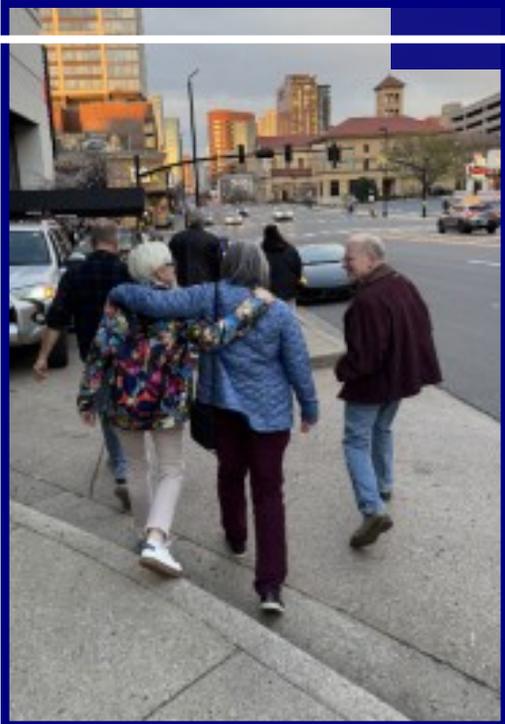
The Association of Psychology Training Clinics (APTC) is a professional organization for directors of doctoral-level psychology training clinics, as well as interested associates and affiliates. The organization is affiliated with the American Psychological Association (APA). APTC has established a multipurpose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

A Promote high standards of professional psychology training and practice in psychology training clinics;

B Facilitate the exchange of information and resources among psychology training clinics that provide doctoral-level practicum training in professional psychology; and

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

PRACTICUM EDUCATION AND TRAINING

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DIVERSITY STATEMENT

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

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EDITOR'S STATEMENT

In this edition of the bulletin, I am brought back to our amazing conference in Nashville with each and every article. The depth and breadth of expertise inspire me as a clinic director, a clinician, and a researcher. The wealth of knowledge within our APTC community and the generosity amongst our members to share that knowledge leaves me in awe! As we plan for our next meeting in Plano, reflecting on the past and focusing on the future is the goal. Putting all we do into words can be a challenge, so with the help of AI, I leave you with this as we celebrate looking back and progressing forward as dynamic and impactful professionals and colleagues.

– Stephanie

Constellations of Purpose

WRITTEN BY STEPHANIE R. MCWILLIAMS, ASSISTED BY CHATGPT

Across the map, a quiet fire—
in city lights and wide expanse,
we rise each day to meet the call
of work that weaves both chance and stance.

Our roles are many—sharp and deep,
a thousand tasks in shifting shape,
yet in our hands, the chaos folds
into a form that minds escape.

One builds with knowledge, steady, sure,
another crafts with words that heal,
some guide with care, some dare to dream,
all work with heart the world can feel.

Though miles stretch long from shore to plain,
your spirits echo in my chest—
each voice a chord within the song,
reminding me to give my best.

You teach me grace in pressure's grip,
how to adapt, how not to stall—
and in your journeys, I find mine,
reflected in the rise, the fall.

We are not close by place or line,
but closer still by shared intent—
a scattered team of stars that shine
in constellations, heaven-sent.

PRESIDENT'S COLUMN

Howdy, APTC Members!

It was truly wonderful to see so many of you in Nashville this past March for our annual conference. There's something magical about gathering in person—sharing stories, catching up with old friends, and warmly welcoming new colleagues into our community. Thank you to everyone who made the trip, contributed to the program, or supported your fellow directors in attending. Nothing beats being among those who truly understand what we do each day! Our theme this past year, *The Art and Science of Clinic Direction*, captured the complexity and craft of our work. I hope you left Nashville with new ideas, practical tools, and meaningful reflections to bring back to your clinics. Perhaps you're already experimenting with new strategies or having rich conversations with your programs about how to strengthen training and client services.

Looking ahead, I'm excited to share that the theme for our next conference will honor a significant milestone: 46 years since the founding of APTC. Over nearly five decades, our organization has grown, matured, and evolved. We'll take time to celebrate our roots and the ways collective wisdom has deepened across the years, while also reflecting on how each new generation of directors brings fresh energy, insight, and innovation to our work. This theme resonates with me personally. When I was a child, there was an elderly member of our community who, each week, would reflect on the generations that had come before and those who were growing up. He often repeated the phrase, almost rhythmically, "from generation to generation…" My friends and I used to mimic him, but as an adult, I've come to appreciate how profound those words truly are.

Now, I see this cycle more clearly. I watch my children grow and begin to find their places in the world. I am starting to care for aging parents. As a director, many of my mentors have retired, and I think about (or dream about!) my own retirement. At the same time, I'm energized by the passion and creativity of our mid-career and new directors. What strikes me is that these influences are not linear. We don't simply pass the torch in one direction. Instead, we continually shape and reshape one another. Seasoned directors continue to inspire with their wisdom and perspective, while newer directors bring fresh ideas that spark innovation for us all. Those in the middle of their careers both guide and are guided, weaving a dynamic, reciprocal pattern of influence that makes APTC stronger.

This is the heart of APTC: a living, breathing organization that grows stronger through the contributions of each generation of clinic leaders. Next year's conference will not only reflect on where we've come from, but also look with hope and enthusiasm toward where we are headed—from generation to generation. And of course, our commitment to one another is not limited to the annual conference. Our committee work is in full swing, and this is a great time to think about getting more involved. If you've been inspired to lend your expertise, please don't hesitate to reach out to our committee chairs. There is truly a place for everyone who wants to contribute, learn, and grow together.

Our mission has always been to ensure that no director feels alone in this work. Whether you're a seasoned leader or brand new to clinic direction, APTC is here to support you. Thank you all for being part of this incredible community. Let's continue the conversations we started in Nashville and keep building this strong network of support throughout the year. I look forward to seeing y'all in Plano, Texas, in March!

Jennifer Schwartz, Ph.D., ABPP
Director of the University of North Texas
Psychology Clinic; Clinical Professor
Association of Psychology Training
Clinics- President

A P T C A W A R D S

2 0 2 5 C O N F E R E N C E

The APTC Spruill Award

Jennifer Schwartz

In recognition of your longstanding active involvement in APTC, commitment to excellence in training, dedication to innovative and best practices in doctoral psychology training clinics, and inspirational leadership.

Stephanie McWilliams

The APTC Research Award

In recognition of the APTC Clinic Director who is conducting important research in and/or through their training clinic.

Mentorship Awards

Robyn Mehlenbeck

In regonition of the APTC Training Clinic Director who demonstrates extraordinary mentorship of another training clinic directors.

The Clinic Innovations Award

Anne Stevens

Sarah Taber-Thomas

Nancy Liu

TO LICENSE, OR NOT TO LICENSE?

THAT IS THE QUESTION

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According to responses from the 2024 Association of Psychology Training Clinics (APTC) member survey, approximately 82% of training clinics offer sliding scale rates; however, with average fees under $500 per assessment and $20 per therapy session, training clinics often require additional revenue beyond client fees (Hersh & Farmer, 2024). For clinics in one of the 20 states that allow licensure at the master's level (APA, 2025), contracting with insurance providers to bill for reimbursement may be one option.

In North Carolina, individuals may apply for licensure as a Licensed Psychological Associate (LPA) after completing their master's degree and 500 hours of supervised clinical experience. The UNC Greensboro (UNCG) Psychology Clinic requires students in the MA-PhD Clinical Psychology Program to obtain LPA licensure, which enables them to bill for reimbursement while still under the supervision of licensed faculty. Although 7% of psychology training clinics accept insurance (Hersh & Farmer, 2024), to our knowledge, they bill for the services of licensed providers (faculty, supervisors), making UNCG unique in its approach to billing for student clinicians. This article reviews the costs and benefits of this process.

Financially, the Clinic covers all costs for licensure and credentialing applications, background checks, and exam fees – about $1,200 per student. While private insurance companies offer higher reimbursement rates, we contract with select Medicaid managed care organizations (MCOs) to expand access to care and offer unique training experiences for clinicians; otherwise, clients are considered "self-pay" and can apply for financial assistance to determine a rate on an income-based sliding scale. This past year, 87% of clients qualified for and utilized the clinic's financial assistance. NC Medicaid pays about $108 per therapy session, similar to our standard fee. Given the high utilization of our financial assistance, self-pay clients pay on average $38/session. Similarly, Medicaid reimbursement ranged from $500 to $1,500 per client, depending on the time and whether prior authorizations were approved. Despite a standard self-pay rate of $1,365 per assessment, the average payment for self-pay clients is $590. This means that accepting Medicaid cases has the potential to yield more income than the average rate charged to self-pay clients: approximately $70 more per therapy session and up to hundreds more per assessment, mutually benefiting both clients and the clinic. With steady clinician and client

availability, this model could cover the cost of student licensure and earn additional income -- with this clinic historically generating excess revenue, offering payment to advanced students for conducting assessments after finishing practicum requirements, but it is impacted by many factors.

Students are expected to obtain licensure before their advanced practicum (AP) year in the clinic (generally 4th year in the program), when they must complete 350 direct contact hours. In practice, their timeline is sensitive to delays completing master's theses, submitting licensure material, constraints by university-set degree conferral dates, and application review time from the state board (e.g., 3-6 months) before students have a 4-month window to take the EPPP. Ultimately, students may only have a few months of supervised practicum in the clinic after licensure. However, being licensed is an asset that allows our graduate students to receive funding for clinical training at external practicum sites (e.g., hospitals) where they can bill for licensed services.

