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PRESIDENT'S MESSAGE

Innovative CBT Delivery Model Being Rolled Out in Ontario, Canada

Martin M. Antony,
Ryerson University

IT'S AN HONOR to continue serving ABCT as president and to contribute to this special issue of *the Behavior Therapist*, focusing on contemporary issues in clinical training as well as increasing access to cognitive-behavioral therapy (CBT) and related evidence-based treatments. Consistent with the theme of this issue, this column includes some exciting news that relates to both training and access.

On March 3, 2020, the Government of Ontario announced ongoing funding for *Mindability*, a publicly funded, stepped-care, CBT-based program for anxiety disorders (including panic disorder, agoraphobia, generalized anxiety disorder, social anxiety disorder, and specific phobia), posttraumatic stress, obsessive-compulsive disorder, illness anxiety, and depression. Previously known as the Ontario Structured Psychotherapy Program, the program has been in development and piloting both high- and low-intensity[1] services for the past 3 years. I have served as the Provincial Clinical Lead of the program since January 2019. We are delighted to be

[1]For the purposes of this initiative, "intensity" refers to the level (e.g., frequency and duration) of therapist contact.

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ABCT congratulates

►Richard "Dick" Suinn
►Steven D. Hollon

Richard "Dick" Suinn, our 27th President, will be receiving the American Psychological Foundation/American Psychological Association's 2020 Gold Medal Award for Life Achievement in Psychology in the Public Interest this August during their Annual Convention in Washington, D.C. The citation acknowledges his outstanding lifetime contributions to cognitive/behavior therapy, sport psychology and ethnic minority issues and his leadership in the community and professional organizations.

Steven D. Hollon, our 33rd President, has been selected as a recipient of the American Psychological Association's 2020 Distinguished Scientific Award for the Applications of Psychology.

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INSTRUCTIONS *for* AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

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able to share the news that Mindability is now officially part of Ontario's new long-term strategy for enhancing mental health services across the province. Ontario has a population of close to 15 million, and Mindability is expected to provide services to around 80,000 individuals per year when it is fully implemented across the province. To our knowledge, Mindability will be the largest program of its kind in North America.

Mindability is based closely on England's successful national initiative, Increasing Access to Psychological Therapies or IAPT. Treatments are consistent with established guidelines, including those from the United Kingdom's National Institute for Health and Care Excellence (NICE) and Health Quality Ontario. Clinicians in Mindability are all from professions permitted by legislation to engage in the "controlled act" of psychotherapy in Ontario, including social workers, nurses, occupational therapists, registered psychotherapists, and psychologists. As in IAPT, clients complete weekly assessments to track progress, including general measures of anxiety, depression, and functional impairment, as well as measures that assess core features of their main identified problem (e.g., posttraumatic stress, social anxiety). Mindability is designed to be a program that "learns" over time. As we track more and more cases, our data will highlight what is working and what needs to be improved. We are currently in the process of setting targets for wait times, outcomes, and data completion rates, based in part on the experience in IAPT.

Mindability is a stepped-care program. The program begins with an assessment to identify the presenting problem and inform decisions regarding treatment. Most clients begin the program at the first step, designed to provide services with less intensive therapist contact. Interventions at this step will include clinician or coach-guided bibliotherapy, clinician-supported online CBT, and larger group-based interventions (e.g., psychoeducation classes). Clients who do not respond adequately to this first step will be "stepped up" to receive a full course of face-to-face CBT, and some clients will start with face-to-face CBT, depending on the nature and severity of their presenting problems. In addition to collecting outcome data weekly, occasional monitoring will continue during a follow-up period. We want to ensure that clients in the program are getting better and staying better.

An important core principle underlying Mindability is ensuring equitable access to care. The expectation is that clients will be able to enter the program in a number of ways, including a referral from their primary care physician, a referral from another clinician, or through a self-referral (e.g., online, using a toll-free phone number, or walk-in to a clinic). Services will be offered both during regular business hours, and during evenings and weekends. The program will be available in both of Canada's official languages (French and English), and some services will be offered in a range of other languages. We will also ensure that culturally appropriate services are offered in Ontario's indigenous communities. Another principle is "care close to home." Compared to England (which has around 430 people per square km), Ontario (around 15 people per square km) is very spread out. Mindability is committed to ensuring that residents in rural and remote areas can access our assessments and treatments. A range of services will be available face-to-face, by phone, and online.

As in IAPT, all clinicians providing treatment in Mindability will complete a comprehensive training program. Completion of our training program is expected to take up about a day per week for between 12 and 18 months, and includes a mix of online courses (blended with live interactive components), readings, and weekly clinical consultation. Clinical consultation is expected to continue after completion of the training program. Clinicians take courses on the fundamentals of CBT as well as courses on applying CBT to each of the problems targeted in Mindability, based on established protocols. All courses were developed collaboratively by education specialists and content experts (including a number of individuals who developed the widely disseminated treatments being used). Over time, we expect to introduce additional training modules on topics such as motivational interviewing, transdiagnostic treatments, and treating anxiety and depression in the context of other problems (e.g., substance used disorders, autism spectrum disorders).

To summarize, some of the core features of Mindability include a stepped-care structure to ensure that the largest number of people can access high-quality care in the most cost-effective way, evidence-based assessments and treatments for some of the most common psychological problems, weekly assessments to inform therapy and assess outcomes, and a rigorous training and consulting program for all participating clinicians. We look forward to replicating the success of IAPT as we adapt it for the Ontario context. I look forward to sharing more about Mindability with ABCT members as the program continues to develop and expand.

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The author is the Provincial Clinical Lead for Mindability, which is the focus of this column.

Correspondence to Martin M. Antony, Ph.D., Department of Psychology, Ryerson University, 350 Victoria Street, Toronto, ON, M5B 2K3, Canada; mantony@ryerson.ca

From Your Executive Director: What Your Leadership and Staff Are Working on to Serve You Better

Mary Jane Eimer, *Executive Director*

IT IS MID-MARCH as I write this and our focus is on how we, as an organization, can support you as we face the threat from the COVID-19 and its potentially devastating impact on the health and safety of our membership, colleagues, family, friends, and, of course, the ABCT central office staff. This threat impacts how we do business and restricts where we can travel or gather. New terminology has entered our lexicon: social distancing. We are challenged to be nimble in how we communicate and teach, and how therapy is conducted—telehealth has become a necessity complicated by lack of legislation in some states or an understanding of privacy laws.

Your leadership and staff are addressing the situation by extending the deadline for the 2020 Call for Papers; our Public Education and Media Dissemination, with input from the Board, crafted information on how to help your anxious clients cope with this threat; and staff are working with members and convention committees to organize free online presentations that address tips on teaching remotely, things you should know regarding telehealth, and how to conduct exposure sessions via telehealth, and whatever other suggestions we get from the membership via the list serve. Every effort will be made to assist members during this pandemic. Special thanks to member Dan Beck who presented our first session on teaching remotely.

I am very proud of your ABCT staff. We are developing new systems to keep the work we are responsible for moving forward with an eye to having coverage in the central office even as conditions and information change daily. We encourage you to contact us via email as opposed to calling. Every staff member can log on to our system and work remotely; and we will do our best to answer your queries as quickly as possible. Opposite is a quick directory of staff, their major responsibilities, and email addresses.

A few highlights on the work we are addressing now includes the annual financial audit, working with the World Confederation of Cognitive and Behavioral Therapies' articles of incorporation, updating our International pages on the website, and refining the environmental scan that will be used for the triannual strategic planning retreat in addition to addressing trends impacting all categories of membership. We have posted the Outreach and Continuing Education Manager position on our list serve, job bank, and website. If you know someone who would be a good addition to our staff, please encourage them to contact me directly at mjeimer@abct.org

Staff members have been working closely with the survey subcommittee of the Task Force to Promote Equity, Inclusion, and Access. If you haven't already done so, please be sure to complete their survey.