The clinic ranges between zero and five licensed and Medicaid-credentialed clinicians (with an average of 1-2 per adult and child rotation) throughout the year, based on cohort size and as students reach their milestones. Given the low number of providers, the clinic contracts with only two Medicaid MCOs. Even so, waitlist times for Medicaid assessments are regularly six months or longer. Medicaid-eligible clients are offered the option to decline using benefits to self-pay with financial assistance, although this may be less financially beneficial to both parties, to potentially be seen sooner by one of our many non-licensed trainees.

After credentialing, students must complete 3 Medicaid assessments or therapy cases at the clinic to offset licensure costs and generate revenue. Unfortunately, this does not always happen as students have left the program prematurely (after licensure has been funded), attained licensure too late, and/or historic vacancies in trained staff to submit claims. This past year, licensed students completed 3-4 cases (yielding $2000 to $3500 revenue per clinician), though one outlier, licensed earlier than peers, saw 17 Medicaid cases.

Concerns regarding managed care for mental health are well-documented (e.g., Sanchez & Turner, 2003). Even with a dedicated billing coordinator, funded by the university/department, Medicaid claims are time-consuming and often denied. For example, dually insured clients require that out-of-network claims be submitted to their primary insurance company before Medicaid will review them, leading this clinic to historically offer these clients services pro bono due to low success rates.

To alleviate the impact of insurance restrictions, the clinic encourages clinicians and supervisors to base clinical care decisions on best practices regardless of prior authorization. As a result, additional services (e.g., more hours, uncovered types of services such as educational testing) are sometimes provided without reimbursement. Additionally, unlicensed trainees may occasionally be permitted to see Medicaid clients who have declined the option to self-pay for services on a pro bono basis, according to training needs and waitlists, benefiting both trainees and clients.

From a training perspective, the clinic must also teach didactic content to Centers for Medicaid and Medicare Services (CMS) guidelines, such as how to add Current Procedural Terminology (CPT) codes for services and enforce requirements for adequate documentation of services, including obtaining final

supervisor signatures in a timely manner, as there are potential consequences for "clawbacks" of CMS revenue (i.e., taking back money already paid to the clinic) for non-adherence to policies.

In addition to the authors' perspectives as a current student and clinic director, the authors gathered feedback from five program alumni at various career stages (two recent internship graduates, two recent early-career psychologists, and one mid-career psychologist) to reflect on their experiences applying for Master's-level licensure before internship. Their reflections, synthesized below, capture a range of perspectives, from strong endorsements of the requirement to critical concerns regarding its timing and practicality.

Financial: Students valued not having to retake the EPPP to become a licensed psychologist (LP) after graduation, as most pass at the doctoral level, and appreciated that the program covered all initial licensure costs. One cited a distinct benefit compared to peers applying for licensure while on a postdoc, where reimbursements were capped, if offered at all. Another highlighted the advantage of potentially using their license to see clients immediately after internship graduation if remaining in the state.

Professional Considerations: Several students reported feeling pressure from Clinic supervisors to prioritize Medicaid clients from the long waitlist, which sometimes conflicted with their training goals. Some students recalled that internship sites were impressed by their passing of the EPPP, whereas another student noted that prospective sites didn't seem to understand their licensure.

Timing and Recall of EPPP Content: One student described that "taking [the EPPP] during grad school

is honestly the best time, when coursework was fresh and study habits intact. Another indicated her "postdoc peers spent a longer time preparing because they had forgotten a lot of the information." Alumni noted that during an internship or postdoc, studying would have been harder as the "cognitive load is dedicated almost exclusively to client care" and job searches.

Stress, Burnout, and Timing Challenges: Several described significant emotional and logistical costs. One student recalled feeling like an imposter after applying for licensure before completing coursework and felt significant pressure to pass the EPPP at the doctoral level. One graduate recounted, "The semester I studied for and then took the EPPP, my mental health was at its worst... I required more [emotional] and social support, got less sleep, worked every weekend, and really struggled to have a work/life balance." Some argued the requirement overlapped too heavily with other program milestones and should be restructured to eliminate a different requirement. One remarked that it felt slower-paced and could have been less stressful to study during a postdoctoral position rather than graduate school.

Lack of Structured Support: Alumni reported feeling a lack of guidance for licensure applications, exam preparation, and timing. They recommended more apparent timelines with earlier preparation, didactic integration, and peer-led study groups. The program has since developed more resources, including annual meetings, though timing and workload challenges persist.

Student perspectives varied widely – from strong endorsements ("I 1,000% think we should keep it as a requirement) to outright doubt in the requirement's value ("I wish students weren't placed in this

position…"). Some called it "helpful and worth it," while others described it as unnecessarily stressful.

Clinics considering this approach must weigh the fee structures, client demographics, state requirements, and the ability to process claims effectively. From the trainee's perspective, early licensure may offer financial and professional benefits, but it may also add emotional and logistical burdens. Programs that require students to apply for licensure should provide clear timelines, minimize overlapping requirements, and integrate structured EPPP preparation to reduce burnout and emotional exhaustion during the years in the program when risk is highest (i.e., the third and fourth years; Rico & Bunge, 2020).

Overall, whether the requirement for graduate students to obtain licensure at the master's level is "worth it" may depend on who you ask and how the clinic is otherwise funded. The costs of timeline challenges for students becoming licensed, fluctuations in trained billing staff, delays between services provided and receiving reimbursement (not guaranteed; often requires multiple submissions and additional documentation to justify service provision), and student stress surrounding the EPPP remain outweighed by the benefits. When all goes well, this requirement has the potential to be rewarding for students to have licensure covered and gain unique clinical experience, including potential paid opportunities, while financially benefiting the clinic and expanding access to care. The UNCG Psychology Clinic is proud to offer these training experiences to students and expand the impact of our services in the community.

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BEYOND CLINIC WALLS

THE ROLE OF OUTREACH IN BRIDGING THE GAP FOR UNDERREPRESENTED STUDENTS

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Underrepresented students in higher education face higher rates of mental health challenges compared to their peers. Their elevated mental health issues are often linked to systemic inequities, campus climate, and the difficulties of navigating institutions that may not reflect or support their lived experiences (Frost et al., 2020). Mental health support systems for these students are frequently inadequate, which lowers their likelihood of seeking help (Frost et al., 2020; Kook et al., 2023; Lipson et al., 2023). Traditional mental health services on campuses have shown mixed results in engaging these populations (Abrams, 2022).

A history of marginalization and medical harm has justified mistrust in healthcare and a hesitancy in mental health treatment seeking among minority communities (Armstrong et al., 2008; Atdijan & Vega, 2005; David, 2010; Nurriden et al., 2020; Richmond et al., 2024; Suite et al., 2007). For underrepresented college students, stigma, underrepresentation, and an age-appropriate unfamiliarity with healthcare systems further decrease their likelihood of pursuing treatment (Frost et al., 2020; Lipson et al., 2023). As a result, interventions that incorporate cultural awareness and humility have become essential to providing quality care and advancing health equity (Brooks & Hopkins, 2017; Chin, 2000; Cross, 1989; Fischer et al., 1998; Sue et al., 1982). On campuses, efforts such as

multicultural competency, adapted interventions, and proactive outreach are culturally responsive strategies aimed at addressing structural inequities, though additional considerations are still needed (Frost et al., 2020; Golightly et al., 2017; Lipson et al., 2023; Reetz et al., 2016). In response to these systemic barriers, our training clinic developed a model that integrates identity-matching with culturally responsive therapy and outreach to better support underrepresented college students.

The CSS Model: Clinical and Outreach Integration

Our training clinic at the University of Wisconsin-Madison developed the Community Support Specialist (CSS) role in partnership with University Health Services. UW–Madison is a large public institution with over 51,000 undergraduate and graduate students enrolled (University of Wisconsin–Madison, Office of the Registrar, n.d.). It is a predominantly white institution, with approximately 56.5% of students identified as white (University of Wisconsin–Madison, Office of the Registrar, n.d.). The CSS position is designed for advanced doctoral trainees in our training clinic, which combines both clinical and outreach responsibilities. CSSs are selected for their critical thinking skills and their ability to implement theory-driven, evidence-based, and culturally responsive interventions.

Research indicates that shared racial or cultural identity between client and provider enhances the therapeutic alliance, building trust and increasing engagement (Chao et al., 2012). Therefore, CSSs are also selected based on their identity, background, and training, with identity encompassing dimensions such as race, ethnicity, gender, sexual orientation, socioeconomic status, and other lived experiences. Training for CSSs emphasizes cultural humility and identity-informed care because many CSSs share similar identities and lived experiences with the students they serve, fostering deeper rapport and trust.

Clinically, CSSs offer individual therapy to underrepresented students affiliated with campus scholarship programs. This involves offering one-on-one, long-term therapy sessions at no charge to students, scheduled on a weekly or biweekly basis. Clients and therapists are paired based on identity and client preferences. CSSs are encouraged to utilize various theoretical orientations as part of case conceptualization while being guided to include frameworks that emphasize culturally responsive practices, cultural humility, and justice advocacy. The therapeutic approach extends beyond immediate concerns to include a broader understanding of clients within their family, cultural, and historical contexts. This involves examining systemic influences, identifying support systems, recognizing cultural strengths, and integrating indigenous or culturally specific healing practices. Many CSSs follow guidelines from the radical healing framework (French et al., 2020), prioritizing client agency and community support throughout therapy.