Kate Gunthert, our Membership Issues Coordinator, is gearing up efforts to promote ABCT's Find a CBT Therapist in conjunction with our Clinical Directory and Referral Issues Committee on Wednesday, April 22. All ABCT members who take referrals or make them will be asked to post our Find a CBT Therapist directory on their personal Facebook page. We will track to see if the effort increases traffic to our site. Follow our list serve for updates.

We have to be smart. We have to be vigilant. We have to be safe. There is no crystal ball to let us know when a vaccine will be available or when it is safe to gather together again. In the meantime, your staff and leadership will continue to think proactively and creatively to keep your professional home providing you with service you depend upon and the information you need to get us through this global health crisis.

Stay safe, everyone. Until next time!

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Correspondence to Mary Jane Eimer, CAE, Executive Director, ABCT, 305 Seventh Ave., Suite 1601, New York, NY 10001; mjeimer@abct.org

The leadership and staff are concerned both professionally and personally for our members during this time of upheaval and constant change. As your professional home, we are working to be nimble and to share resources we believe will help you with your practice, especially with telehealth; teaching remotely; and offering resources to share with your clients.
Please visit our website at www.abct.org and click: http://www.abct.org/Information/?m=mInformation&fa=COVID19 for updates and resources.

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www.abct.org

MESSAGE FROM THE EDITOR

Introduction to the Special Issue: Contemporary Issues in Clinical Training

Richard LeBeau, *UCLA*

THIS ISSUE of *the Behavior Therapist* is a special collection of articles that cover contemporary issues in clinical training. The first three articles discuss systematic approaches to dealing with paradigm shifts that are currently occurring in our field, including the expansion of access to care through the training of master's-level mental health providers, the development and implementation of detailed and uniform standards for clinical supervision, and the adoption of value-based care models in behavioral health reimbursement. In each of these three cases, the field is making much-needed movement toward enhanced quality of care and access to such care. Nevertheless, there are many unanswered questions about how to best translate these often-lofty goals into practical realities. This trio of articles addresses several of these questions. The next two articles are written by clinical trainees and cover two increasingly prominent clinical training issues: the need for coordinated programmatic support for trainees with nonbinary gender identities and the unique benefits and challenges of supervised clinical training in settings utilizing very brief treatment models. The issue ends with a humorous piece about a provider who signs up for a continuing education course to advance his own clinical training but gets a bit more than he bargained for.

This special issue is particularly notable for its genesis. Typically, special issues are planned several months (sometimes years) in advance of publication and are heavily shaped by the editors, who solicit articles from experts in the respective topic areas or cull from a pool of articles submitted in response to a specialized announcement. In contrast, this special issue is simply a collection of articles that arrived in my inbox during the first months of my editorship that all converged on the same topic area—how our field can respond to paradigm shifts with thoughtful, deliberate, evidence-based actions aimed at improving clinical training and clinical service delivery. Taken together, I believe they provide an interesting overview of several major changes occurring in our field, as well as conceptual frameworks and concrete tools to address them. I hope that you find the articles in this issue to be thought-provoking, practically useful, and a springboard for important discussions.

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Training Competencies for Master's Programs in Health Service Psychology

Lee D. Cooper, *Virginia Polytechnic Institute & State University*

Andrew Bertagnolli, *Alliant International University–San Francisco Bay Campus*

Yevgeny Botanov, *Pennsylvania State University–York*

Janie J. Jun, *Lyra Health*

Helen Valenstein-Mah, *University of Minnesota*

Jason J. Washburn, *Northwestern University Feinberg School of Medicine*

David Teisler, *Association for Behavioral and Cognitive Therapies*

DOCTORAL-LEVEL TRAINING has long been considered essential for the practice of health service psychology (HSP; American Psychological Association [APA], 2011). HSP has been defined as the "integration of psychological science and practice in order to facilitate human development and functioning" (APA, 2015, p. 1). Although doctoral-level psychologists have been instrumental in the development and application of effective services for a wide variety of mental health issues (e.g., Barlow, 2014; David et al., 2018), high rates (over 50%) of mental disorders go untreated due to the lack of qualified providers (Eisman et al., 2018). Moreover, this shortage of providers is projected to negatively impact access to mental health care for the near future (Health Resources and Services Administration National Center for Health Workforce Analysis, 2015).

It is theoretically possible that this shortage could be addressed by increasing the existing doctoral psychology workforce; however, this is unlikely given the time and cost necessary to produce doctoral-level psychologists. It is also possible that this shortage can be addressed by increasing the numbers of providers other than HSP, such as master's-level clinical workers, counselors, and therapists. HSP, however, brings a unique set of competencies that are not found among other professionals, such as a strong scientific foundation, the integration of science and practice through evidence-based practice, and skills in both psychodiagnostic assessment and psychological intervention.

From a workforce perspective, master's-level HSP providers could help alleviate this shortage. In this context, the issue of the practice of psychology at the master's level—as opposed to strictly doctoral-level—has been discussed and debated in a large number of psychology conferences, councils, and task forces

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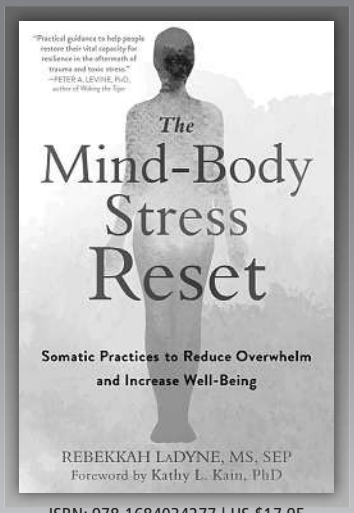

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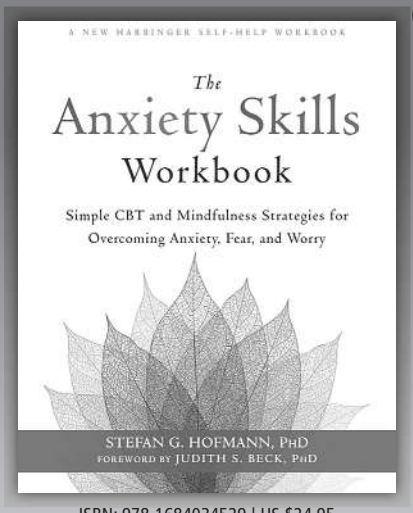

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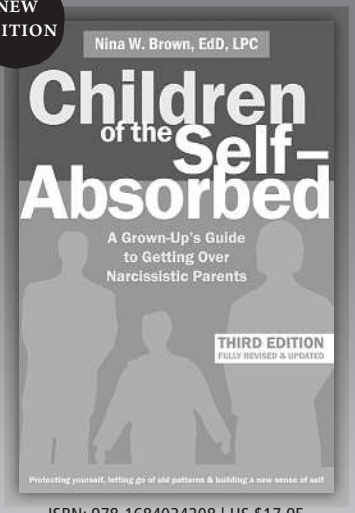

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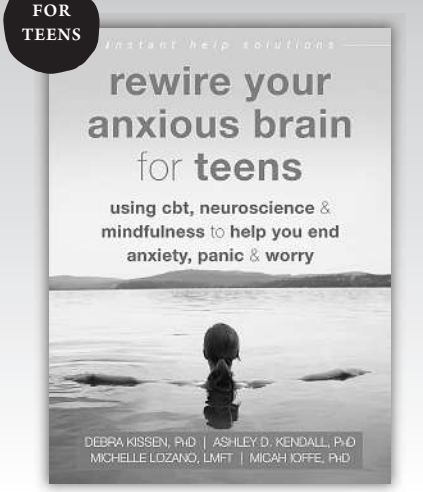

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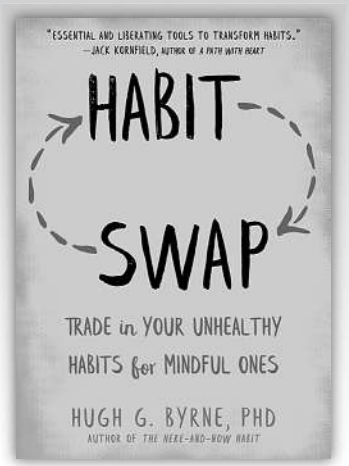