Complementing this work, CSSs participate in outreach activities that provide collective support. Many underrepresented students in the scholarship programs arrive on campus in cohorts, bringing cultural values that prioritize community care over individual treatment. In response, the CSS outreach model was created to connect clinical services with community wellness, changing how students engage with mental health support. Outreach is based on student-requested topics (e.g., imposter phenomenon) and adapts to campus dynamics and broader sociopolitical events that shape student needs. By expanding mental health conversations beyond traditional clinical settings into familiar community spaces, CSSs help normalize seeking mental help and reduce stigma. These efforts are rooted in authenticity and shared vulnerability, as CSSs model openness by sharing personal experiences and acknowledging the barriers faced by underrepresented students at predominantly white institutions. This approach builds trust, enhances peer connections, and helps students realize they are not alone in their struggles. Outreach sessions are designed to accommodate students at different comfort levels, including the use of worksheets for individual reflection during group discussions. In the 2024-2025 academic year, CSSs conducted 29 outreach sessions, reaching 581 students over 36 hours, with each session leading to more requests for both follow-up visits and individual therapy appointments.

Identity-Informed Care and Outreach

The effectiveness of the CSS model is further supported by research on identity-informed care and outreach. Client-therapist identity alignment interventions can build trust and engagement, especially when shared identity strengthens the therapeutic alliance—a key predictor of clinical success (Cruwys et al., 2023; Pettyjohn et al., 2020; Steffens et al., 2021; Wampold & Imel, 2015). For underrepresented populations, racial/ethnic matching

is often preferred and improves engagement and outcomes (Cabral & Smith, 2011; Kim & Kang, 2018). Although findings on racial/ethnic matching vary, studies suggest that when used thoughtfully—considering client preferences, intersecting identities, and provider characteristics—matching can enhance treatment (Cabral & Smith, 2011; Imel et al., 2011; Kim & Kang, 2018). For instance, Kim & Kang (2018) found that matched dyads had higher attendance and better treatment gains, influenced by provider traits. Intentional identity matching is, therefore, a promising approach to reducing disparities affecting these students.

Furthermore, the preference for identity matching emphasizes the importance of community-based outreach led by underrepresented clinicians. This expands service delivery beyond the clinic, supporting psychoeducation, health promotion, and collaborative prevention efforts—while also showcasing institutional commitments to equity and inclusion (Golightly et al., 2017; Reetz et al., 2016). Since 2009, the Association for University and College Counseling Center Outreach (AUCCCO) has recognized outreach as a vital strategy for reaching underserved students (Reetz et al., 2016). Overall, the literature advocates for institutional investment in identity-informed interventions to increase service use by underrepresented college students. Accordingly, the CSS model intentionally integrates identity matching into both clinical and outreach efforts.

CSS Voices: Reflection of Impact

The CSS role provides unique, comprehensive training opportunities for advanced doctoral trainees. Trainees gain hands-on experience in delivering culturally responsive care for a variety of presenting issues while being fully embedded in the student community. This environment encourages CSSs to incorporate cultural humility into their clinical and outreach efforts, utilizing supervision, peer consultation, and scholarly literature. CSSs are supervised by a licensed psychologist who emphasizes reflective practice, ethical boundaries, and outreach-specific consultation. Because this work requires emotional investment and relational depth, the role can be both emotionally and intellectually demanding, making ongoing supervision and support essential for sustaining CSSs in this community-focused position. CSS trainees have reflected on the transformative impact of their roles, highlighting the importance of community-centered care, identity and representation, and professional development (Microsoft, 2025).

CSS trainees, who are also co-authors of this paper, emphasized the importance of meeting students where they are—physically, emotionally, and culturally. As **Kevon** shared, "Equitable care requires more than clinical skill. It sometimes demands boots on the ground and being trusted advocates." **Chi** echoed this, noting, "Making mental health more accessible means stepping outside the therapy room—into our communities, to listen, to learn, and to serve." They also reflected on the power of shared identity, which emerged as a key factor in building trust and increasing access. **Kevon** reflected, "I have witnessed how my visibility as a Black man impacted access, seeing young men of color seek therapy after outreach events I co-facilitated." Similarly, **Nasitta** noted, "Working with students who shared similar identities and experiences deepened my reflexive practices, strengthening my professional identity and personal growth." Moreover, the CSS role challenged trainees to grow both personally and professionally. **Natalie** described the experience as "deeply

humbling and challenging, pushing me to confront my own biases, practice new levels of reflexivity, lean on support systems in new ways, and redefine what caring for myself looks like."

Conclusion and Call to Action

We urge training clinics to adopt identity-informed clinical and outreach models, such as CSS, to foster equity, representation, and access in mental health care. By embedding care into community environments and centering shared identity, CSS roles foster trust, reduce stigma, and expand access to mental health support for underrepresented students (Microsoft, 2025). These roles move beyond traditional therapy by meeting students where they are—physically, culturally, and emotionally—through outreach, consultation, and systems-level collaboration. Trainees gain hands-on experience in both individual therapy and community-based care, developing essential skills in equity-focused service delivery, advocacy, and collaboration. This dual approach not only strengthens social capital and campus partnerships but also prepares future psychologists to deliver culturally responsive care. Supervisors play a critical role in modeling flexibility, cultural humility, and advocacy—qualities vital for sustaining non-traditional roles (Benuto et al., 2018). In supervision, we also address the potential pitfalls of ethnic and racial glossing, where shared identity markers may lead trainees to over-assume similarity in lived experiences with clients. CSS trainees are encouraged to remain reflexive and curious, recognizing that identity matching can foster connection but must be approached with nuance and humility. We emphasize that cultural responsiveness involves not only shared identity but also an openness to difference, complexity, and the unique narratives each client brings. Ultimately, the CSS model demonstrates how integrating identity matching with place-based clinical and outreach practices can transform mental health access and outcomes for historically marginalized students.

Acknowledgement

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Supporting Student Clinic Directors in
RECOGNIZING AND PREVENTING BURNOUT:
Introducing Habits for Career-Long Sustainability

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In addition to the already rigorous training expectations doctoral students manage, those who additionally become Student Clinic Directors (SCD) must balance and task-switch among significant administrative roles such as managing personnel and clinic liabilities, training others on policies/procedures, overseeing audits, and program development efforts. These roles require 1) insight into personal capacity and 2) a necessity to enforce boundaries, which can be challenging for trainees who may be overachievers or perfectionistic at baseline. Acquiring these competencies can impact long-term personal sustainability throughout our careers, far beyond graduate school.

What is burnout, and why does it matter?

The International Classification of Diseases (ICD-11) defines burnout as an occupational syndrome that occurs when chronic workplace stress is not managed, characterized by dimensions of exhaustion, distance or cynicism toward work, and low self-efficacy (World Health Organization, 2022). Burnout has notable consequences for life satisfaction, typified in the once passionate professional who becomes apathetic due to an unsustainable workload, and it also impacts productivity and incurs economic losses (Edu-Valsania et al., 2022). Burnout is posited to be triggered by organizational factors such as high demands, inadequate support, low autonomy, and emotional labor (Edu-Valsania et al., 2022), factors often prevalent during graduate school and in academia. Burnout rates show increasing trends since COVID-19 among mental health care workers (Mohr et al., 2025), with a need to build upon our knowledge of what strategies work to prevent and address it (Dreison et al., 2018). Though some work stress may be out of one's control, the effects of this stress are influenced by individual factors such as personality and coping styles (Edu-Valsania et al., 2022).

The close professional relationship between a Clinic Director (CD) and an SCD offers a unique opportunity for modeling, mentoring, and parallel processing regarding burnout that can translate beyond graduate school into internship, early career professions, and everyday life. Prioritizing this skillset in training is arguably more important than ever, as our trainees are working in a post-pandemic world in which the opportunities to "remote in" for work, regardless of whether you're sick, on vacation, or not scheduled, have reinforced a culture of constant accessibility, coupled with ever-growing mental health needs across the nation.

Implemented Strategies

Calendar Autonomy
Though it might feel counterintuitive, we have found that *expanding* operational hours and calendar

autonomy protects against burnout more than forcing schedules upon others (e.g., closing the clinic at 4 PM to "force" evenings off). For example, our clinic is now open year-round, 8 AM – 9 PM Monday – Friday, and by appointment on Saturdays, and no one is forced to observe a specific holiday schedule. Rather, students are encouraged to engage in self-reflection to determine their own holidays and schedule needs. We have found that not only is this more inclusive of student diversity and values, but it also better meets the needs of clients and creates space for students to *participate fully and thoughtfully* in managing their boundaries, time, and rhythms for productivity and renewal.