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(Callahan, 2019; Campbell et al., 2018), but with little resolution and actual implementation. However, in 2016, APA held the Summit on Master's Training in Psychological Practice to determine if APA "should embrace the training of psychological practitioners at the master's level" (APA Minority Fellowship Program, 2016, p. 4). After reviewing the summit proceedings, the APA Council of Representatives voted to approve the creation of a system for the education and training of master's-level providers in HSP (Worrell et al., 2018). Additionally, they charged the APA Board of Educational Affairs (BEA) with developing an accreditation blueprint for master's-level health service psychology (ML-HSP) training programs (APA BEA, 2019). Based on the blueprint, APA formed the BEA/Board of Public Affairs Master's Health Service Providers Competencies Task Force with a goal of delineating "a set of professional competencies for students completing a master's-level program in health service psychology and distinguishing such from those of individuals trained at the doctoral level" (communication with Tim Cavell). As recently noted by Grus (2019, p. 90), "there is little sense of what competencies may be shared across subfields within HSP at the master's level." Hence, competency-based training guidelines for entry to practice with a terminal master's degree would go a long way towards ensuring these providers are given the skills necessary for the tasks they are being asked to perform.

To help with this vitally important and complex endeavor, the Academic Training and Education Standards (ATES) committee of the Association for Behavioral and Cognitive Therapies (ABCT) formed a workgroup to develop a set of competencies for the education and training of ML-HSP providers. The goals of the ATES include developing curricula and other resources for teaching or supervision of cognitive-behavioral assessment and therapy; promoting educational standards (curricula, competency standards) in training programs in psychology and for other relevant settings and disciplines; and acknowledging academic education and training excellence. The workgroup (members are the authors) held eight video conferences July–December 2019, and a face-to-face meeting of ATES held on November 22, 2019, provided a review and feedback. It is our hope that these competencies can inform, guide, and advance discussion, development, and implementation of competency-based approaches to trainee learning.

Several consensus points guided this effort. First, scientific knowledge should be the foundation of education and training. It is imperative that ML-HSP training be infused with a scientific perspective as it relates to practice, but not with the responsibility to also produce science. Second, a goal to develop a set of recommendations for training competencies, rather than prescriptive course or practicum requirements. Third, as a master's-level degree is typically completed through a 2-year program, it is only reasonable that a subset of all identified competencies (Fouad, et al., 2009) can be learned and demonstrated. Thus, we have attempted to identify the competencies most necessary for effective and safe delivery of mental health services (see Table 1). The overall goal is to train ML-HSP providers to have the knowledge, skills, and attitudes needed to competently deliver care in an applied clinical setting. Accordingly, one purposeful omission in this proposed set of competencies is research skills. Fourth, the intended use of these competencies would be across theoretical models and for transdiagnostic client populations.

The overall goal of a ML-HSP workforce is to help reduce the burden of mental health problems through multiple means and pathways, including the models and aims of training and education for this workforce. Hence, our aim was to develop guidelines consistent with a competency-based approach and a science-based orientation that was compatible with major theoretical models and could be applied to a broad range of mental health problems.

Training Competencies

Table 1 presents five core competency domains for ML-HSP training. In each of the five core domains, both general and specific competencies are enumerated. The core domains include scientific foundations, common factors, assessment, intervention, and professional values. The essential competencies indicate the degree of knowledge, skill, and attitudes expected of ML-HSP trainees. The specific competencies describe the breadth and development of knowledge, skill, and attitudes expected within each essential competency.

Scientific Foundation Competencies

Scientific training provides the foundation for ML-HSP because errors in decision-making and reasoning (i.e., cognitive biases) are common across professional disciplines, including mental health practice (e.g., treatment choice, misunderstanding of a treatment's efficacy; for a review see Lilienfeld et al., 2014). Being scientifically minded and able to demonstrate core scientific competencies (Bieschke et al., 2004) has the potential to safeguard against biases that lead providerss to provide ineffective or iatrogenic care. While the debate concerning the definition, specification, and assessment of scientific competencies continues (e.g., O'Donohue & Boland, 2012), consensus indicates it is essential for mental health professionals (e.g., Schaffer et al., 2013; Washburn, 2019). Simply speaking, to provide ethical and effective care, ML-HSP trainees must understand and apply (e.g., identify etiology, select treatments, monitor progress) science.

To achieve scientific competency, trainees must be familiar with the skills of basic interpretation of social science and health statistics. For the array of problems ML-HSP providers are likely to encounter, a basic understanding of statistics is necessary to provide ethical and effective care. To choose an appropriate treatment, ML-HSP trainees must be familiar with the meaning of common statistics (e.g., p-values and effect sizes), to ensure a treatment is likely to be effective for their clients. Furthermore, ML-HSP trainees should be able to identify the limitations of these statistics (e.g., p-values are sensitive to sample size) and compare the utility of statistics (e.g., p-values are less clinically relevant than effect sizes). In addition to competency in social science and health statistics, ML-HSP trainees must demonstrate basic competence in study design and methodology to be able to effectively interpret empirical literature relevant to their clinical practice. Since study design determines validity and reliability of findings (e.g., etiology, assessment, treatment efficacy), trainees must be able to understand the strengths and limitations of study design (e.g., randomized controlled trials are the gold-standard for determining treatment efficacy). However, degree of validity (e.g., credible placebo-controlled trials provide stronger evidence for efficacy than no-treatment control groups) and reliability (e.g., participant sampling techniques) are highly dependent on methodology. One cannot expect a ML-HSP provider to effectively choose from hundreds of treatment options without understanding the scientific methods and

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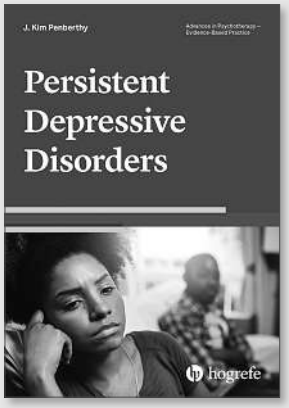

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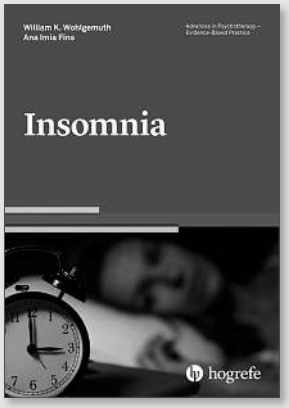

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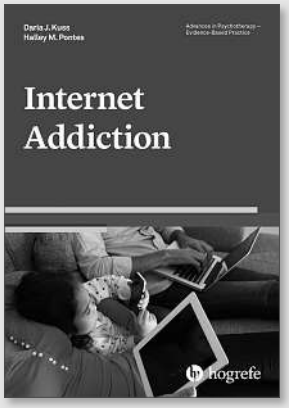

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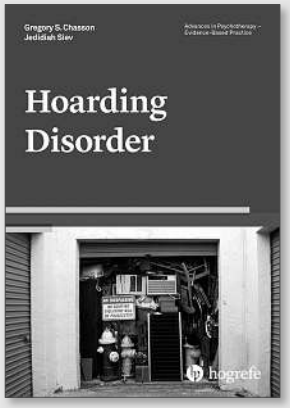

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designs employed to evaluate those treatments.

Paramount to scientific competency is the ability to integrate statistical and methodological knowledge within the greater scientific knowledge base. This requires skills in thinking critically and scientifically about evidence (e.g., understanding the difference between science and pseudoscience). A critical/scientific lens is key due to a checkered history of mental health treatments, which is replete with pseudoscience and iatrogenic treatments (e.g., Lilienfeld, et al., 2015; Lilienfeld, 2007). Similarly, emerging concerns regarding replicability (e.g., Tackett et al., 2017) and reliance on clinical trials that are fraught with reporting errors, low-power, inflated rates of significance, and weak controls (Sakaluk et al., 2019), highlight a need for scientifically minded practitioners.