Schedule Flexibility

SCDs have the ability to flex hours and modify schedules throughout their rotation. A shared spreadsheet is kept to monitor any overwork that might occur, so students can accordingly take time off to recalibrate. In the spreadsheet, students can organize time spent in SCD-specific duties (e.g., answering questions for peers; restocking copies/files, responding to emails). This tool draws their attention to the level of necessity and sophistication of their tasks, while allowing us to collaborate on titrating appropriately. Insights that follow: "I'm spending too much time answering other students' questions – how can I set a boundary without being mean?", "I want to increase my time with clients, but the admin tasks feel equally important – what if I delegate incorrectly?" Whereas the CD may look at the spreadsheet and note, "I see emails and documentation are taking increased time, let's discuss some strategies to help," or "Data suggests you still have 15 hours of overtime banked. What is getting in the way of you taking this time off for yourself?" These conversations help students build delegation, leadership, inhibition, and time management skills

important for administrators in training. *Clinic work and administration are like laundry. There is always something to be worn or washed, and it is not all of equal importance at all times.*

Behavioral Activation Dress Code

We propose that professionalism is fostered through character and behaviors rather than arbitrary dress codes (which tend to lack inclusivity as well). SCDs are shifting between many roles throughout a given day, often walking extensive distances and being away from home for long periods of time. Having close proximity to campus amenities like the gym and outdoor spaces can be highly protective against burnout, but only if students have feasible opportunities to access them (facilitated by Calendar Autonomy and Schedule Flexibility discussed above). Allowing for behavioral activation conducive dress increases accessibility, inclusion, and overall comfort as it relates to movement, connection, and recovery throughout the day – all of which have de-stressing impacts and protect against burnout. *Practicing what we preach is a valid form of professional development.*

Purposeful Mentorship

Prioritizing didactics, supervision, modeling, parallel processing, and bidirectional accountability is key to preventing, recognizing, and addressing burnout. There are numerous ways to incorporate our training on reinforcement, operant, and relational conditioning, "thinking traps", unhelpful stories, values-driven action, and more in scaffolding SCDs to examine and identify variables contributing to burnout. Connecting burnout to the concepts, theories, and interventions you are already teaching can be relevant and seamless. It also encourages engagement in the self-reflective process and appropriate supervision-seeking. Receiving this

training during graduate school is likely a critical developmental window that, if missed, may require extensive life/work circumstances (and unwanted consequences) before acquiring prioritization skills. *The time is now: burnout prevention should not be an elective training experience.*

Just Say "No"

No matter how much you preach about setting boundaries, SCDs can never learn to master this skill without 1) consistent opportunities for deliberate practice, and 2) safety/support when saying no. Fortunately, SCDs are given more opportunities than they can ever feasibly commit to, so this role facilitates excellent "strength training" for building the "no" muscle. Strategies that can be helpful include encouraging autonomy when prefacing opportunities, such as saying "Remember, choosing no is an option" and processing decision-making afterwards ("Which factors led you to say yes/no to this responsibility?", "How do you feel about your yes/no now?"). Radical recognition can also be helpful: "I'm hearing a soft no; give me a firm unapologetic no," or "excellent no'ing!". Modeling the use of deliberate "no'ing" by the CD is also a meaningful training strategy. This may take the form of a mental health day—when one says "no" to an entire day of work. Ideally, these mental health days are seen as a professional development strength, and this mindset is promoted when training directors utilize Purposeful Mentorship as discussed above. Developing insight into our capacity and practicing boundary setting in many forms helps students build a differentiated "no" muscle.

Student Clinic Director Reflections

SCDs have been receptive to these strategies, though not without a sense of uneasiness and skepticism in some cases. Many SCDs might be used to regular working hours and deadline expectations, and acquiring these burnout-prevention skills is often an iterative process. When first told that they can say no to opportunities, an SCD might wonder if saying no will later affect evaluations and put them behind other students.

For one SCD, individual supervision meetings were especially helpful for building burnout prevention skills and clarifying work expectations in a more flexible environment. Openness to evaluating the decision-making process, such as "These are the reasons why I feel compelled to say yes, say no, or delegate this responsibility or opportunity; I'm noticing I feel pulled in _____ direction; are there other factors I should consider?" fostered helpful supervisory conversation and scaffolding.

Another SCD, now an Early Career Professional, expressed: "My time as an SCD deepened my understanding of my values as a student, leader, and person. I recognized that exhaustion could no longer serve as a metric for my personal and professional worth and that I was not on a sustainable trajectory. I navigated the discomfort of taking time for rest within a culture fueled by overachievement and was mentored to protect my well-being with the same determination and fierceness I used to pursue my goals. Now, I recognize I'm a better clinician, researcher, and human when I pause, recharge, and stop allowing myself to run on empty chronically. Having landed in a toxic rotation during internship, these protective SCD gifts proved invaluable and continue to inform healthy practices for my early career."

Clinic Director Reflections

Being in this role during and post-pandemic, workplace traditions have been challenged and explored like never before. Some folks discovered their work was best when followed by an afternoon walk outside, when condensed to the very early mornings, or when chunked into AM and PM time-blocks with space in between for rest, play, or connection with others. I have found that creating a workspace and a training space that not only allows for this exploration but also encourages it is a critical component of burnout prevention and creating a healthier workforce.

Not only is this a gift I strive to give SCDs, it is a gift I continue to receive when they encourage me to maintain my own burnout-prevention strategies: "I noticed you have not been leaving to play basketball lately – do you need a burnout check in?" and by way of reinforcement: "I negotiated extra bereavement leave and was able to take the full week to travel back home – guilt free," (former SCD 4 years prior, now on Post Doc) or "Carved out extra time for maternity leave – check out these pictures of my baby!" (former SCD 6 years prior, now fully licensed).

Directors are in a unique position to break patterns of unhealthy (and sometimes arbitrary) workplace rules and rhythms. The time is ripe for modeling burnout prevention to promote a new work culture that values sustainability, such that our actions reflect what we know to be true about prioritizing wellbeing.

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Using Spanish Proverbs:
PROFESSIONAL ETHICAL IDENTITY DEVELOPMENT OF HISPANIC PSYCHOLOGY STUDENTS

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"Dime con quién andas y te diré quién eres." ("Tell me who you walk with, and I'll tell you who you are.") My Mexican American mother shared this wisdom with me during my teenage years, emphasizing the importance of surrounding myself with people of good character to foster my own values and beliefs. Concerned about peer pressure and immaturity, she wanted me to develop a strong moral foundation to contribute positively to society. As I began associating with academically driven individuals, I internalized her teachings, focused on achieving an education, and learned the significance of role models in shaping my purpose. Now, as I guide Hispanic psychology students, I recognize the profound influence of mentorship on their ethical identities and cultural values. The relationship between psychology supervisors and students is crucial for instilling integrity in emerging professionals, as it transcends mere ethical codes, fostering internalized values and behaviors reflective of the profession's core ethics. Hence, supervisors play a vital role in shaping the ethical compass of future practitioners.

As supervisors, we must facilitate the development of ethical practitioners in an age of social media and misinformation by drawing from our experiences, research, and ethical guidelines. As a Latina supervisor, I can uniquely integrate Spanish cultural values into this transformative process for our Hispanic students. Hispanic cultures are rich with proverbs and wisdom from our ancestors that can enhance the professional ethical identity of psychology students.

By incorporating traditional Spanish "dichos" (proverbs) into our training, we can deepen their understanding of ethical values and beliefs in helping others. Below, I present a selection of traditional Spanish proverbs, "dichos", that can be integrated into the professional ethical identity development of Hispanic psychology students (Lifeder, n.d.; Rupert, n.d.).

1. Modeling Ethical Behavior

Proverb: "El ejemplo arrastra."
Translation: "Example leads."
Integration: This proverb underscores the idea that actions speak louder than words. Supervisors who model ethical behavior provide a powerful, culturally resonant example for students to follow. One of the most powerful tools a supervisor possesses is the ability to model ethical behavior. Students often learn more from observing how their supervisors handle ethical dilemmas than from textbooks. When supervisors demonstrate transparency, respect for client autonomy, confidentiality, and cultural competence, they provide a living example of ethical practice.

2. Creating a Safe Reflective Space

Proverb: "En el silencio se escucha el alma."
Translation: "In silence, the soul is heard."
Integration: Encouraging students to practice quietness to create a reflective environment, promoting a safe space for ethical exploration and growth.

Supervisors foster ethical identity development by creating a safe environment where students can reflect on their values, biases, and ethical uncertainties. Encouraging open dialogue about ethical challenges allows students to explore their reactions and decision-making processes without fear of judgment. This reflective practice is essential for developing moral reasoning and ethical sensitivity (Falender & Shafranske, 2004).

3. Facilitating Ethical Decision-Making Skills

Proverb: "La conciencia no necesita testigos."
Translation: "Conscience needs no witnesses."
Integration: This proverb emphasizes integrity and internal moral compass—key elements in ethical decision-making. It supports the importance of thoughtful, proactive ethical decision-making, a skill supervisors help students to develop. Ethical identity is strengthened through the development of decision-making skills. Supervisors guide students through structured ethical decision-making models, helping them weigh competing values, consider the consequences of actions, and consult relevant ethical codes and laws. This scaffolding supports students in building confidence and competence in navigating complex ethical situations (Handelsman, Gottlieb, & Knapp, 2005).

4. Providing Constructive Feedback

Proverb: "Corrige con cariño y enseñarás con respeto."
Translation: "Correct with kindness and you will teach with respect."
Integration: This proverb emphasizes the supportive and developmental nature of constructive feedback and is a critical component of supervision. Constructive feedback, even when difficult, can lead

to growth and ethical maturity—an idea reflected in this saying. Ethical identity is not static; it evolves through experience and reflection (Cruikshanks & Burns, 2017). Supervisors provide formative feedback that challenges students to think critically about their actions and assumptions. Constructive feedback helps students recognize ethical blind spots and reinforce ethical standards and professional accountability (Cruikshanks & Burns, 2017).