Common Factor Competencies

Several factors that are common across different intervention models have been associated with improvement in symptoms and functioning in people suffering from mental health problems (Castonguay, 1993). For example, developing and maintaining an optimal therapeutic alliance between the client and provider is common among all intervention models (Cuijpers et al., 2019). Based on reviews of psychotherapy outcome research, correlational evidence (Cuijpers et al., 2019) indicates approximately 30% to 50% of improvement in psychotherapy is attributable to common factors, whereas only 15% to 17% is attributable to factors or "techniques" that are specific to an intervention model (Cuijpers et al., 2012; Lambert, 1992). Further, common factors appear to actively contribute to improvement in psychological interventions, rather than simply serving as foundational conditions necessary for specific factors to spur improvement (e g., Solomonov et al., 2018). Common factors are often delivered along with specific factors, and evidence suggests that they likely act in combination to improve symptoms and functioning in psychological interventions (de Felice et al., 2019). Table 1-B lists essential and specific competencies for guidance for how to train ML-HSP providers in developing the common factors necessary to be effective (e g., Cuijpers et al., 2019).

Assessment Competencies

All successful treatments must begin with thorough assessment in order to gain an understanding of the client's presenting issues and to formulate a treatment plan. ML-HSP training is encouraged to cover the core assessment competencies identified in Table 1-C as: (a) diagnostic assessments, (b) functional assessments, (c) case conceptualization, (d) treatment planning, and (e) measurement-based treatment. ML-HSP trainees should approach assessment with a scientific mind by using empirically validated measures to inform diagnoses, and developing functional analyses of presenting problems. These will then lead to an accurate case conceptualization and effective and efficient treatment planning through identifying which intervention strategies should be applied to the hierarchy of treatment targets (Antony & Barlow, 2010). The importance of continual assessment throughout treatment should be highlighted through the use of ongoing measurement-based care in order to inform the clinician and client how progress, or lack thereof, is being made, which can then lead to adjustment of care if necessary (Scott & Lewis, 2015).

Intervention Competencies

Paramount to quality ML-HSP education is training and attainment of skills in evidence-based transdiagnostic intervention strategies. Training in transdiagnostic interventions is advantageous for the following reasons: First, there are high co-occurring rates across many mental health problems, with considerable overlap in underlying vulnerabilities that can be addressed with the same interventions (Brown et al., 2001). Second, it alleviates the impractical training burden that is brought on by the expectation for ML-HSP trainees to learn numerous single-disorder treatment protocols.

The following seven broad transdiagnostic intervention strategies were identified, listed in Table 1-D, as key components to various treatment protocols across different theoretical orientations: (a) motivation, (b) awareness, (c) distress tolerance, (d) psychological flexibility, (e) decreasing avoidance and increasing engagement, (f) clarifying values, and (g) interpersonal effectiveness. ML-HSP trainees should understand the function and putative therapeutic mechanism for each of these intervention strategies in order to effectively and flexibly apply them to each clinical case.

Professional Values Competencies

In addition to competency in assessment, transdiagnostic intervention, common factors, and a solid foundation in scientific knowledge, an essential element in training ML-HSP providers is a focus on the development of professional values. While training institutions may address additional professional standards, three fundamental values have been identified within this domain: ethics (Table 1-E), diversity and equity (Table 1-F), and interdisciplinary collaboration and professional consultation (Table 1-G). Regarding ethics, at a basic level, ML-HSP trainees should be familiar with relevant ethics codes (e.g., APA, 2017) and state laws; training institutions should also focus on educating trainees in ethical "grey areas" they will likely face as delivery methods evolve (e.g., providing assessment and psychotherapy services via app-based platforms). At a more fundamental level, ML-HSP trainees should be trained in self-reflection (e.g., Cooper & Wieckowski, 2017) and decision-making processes to recognize and address ethical dilemmas. Exposing trainees to different ethical decision-making models (Cottone & Claus, 2000) and engaging in practice using these models in their clinical work may help prepare ML-HSP trainees to more systematically address ethical dilemmas as they inevitably arise in clinical practice.