5. Encouraging Professional Identity Integration

Proverb: "Dime con quién andas y te diré quién eres."
Translation: "Tell me who you walk with, and I'll tell you who you are."
Integration: This highlights the importance of community and professional affiliation in shaping identity, encouraging students to engage with ethical role models and professional networks. Ethical identity is deeply intertwined with professional identity. Supervisors help students integrate their personal values with the ethical standards of the profession (Dollarhide et al., 2023; Gibson, Dollarhide, & Moss, 2010). This integration fosters authenticity and commitment to ethical practice. Supervisors also encourage students to engage with the broader professional community, including attending ethics workshops, joining professional organizations, and participating in peer discussions.

6. Navigating Power Dynamics and Boundaries

Proverb: "Ni muy cerca que queme, ni muy lejos que enfríe."
Translation: "Not so close that it burns, nor so far that it chills."
Integration: This adage reflects the importance of self-awareness, navigating roles, and maintaining a

healthy distance and balance in relationships. It reinforces the ethical importance of respecting boundaries and power dynamics in supervision and clinical practice. Supervisors must be mindful of the inherent power dynamics in the supervisory relationship. Ethical supervision involves maintaining appropriate boundaries, respecting student autonomy, and avoiding dual relationships (Vekaria et al., 2023). By managing these dynamics ethically, supervisors teach students how to navigate similar issues in their future client relationships.

7. Supporting Culturally Diverse Students in Supervision

Proverb: "Cada cabeza es un mundo."
Translation: "Every mind is a world." (my personal favorite)
Integration: This saying affirms the uniqueness of each student's cultural and ethical perspective, encouraging supervisors to honor and integrate diverse worldviews into ethical development. It highlights the unique challenges that culturally diverse psychology students may face during supervision, such as cultural misunderstandings, biases, and the difficulty of integrating personal cultural values with professional ethical standards. It emphasizes the supervisor's responsibility to create an inclusive, culturally responsive environment that supports these students' ethical identity development.

Conclusion

The psychology supervisor is not merely a gatekeeper of knowledge but a cultivator of ethical identity. As supervisors of psychology students, we strive to integrate the culturally rich values of Hispanic cultures and the Spanish language to enhance our ways of teaching and the development of our Hispanic students' professional identity. It is through modeling, reflection, feedback, and guidance

that supervisors shape the ethical landscape of the next generation of Hispanic psychologists. The infusion of Spanish proverbs serves as cultural benchmarks, reinforcing ethical principles in a way that resonates with Hispanic values and traditions. These sayings often reflect collective wisdom, values, and social norms, and are considered part of the culturally diverse society of norms that help in the formation and development of a person's "good character" and values for the next generation of bicultural Hispanic psychologists.

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SOARing Into New Territory:

IMPLEMENTING A GRANT-FUNDED SPECIALTY PROGRAM WITHIN A UNIVERSITY TRAINING CLINIC

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Training clinics fill unique needs in their communities while training the next generation of psychologists. However, training clinics are often under-resourced and must implement creative strategies to maintain operations. One way to increase resources while filling a service gap is through grant-funded specialty programs (GFSPs). The University of Southern Mississippi Center for Behavioral Health (USM CBH) recently launched the CBH-SOAR (Screening, Outreach, Assessment, and Resilience) program to provide preventative services for individuals at clinical high risk for developing psychosis (CHR-P). The program, funded by a $2.3 million grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), is the first of its kind in Mississippi and perhaps the only CHR-P program housed in a training clinic. In launching this program, we quickly recognized the advantages a GFSP brings to trainees, faculty, and the community. We offer recommendations for implementing a GFSP, using the CBH-SOAR program as an example, and close with faculty and student reflections on the impacts a GFSP has on training and professional development.

Implementing a GFSP

Step 1: Identifying Need and Funding

An important initial step is to identify community needs and collect data on the individuals your clinic serves. The ability to communicate the needs of the individuals your clinic serves—or those you're unable to reach due to limitations the grant could address—can be powerful. Funding can support the development and sustainability of specialty programs. While the federal funding environment waxes and wanes, some federal agencies have historically invested in building out community programming and could be a good fit for training clinics. SAMHSA funds the CBH-SOAR Program, and the authors have received funding for clinical programming from the Health Resources and Services Administration (HRSA). Foundations may also be appropriate. Funding sources can be identified through various sources, such as organizational listservs, websites (e.g., Grants.gov), and search engines. Federal funding applications tend to be complex, so applicants may benefit from partnering with an experienced grant writer and/or working with university-sponsored programs offices.

Step 2: Navigating Complex University Processes

Research faculty may know how to navigate grant-related university processes, whereas clinic directors are familiar with university administrative processes. In implementing our GFSP, collaboration between the clinic director and a research faculty member was critical for success. The clinic director had expertise and stewardship over the training clinic environment and its procedural nuances, allowing them to establish

the necessary program infrastructure. The research faculty member had clinical and research expertise in the program specialty area, and championed grant writing, metric reporting, and budget management—which paralleled that of research grants, despite its focus on service provision.

There were some factors with our grant mechanism, including the matching of federal grant dollars and the generation of program income, that made financial planning unique. Although not all grants require these components, they were complex tasks that required creativity and considerable university support. Conversations with university research administration began months ahead of grant submission and were integral in committing matched funds to secure the grant. This exemplifies the importance of having a program co-director who is savvy in university research processes.

Step 3: Implementation

By now, clinic directors are probably tallying up things that must occur for the program to function, and you may be asking important questions like "How will we handle referrals?" or "How do we incorporate grant requirements into our standard process?". Mapping out clinical services and flow is an important step to help you assess how much time you need to develop supporting processes, documents, and staffing before program launch.

Once a program launch date is set, training clinics should connect with University Communications to develop a media release. Your specialty program is something for your institution to brag about, and they can help maximize your reach. We worked closely with our communications team; within hours of the initial media release, news stations picked up the story, and interview requests were coming our way.

Lessons Learned

Advantages

The launch of the CBH-SOAR program has benefited the CBH, faculty, students, and community. Tangible outcomes related to grant funding include summer pay for faculty on the grant, paid student positions, and increased technology in the CBH, among others. Students, staff, and faculty have also directly benefited from high-quality training, such as a two-day Structured Interview for Psychosis Syndromes (SIPS) training. Moreover, students gain clinical experience in screening, assessing, and treating serious psychopathology early in their careers. This is impactful because trainees are more likely to provide services for individuals with SMI if they have had practicum experiences in this area during their training (Brand et al., 2025); yet, many trainees never receive this experience (Rackemann et al., 2025). As such, our GFSP benefits not only clinicians but also the community in both the short- and long-term.

Additionally, the launch of the program generated significant media attention, which bolstered the CBH's visibility and fostered networking opportunities that have long-lasting benefits. For example, partnerships and collaborations between the CBH and our state department of mental health, other mental health agencies and universities in Mississippi, and national efforts for CHR-P care were developed because of this program.

Challenges

As with any new program, there have been challenges. Navigating multiple state-agency procedures to facilitate sub-awards and grant reporting is the most notable. While we are grateful

for our work with the funder and local agencies, multi-site projects require layers of reporting and management, necessitating a high level of effort and expertise. Developing program protocols and implementing them in a way that is specific to the program, yet integrated seamlessly within the broader CBH, has also been challenging.

Recommendations

Here are our biggest takeaways, one year into our GFSP:

- *Go for it!* The benefits of a GFSP far outweigh the challenges.
- *Get creative.* This is what we do best as clinic directors. If you can run a clinic on a shoestring budget, you can jump any hurdle associated with a GFSP.
- *Assess needs.* Think about what the specialty program will need, and how staffing can support that program while also filling broader clinic needs.
- *Consider research benefits.* Research faculty can both facilitate the pursuit of specialty program funding and benefit from the participant population it brings.
- *Connect with partners early.* Grant applications take time, and there will be a lot to coordinate!
- *Partner with colleagues you enjoy.* You will spend a lot of time with your colleagues. Some tasks will be difficult and require collaboration within your team and across multiple agencies. Collaborations are much smoother when you work well together. We have often commented sentiments such as "This is hard, but I'm glad we are doing it together."

Professional Opportunities

Student Reflections

Graduate assistants (GAs) highlighted multiple training opportunities made available through our GFSP, including experience working with individuals at CHR-P, as well as training in new assessments (e.g., SIPS) and treatments (e.g., Cognitive Behavioral Therapy for Psychosis), which GAs noted increased their confidence in working with these populations. Further, program training was reported to increase cultural awareness of factors that may affect psychosis risk. Group supervision is akin to interdisciplinary treatment team meetings, with psychologists, social workers, and trainees providing insights from different training backgrounds. This allowed GAs to gain professional experience creating multi-faceted treatment plans that include goals outside of individual therapy and encountering unique ethical considerations, including decisions on medication management referrals. Finally, involvement in the CBH-SOAR program provided insight into the process of developing GFSPs, particularly in rural, low-provider areas, which was beneficial for GAs aiming to provide services in rural areas in their future careers.

Faculty Reflections

As faculty members, we must continually assess how we spend our time and if it yields measurable results individually (e.g., tenure, promotion) and for the clinic, training program, or department. Implementing a GFSP had clear individual benefits for research faculty whose evaluation relies upon securing grant funds and furthering research programs. Implementing a service grant created a unique avenue for collecting research data to further

research agendas and goals. The specialty program also allowed faculty to develop new administrative skills transferable to other roles in their department, which is important for preparing early-career professionals for futures in academic and clinic administration.

In time, it became clear that the benefits afforded to the clinic and graduate programs. Implementing a GFSP brought unique resources to the training clinic, and all faculty and trainees are enhancing learning as a result. Illustrating this point, when the GFSP began operating, all CBH supervisors and trainees completed a brief orientation and training. They learned about psychosis risk and methods for assessing someone's potential need for such services, allowing trainees to apply this knowledge to their assessment and therapy cases. As part of program operations, full-time staff offer ongoing consultation and support to students to help determine if clients may need increased support for psychosis risk, as well as education on evidence-based treatments for psychosis. While some factors made implementing a GFSP challenging—such as increasing roles and administrative tasks for the clinic director—the specialty program brought invaluable resources and training that would otherwise not be there.

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MULTIPLE HATS, ONE VISION:
Clinic Directors' Distinct Role in Bridging the Science–Practice Gap

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The integration of science into clinical psychology training has served as a foundational framework for most doctoral-level programs, underscoring the profession's identity as a scientific-minded discipline (McFall, Treat, & Simons, 2015; Rodolfa et al., 2014; Stoltenberg & Pace, 2007). Moreover, we have an ethical obligation in our professional training programs to foster the foundational competencies of evidence-based professional practice (American Psychological Association [APA], 2017; Canadian Psychological Association [CPA], 2017; CPA 2023; Kaslow, 2004). However, training students effectively in both science and practice within the constraints of existing program structures can present logistical challenges. As such, trainees may be left with the impression that there is a choice to be made between academic research and clinical practice for their career (Gee et al., 2022; Hayden, 2024).

As directors of Psychology Training Clinics (PTC), we are in a uniquely influential position to demonstrate how science and practice can be meaningfully integrated. Wearing multiple hats of responsibility, directors apply data-informed decision-making to a range of training responsibilities, including administration and management; client care program innovation, implementation, and evaluation; supervision, and service delivery. By modeling data-informed decision-making and by making these processes visible to trainees, clinic directors support the development of adaptable, evidence-informed competencies among students. This includes preparing trainees to apply these skills to complex, real-world problems and diverse professional pathways beyond graduate training.

Modeling Data-Driven Management Decision-Making

Administration of training clinics often occurs behind the scenes, and students may not be aware of the application of clinical competencies for everyday management decision-making. By sharing the process and decision-making steps, directors have an opportunity to foster trainee competencies in data-driven applied practice. Specifically, it may be helpful to students when PTC Directors organize steps of administrative problem-solving into clearly defined procedures to illustrate the use of data and a research mindset for management competencies.

Illustrative example from the University of Waterloo

After the onset of the COVID-19 pandemic, there seemed to be an increase in the number of cancelled sessions in the training clinic, both by clients and by clinicians. As years progressed, attendance rates did not return to pre-pandemic levels but seemed to reflect a 'new normal'. This was theorized to have an impact on student hours, duration of service, wait times, and number of clients seen; however, the observations were speculative without data. The

following steps illustrate the ways in which a training clinic director may share the process of using data to address this administrative question about cancellations.

1. Identify the problem and formulate administrative questions (e.g., Why are we seeing so many cancelled sessions since the pandemic? What are the consequences of high cancellations?).
2. Determine the indicators/data that will inform an understanding of the problem and analyze the data (e.g., pull aggregate data from client information systems to demonstrate cancellation patterns across time; track unintended consequences such as longer duration of service, fewer new admissions, longer waitlists).
3. Consult and share the findings (e.g., present dashboards of indicators and invite trainees and supervisors to contribute to ideas for action).
4. Develop actionable items to address the problem (e.g., revise cancellation policy, update expectations for service hours per client to incorporate expectations for cancellations).
5. Communicate the outcomes (e.g., share the process and outcomes with trainees and supervisors via creative use of medium).

Modeling Data-Driven and Innovative Solutions for Client Care Program Challenges

PTC Directors also have an opportunity to model competencies in creating innovative, data-driven solutions to improve client care in clinics.

Illustrative Example from Baylor University

PTCs provide high-quality, low-cost services but still encounter obstacles like long waitlists, which exacerbate already existing access to care barriers (Mohr et al., 2010). Research indicates that waitlist placement is a major factor in pretreatment attrition, suggesting the importance of engagement strategies during wait periods (Krendl & Lorenzo-Luaces, 2022).

To address these challenges, the PTC Director at Baylor University identified the problem, partnered with key stakeholders (e.g., graduate student clinicians, supervisors, and clinic leadership), and distilled several best practices for reducing pretreatment attrition, creating an innovative, recovery-oriented, psychoeducational intervention ("BEARSTEPS") that was offered to clients before case assignment.

The intervention included an orientation session that involved socialization to the therapy process, refinement of therapy goals, and collection of baseline data. A brief consultation call followed the orientation.

Data from BEARSTEPS participants in 2019/2020 and 2020/2021 (n = 97, 64.9% female, 33% racial/ethnic minority, mean age = 31.73) were compared to participants in 2017/2018 and 2018/2019 (n = 130). Outcomes indicated that BEARSTEPS clients waited fewer days for case assignment (M = 50.56, SD = 54.69) than nonBEARSTEPS clients (M = 86.41, SD = 86.61; t (219.49) = 3.81, p = .001, d = 0.48) and "true" wait time (i.e., time from last contact with orientation clinician to case assignment) was significantly shorter among BEARSTEPS participants; M = 23.12, SD = 49.62). Post-assignment attrition was lower for the BEARSTEPS group (29.5%) compared to the nonBEARSTEPS group (82.5%); $X2$ (1, n = 84) = 23.72, p = <.001). BEARSTEPS highlights how

patient care processes can be improved by partnering with trainees to develop empirically informed programs to address patient-care challenges.

Modeling Data-Informed Practices in Supervision

Within our clinics, we have the duty to model and train our students actively in data collection, utilization, and dissemination as a routine aspect of psychological practice. This includes administration, assessment, intervention choice, and outcome monitoring. Supervision is where classroom teachings, practical experience, and modeling of professionalism intersect. It is here that we begin to model how to be psychologists in all respects.

Illustrative Example from the University of North Texas

Three ways we can model data-informed practices in our work as supervisors are through coding supervision content and skill development (Supervision Preparation Form- available on APTC resources website and through Titanium), creating data dashboards that can be utilized in both supervision and client care, and by having students create competency portfolios with their videos. Supervision preparation forms can help clinicians prepare for supervision, track session milestones, and facilitate review of competencies and supervisor concerns. Data can be reviewed across cases, students, supervisors, and the clinic to answer questions at a micro and macro level about supervision and student development. A data dashboard on session notes can socialize students to gather repeated measurement data, mapping progress towards goals. Students are trained to operationalize their goals for client change and then expected to consistently monitor progress on those goals. The

competency video portfolio can enable video tagging of competency domains, allowing for sample-based review of competency development.

By integrating these data collection methods, we can foster a data-driven mindset for our trainees, gather macro-level data about training in our clinics, and ultimately further our understanding of what yields the best training outcomes for our students.

Dissemination of Treatment Adaptations for Diverse Clients

When working with trainees to select and apply evidence-based approaches for individual clients, supervisors will ideally encourage students to review the existing evidence and identify if/how it applies (or not) to their client. PTC Directors can model this approach at the clinic level by providing training in treatment adaptations and by engaging in collaborative research projects with clinicians and researchers who are working to develop, implement, and disseminate adaptations. Ethical and optimal care for diverse clients requires an intentional expansion of the scope of evidence-based treatment research.

Illustrative example from Dalhousie University

To address the needs of Indigenous clients referred by a community-based partner organization, the PCT co-Directors established a collaboration with Indigenous clinician, Charity Fleming, who developed Mikwendaagwad (It Is Remembered) Sacred Circle CBT. Students in the Clinical Psychology program and clinic supervisors completed a workshop introducing the need for adaptations and foundations of the adapted protocol. The clinical research team will disseminate the process and phases of developing this deep structural

adaptation, so that the steps can be used by clinician scientists to address the diverse needs of other groups and regions. The process includes phases of relationship building, information gathering with Elders, deepening cultural connections through ceremony, adapting materials to include Indigenous artwork and metaphors, and finally validation and pilot testing. OCAP principles (Ownership, Control, Access, and Possession) for Indigenous research governance guide each step of the process.

Conclusions

With intentionality and explicit modelling, PTC Directors play a vital role in supporting the development of student competencies that integrate science and applied practice. This includes modeling how to: (1) frame a management or administrative problem into a research question and then determine the data needed to inform a solution; (2) review the literature to distill best practices, collaborate with stakeholders, and design, implement and evaluate innovative clinical programming; (3) integrate our complex sets of competencies by demonstrating data-informed practices in supervision; and (4) engage in collaborative research to address service gaps for diverse clients.

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APPIC MEMBER INTERNSHIP:

The "Next Frontier" for Training Clinics

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The Proposition

Calling all "mid-level" (whatever that means) training clinic directors. So, you now have your "clinic 'sea legs' " and you've created some pretty cool clinic initiatives and innovations. If you're like many clinic directors at this level, you might have opened a specialty sub-clinic or secured some funding. Or maybe you've made some great connections in your communities or formed a training partnership with a local hospital. But you're just getting started, right? You know that there is MUCH MORE that you can and will do! So, how about starting an APPIC1 (Association of Psychology Postdoctoral and Internship Centers) member predoctoral internship at your clinic?

"An internship?" you may be querying. "There aren't any internships in training clinics; students go away from our clinics (and our programs) for internships, right?" Not necessarily…there might be some real advantages to starting an internship at your clinic, both for your students and for the psychology training community at large. These advantages include: more service provision, more advanced students for complex cases, more layers to the clinic leadership hierarchy, more prestige to your clinic (inside and outside the university), and yes, more funding! If you are interested, please read on to learn whether an APPIC member internship is in your clinic's future.

Self Assessment and Self-Promotion

Let's think about the components of any reputable internship: a diverse patient population for both assessment and therapy; a varied supervisory cadre (who can also provide didactics); the ability to be part of a leadership team; "other" activities such as clinic administration and research; and the opportunity for interns to supervise. By leveraging a little creativity and improvisation, we realized that our training clinic had all these attributes. At any given time, we treat between 500 and 550 patients; our 35-person faculty is very involved in the clinic (and could be "roped in" to teaching didactics), and we have at least 120 graduate students who are always in need of additional supervision. Additionally, we can teach "clinic administration" in our sleep, and faculty members conducting research in the clinic are always eager for assistants. Hence, the groundwork for an internship was apparent (and probably, with a little self-reflection, is apparent in your clinics too). Now, we just had to find some prospective interns who were willing to give us a try, and we had to figure out how to get the University to pay them.

Believe it or not, there are many "non-traditional" students (this might mean "unmatched" students, students who have opted out of the APPIC process, or students whose life circumstances have influenced their training trajectory) in the "psychology training world." These folks tend to be hungry for the training experience that we knew we could provide. They are eager to work hard in exchange for a training opportunity that they could not get from their graduate programs (Of course, we had to interview them to be sure of all of the above). The "hunger" from these students is how we lobbied for their salaries from our university. We expounded on how their full-time schedule, which includes patient care, administrative support, supervision, and possibly teaching, would

bring so much more to our clinic for approximately 33% of the starting salary of any licensed clinical psychologist. Of course, you always want to present the university with a "win-win" situation.

The Dry Run

We did all of this. Capella University and the University of Ponce (in Puerto Rico) were delighted to send us their top applicants, and, after a careful interview, we got two of the best pre-doctoral students that I (Salton) have seen in my 18+ years in academia. They were thrilled to train in a setting that was extremely different than their graduate programs (no training clinics at either school), and their productivity was superb. Plus, while we were training them, we got to pilot the burgeoning internship program that we eventually proposed to APPIC (see Table 1). For example, we formed an alliance with Yeshiva's Physician Assistant (PA) training program, and our interns served as "proctors" for their mental health rotations. We also involved our interns in an initiative at a local hospital where they were able to participate in evaluations for people who were choosing to undergo gender-affirming medical care.

The administrators with the purse strings were pleased, and, most importantly, the interns reported that they found their training to be comprehensive, varied, and aligned with their personal goals. With interns as part of our clinic's hierarchy, not only did our patient census increase, but the interns' higher level of training allowed us to accept more clinically complex patients. The clinic also ran more smoothly and with less dependence on paid graduate student assistants. Our interns even participated in a research project. As we demonstrated the value and validity of our internship "pilot," our Dean sent me (Salton) to the biannual APPIC conference so that we could officially apply.

The APPIC Application Process

There are two things you should know about the application to APPIC. First of all, you really, REALLY want to showcase your prospective internship. Any unique quality of your clinic or graduate program…PLAY IT UP; any innovative rotation or community initiative, LET THEM KNOW. Additionally, spend a lot of time thinking about the didactics you will offer. Tap anyone and everyone on your faculty who does something interesting. To stay in good graces with your program, open your didactics to your pre-doctoral students and faculty (They'll love you for it). All of these details will be compiled in your internship handbook.

The second thing you should know about the application process is that there is a fair amount of bureaucratic considerations. Have you ever written a "due process policy?"; there are ways to figure this out (often, we just pirated from our HR department). Do you have an "intern grievance policy?" If you don't, there are a ton of templates online that you can use, and collaboration with other APTC members is always helpful. Be prepared for LOTS of back and forth with APPIC about these necessary application components (which were NOT part of your graduate school education). But isn't improvisation also the story of our lives as clinic directors? We learn to "write the book as we turn the pages."

It was Halloween of 2024 when we got the email that APPIC had approved our proposed internship. We had some extra candy corn to celebrate (along with other things…)

Onward and Upward

There's a bar on Manhattan's Upper West Side where all our students and faculty gather on the evening before Match Day. We are usually crossing our fingers for our student applicants, but on that night last year, we were also crossing them for our new internship. We hoped for a good match. We had

read applicants' files, conducted interviews, and involved our faculty in the ranking process. We were pleased to see that some of our own students had applied to our site, but the question remained: were we their first choice or their "safety?" It was certainly a new and auspicious experience being on the "other side" of the match. And…it all went well. We matched with our second and third choices! When this article goes to press, our first cohort of "APPIC" interns will have started their training year.

Of course, we fully recommend that you create a predoctoral internship at your training clinic and that you then join APPIC. Many of your clinics have enriching and diversified training opportunities, along with the potential for clinic administration, that many interns would benefit from.And, you could certainly use the extra "person-power" to increase your service potential. For those inspired by our article, we would be happy to consult with any of you who want to try this "next frontier." For us, it's "next stop APA accreditation!"

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Table 1

Training Area	Description

Clinical	• Treat up to 10 patients in the "general clinic" or sub-clinics of Parnes, including:
	  ○ Nonverbal Learning disabilities clinic.
	  ○ Older adult program.
	  ○ Clinic for patients with psychiatric and medical disorders
	  ○ Food and beverage workers sub clinic.
	• Conduct psychological assessments, based on clinic needs
	• Conduct and assign "screener" phone calls with prospective patients
	• Participate in rotations with hospital and community partners
	  ○ Pride Clinic that provides gender affirming care at Jacobi Medical Center
	  ○ Psych-oncology Clinic at the Albert Einstein College of Medicine.
	• Receive 4-5 hours of supervision per week.

Administrative	• Support ongoing projects and program development initiatives with Clinic Director and Assistant Director • Collaborate with clinic students and administrative staff to support the daily operations of the clinic • Promote the mission of the Parnes Clinic at University and community events
Supervision	• Proctor students in the Yeshiva University Katz School of Physician's Assistant Program • Provide supplemental supervision to student therapists in the clinic, as needed • Offer mentorship to pre-doctoral students
Research	• Contribute to ongoing projects that are sponsored by both clinical and departmental faculty • Support initiatives that aid in the creation and maintenance of clinic research database

WHEN GUIDELINES BECOME HARM

Why the *APA Guidelines for Psychological Practice with Boys and Men* Undermine Clinical Competence and Training in Work with Male Clients

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"Traditional masculinity — marked by stoicism, competitiveness, dominance, and aggression — is, on the whole, harmful." **(Pappas, 2017, p. 34)**

In 2018, the American Psychological Association (APA) published its Guidelines for Psychological Practice with Boys and Men (APA, 2018), intending to foster culturally competent care for male clients. Instead, these Guidelines sparked both support and outrage, with critics describing them as an example of how ideological framing can corrode trust in clinical effectiveness of psychotherapeutic intervention, our institutions, and the training of psychologists. The Guidelines were published seven years ago, recommending periodic reviews and updates every eight to ten years.

For directors of psychology training clinics who are charged with preparing students to provide ethical and effective care, the Guidelines present particular risks. They encourage therapists to adopt ideological stances, pathologize normative male identity, and disregard both empirical complexity and client autonomy. Furthermore, they pose a risk of alienating male clients from therapeutic treatment and exacerbating male psychological distress.

This review article critiques the Guidelines' framing and empirical support, documents examples of clinical contraindications, and offers recommendations for training clinics committed to developing the art and science of competent clinical training.

The Guidelines are not rooted in clinically effective literature, but in an ideological framing that prejudges masculinity as pathological.

From its opening pages, the Guidelines adopt an ideological posture that treats masculinity itself as a problem. They define "traditional masculinity" almost exclusively in negative terms: "anti-femininity, achievement, eschewal of weakness, and adventure, risk, and violence" (APA, 2018, p. 1). Absent from this framing is recognition of empirically supported, adaptive masculine traits such as stoicism under duress, courage, protectiveness, loyalty, leadership, and group solidarity, that contribute meaningfully to resilience and well-being (Seidler et al., 2016; Wong et al., 2017). Rather than acknowledge that any personality feature which becomes overly pronounced or unidimensional has both costs and benefits (Carter et al., 2018), the Guidelines focus solely on a rigid, stereotypically negative eschewal of the broad spectrum of dimensionality that characterizes masculine personality iterations.

As Steven Pinker (Edsall, 2019) noted, the Guidelines amounted to a moral indictment of male roles "blinkered by dogmas," not an empirically balanced analysis. Haidt & Lukianoff (2018) have warned that applying oppressor/oppressed models to gender psychology risks distorting both science and

clinical practice.

The theoretical backbone of the guidelines derives from gender role strain theory (Pleck, 1995) and the sociological construct of "hegemonic masculinity" (Connell, 2005). Both concepts are rooted in critical gender studies, not clinical psychology. While such theories can offer useful insights into how rigid gender norms can harm some individuals, critics noted that the guidelines present them as an explanatory framework without discussing biological, developmental, or multidimensional perspectives on masculinity (Wong et al., 2017). Nor do they acknowledge how men from different cultural or occupational groups may value and rely upon masculine norms for identity, community, and coping (Brooks, 2010; Wong & Wester, 2016).

Crucially, they ignore a growing literature showing that when expressed adaptively, many traditionally masculine traits correlate positively with life satisfaction, resilience, and mental health. This oversight can be elucidated through a survey of salient empirical findings. The pursuit of status, attributed as a traditional masculine norm, has demonstrated an association with lower risks of depression (Sileo & Kershaw, 2020). Additionally, toughness has demonstrated a link to positive mental health outcomes, such as anxiety control (Sileo & Kershaw, 2020). Adherence to certain masculine norms has been linked to enhanced psychological well-being in domains of self-acceptance and environmental mastery (Gerdes & Levant, 2018; Cole et al., 2019). Such findings add to the existing literature elucidating the link between masculine norms, such as dominance, and positive psychological traits, like autonomy (Hammer & Good, 2010; Gerdes & Levant, 2018).

The Guidelines overgeneralize and pathologize masculinity based on weak and selective evidence.

The Guidelines selectively cite research on negative outcomes linked to rigid gender role conformity, while ignoring meta-analytic and clinical evidence that masculine traits can support psychological health.

For example, Wong et al. (2017) found that many masculine norms, such as leadership, courage, and responsibility, are associated with positive outcomes when expressed flexibly. Of clinical importance, Seidler et al. (2016) documented that many male clients prefer therapists who respect and positively integrate masculine norms, and that "The limited empirical traction of 'positivist' models of masculinity does not reflect the quality of this research, but rather reveals 'deficit' models as descriptive and unlikely to transition toward interventions." (p. 115)

Moreover, the Guidelines provide no clear evidence that interventions aimed at "deconstructing masculinity" improve clinical outcomes. The available literature suggests the opposite: that such interventions often provoke resistance, disengagement, and psychological harm.

The Guidelines are clinically contraindicated in many contexts.

Most male clients seek therapy to address specific symptoms or life problems. Clinical wisdom holds that men tend to approach therapists as consultants, seeking active solutions as opposed to "just talking about feelings." Research consistently shows that male clients prefer therapists who respect their values and integrate masculine norms positively (Seidler et al., 2016; Seidler et al., 2024). Efforts to pathologize

or deconstruct masculinity can trigger identity threat, moral injury, and psychological reactance (Brehm & Brehm, 1981), undermining therapeutic engagement. Being mindful of masculinity contexts and discussing them explicitly with male clients is essential when tailoring treatment accordingly (Boerma et al., 2023).

Encouraging male clients to abandon masculine norms may be countertherapeutic or clinically inappropriate in many clinical contexts. Traits often associated with traditional masculinity, such as stoicism and emotional restraint, can serve as protective factors among veterans and first responders. Seidler and colleagues (2021) noted that interventions that encouraged emotional vulnerability or the deconstruction of masculine identity resulted in premature patient dropout and reduced therapeutic effectiveness. Silvestrini and Chen (2023) observed that this perception can lead to resistance, withdrawal, or even an overall avoidance of care.

A similar pattern can be seen in substance use disorder treatment. Klingemann and Klingemann (2023) have argued that clinicians should focus on helping clients develop more adaptive models of masculinity that promote healthy behaviors, recovery, and growth.

Cotter et al. (2023) discussed treatment approaches in which male clients were pushed to abandon stoicism or toxic masculinity without regard for personal values. They summarized: "Past views of women in our society as psychologically abnormal are only reinforced by women's negative attributes. To do the same with men would be unconscionable." (p. 7).

School-based interventions that overlook or conflict with students' expressions of masculinity can backfire, particularly when college preparation is framed in ways that feel misaligned with boys'

cultural identities and values. Kolluri (2022) noted that such program approaches increased disengagement among adolescent boys, who perceived them as failing to reflect culturally situated masculine identities.

Dobbin and Kalev (2018) noted that short-term interventions generally do not change people when they perceive that others are trying to control them. Steele and Vandello (2019) noted that when it frames masculinity as inherently problematic, sexual harassment prevention training can unintentionally backfire. This approach triggers defensiveness and resistance among men and may reinforce gender stereotypes and alienate participants, particularly when they feel labeled or blamed simply for being male.

The Guidelines promote a theoretical frame that undermines therapeutic neutrality.

The framing of these guidelines appears to be orthogonal to APA's Ethical Principles (APA, 2017), which emphasize respect for client values, cultural diversity, and human dignity. For example, the underlying assumption and tone of the document starts by elucidating Gender Role Strain, including subsections titled "oppression," "privilege," and in the application section: "Sexism exists as a byproduct, reinforcer, and justification of male privilege." Indeed, a symposium addressing these guidelines stated, "While many critics situate the American Psychological Association's release of these new guidelines as pathologizing masculinity, the essays in this symposium illuminate the inaccuracy of this perception." The title of the symposium was "Mitigating the Harms of Masculinity" (Barber, 2019).

Moreover, critics argue that the Guidelines' ideological tone undermines core ethical standards of

ideological tone undermines core ethical standards of neutrality, cultural competence, and scientific objectivity. This risks turning therapy into an arena for ideological re-education rather than collaborative healing. Men report actively avoiding therapy for these very reasons (Mahalik & Rochlen, 2006; Rice, 2018; Seidler et al., 2021).

Implications for training graduate students in competent work with male clients.

There has been no direct evidence in the intervening years that the Guidelines for the Treatment of Men and Boys have led to any programmatic advancements, treatment protocols, training approaches, or differential treatment outcomes. Barber et al. (2019) referenced one program for adolescent DBT that mentioned the Guidelines, but did not appear to incorporate them explicitly into the treatment protocol.

In contrast, several well-supported models of therapy with men demonstrate that affirming and integrating masculine strengths into treatment enhances engagement and outcomes. These include: Positive Masculinity Therapy (Englar-Carlson & Kiselica, 2013), Gender Role Journey Therapy (O'Neil, 2015), Strengths-Based CBT (Addis & Mahalik, 2003), and Integrative Men's Therapy (Brooks, 2010). While there are no explicitly male-oriented ACT interventions specifically, clinicians often cite ACT as being male-friendly with its focus on values-aligned action.

Training clinics should prepare graduate students to engage male clients competently, ethically, and effectively. This requires moving beyond the Guidelines' narrow, ideological, and potentially alienating frame. Fortunately, training clinics already excel in the skills necessary for this training. These include a focus on psychotherapy's core factors of

warmth, empathy, and positive regard, as well as training in intersectionality, cultural humility, and perspective taking. There are several unique elements to clinical training that supervisors may leverage for this population. Clinical students are trained to:

1. Recognize and respect the adaptive functions of masculine norms across cultural and situational contexts.
2. Integrate evidence-based, strengths-based approaches that honor and support male clients' identities.
3. Avoid imposing ideological agendas that compromise therapeutic neutrality and client autonomy.
4. Explore the effects of transference and countertransference with all clients to mitigate the impact of preconceptions, including both negative and positive perceptions of men and gender roles.
5. Grant appropriate consideration to intersectionality of identity and avoid viewing any demographic trait or identity orientation (i.e., "male," "female," etc.) as a homogenous construct.
6. Encourage flexibility and client-centered treatment planning, including openness to a more active or strengths-based approach, if indicated.
7. Identify ruptures in the therapeutic alliance and effectively use them to understand, restore, and strengthen the client-therapist relationship.

Training directors must also model this approach in supervision, helping students understand how to foster therapeutic alliances with male clients across contexts. Of critical importance is training how to recognize both therapist and client stimulus values in the therapy room. Presently, most clinicians in training are young women who have very different learning histories and stimulus values from men, especially older men. The fearless engagement with

those differences and recognition of potential bias is foundational for all psychotherapy, not just gendered therapy.

Conclusion

The APA *Guidelines for Psychological Practice with Boys and Men* reflect a troubling fusion of ideology and clinical guidance. They risk undermining therapeutic neutrality, alienating male clients, and promoting ineffective—and sometimes harmful—interventions. Future revisions of the Guidelines have the opportunity to better reach a population often skeptical of the field and to provide meaningful support for their mental health as well, not at the expense of it. In order to accomplish this, such revisions must be firmly grounded in empirical support, refrain from portraying masculinity as a monolithic and pathological construct, and emphasize strengths-based approaches that acknowledge and cultivate positive aspects of a client's gender identity when indicated. Rather than trying to shape the male client to fit the ideals of the therapist, the therapist should work to understand each client across the intersection of individuality, personality traits, social context, and other salient intersections of their lived experience, and find ways to foster psychological growth that considers their unique strengths and perspectives in a way that is socially viable and healthy.

Psychology training clinics are laboratories, and we must chart a better path. By preparing students to engage male clients with cultural humility, empirical rigor, and ethical integrity, we can foster clinical competence and ensure that therapy serves the full humanity of the clients we are privileged to serve. Masculinity is not a pathology; rather, it is a human reality. Our task is to meet it with respect, skill, and care.

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2026 APTC CONFERENCE

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We are still finalizing the details of the programming, however, we've provided a rough, preliminary sketch of what to expect below!

DRAFT CONFERENCE SCHEDULE

THURSDAY, 3/19
Afternoon: New Directors & Mid-career Directors Programming

Early Evening: Welcome Reception & New Director Mentor/Mentee Dinner

FRIDAY, 3/20 & SATURDAY, 3/21
All Day: Keynotes, general sessions, and posters
Early Evening, Friday: Happy Hour

SUNDAY, 3/22
Morning: Executive Committee Meeting*

*Details about Executive Committee time and place of meetings and who should attend from the EC will be shared via EC email correspondence.