A dedicated focus on the values of diversity and equity, with an emphasis on training ML-HSP providers in cultural humility, cultural competence, and advocacy (Whaley & Davis, 2007) is essential for ensuring that providers can address the needs of diverse individuals with mental health problems. Programs should educate trainees on factors that may impact providers' clinical care with individuals from minority groups (e.g., racial bias; Garb, 1997) and provide training in the essential "soft skill" of reflective practice to increase self-understanding and insight into providers' potential blind spots and areas of growth to ensure they are able to provide culturally competent care (Sandeen et al., 2018). Aligned with training in diversity is education in advocacy. ML-HSP trainees should understand social, economic, and cultural factors that impact individuals' ability to access and engage in mental health treatment. Providers should be educated on ways they can advocate for individuals with mental health problems as well as assist their clients in self-advocacy.

Finally, preparing ML-HSP trainees to engage in interdisciplinary collaboration and seek professional consultation when needed is an important element to their

professional training. It is likely that many ML-HSP providers will operate within an interdisciplinary team (including psychiatrists, nurse practitioners, doctoral-level psychologists, social workers, occupational therapists). Thus, ML-HSP trainees should understand the unique role they can play within a team-based approach to mental health care as well as best practices for care coordination and interdisciplinary practice. Finally, ML-HSP trainees should understand and function within the bounds of their scope of practice. They should also be trained to self-reflect on limitations in knowledge/competence, be familiar with consultative resources and seek outside consultation when needed, including supervisors and interdisciplinary team members.

Concluding Remarks

A major shift is occurring in HSP with the promulgation of accreditation of ML-HSP training programs. As the educational and training communities respond to this shift, it is vital that a set of competencies be developed and disseminated in order to guide trainee development and outcomes. The competencies and recommendations presented in the table and the above narratives represent an effort to help in this regard. The general position of this workgroup was to focus on providing a feasible set of competencies commensurate with entry-level practice of a ML-HSP provider. We understand many competencies proposed in the article have been well articulated by prior workgroups or task forces (e g., Fouad et al., 2009) and we don't believe this should be the final examination of competencies for ML-HSP programs. Our guiding boundary was to develop competencies that would reflect state-of-the-art ML-HSP training. It is fully appreciated and understood that these competencies can and will likely be implemented selectively and differentially across programs based on their model, aims, objectives, outcomes, and structure. For example, most state licensing boards already require training in research methods and program evaluation for master's-level providers. This requirement is an ideal opportunity to survey existing master's-level programs for ways to teach and assess scientific competencies. While there are numerous ways to demonstrate competence (e.g., a traditional paper-and-pen examination, including the scientific basis of treatment choice in a case report), our goal is to merely set the goals while not prescribing the methods. Furthermore, training programs may have to rethink the structure of clinical supervision, the elective courses being offered, the scope of training (e.g., types and severity of disorders), and any additional didactic training to meet these competencies.

ML-HSP competencies are of primary importance for mental health consumers and public perception; hence, our aim was to specify the knowledge, skills, and attitudes that will most likely result in high-quality care and professionalism. While this set of competencies has been reviewed favorably by the members of ATES and is in line with Callahan's (2019) item response analysis of recommended ML-HSP competencies, future work will need to include broader vetting of these domains as well as assessing their utility for ML-HSP programs. Despite any limitations, it is hoped that the competencies presented in this article will help guide those charged with developing guidelines and regulations

Table 1. Competencies for Master's-Level Health Service Psychologists

Core Competency	Specific Competencies
A. Scientific Foundations	
1. Be knowledgeable and aware of statistics	Be able to interpret, compare, and identify strengths/limitations of statistics (e.g., *p*-values and effect sizes) in social science and health research.
2. Be knowledgeable and aware of research methodologies	Be able to interpret, compare, and identify strengths/limitations of study design (e.g., case reports, pre/post trials, controlled trials, meta-analyses), especially regarding strengths/limitations of validity and reliability, in social science and health research.
3. Attain skills in critical/scientific thinking	Be able to integrate evidence through a scientific lens about human behavior that includes, but is not limited to, the role of learning, culture, physics, genetics, and biology. Be able to recognize the difference between science and pseudoscience.
B. Common Factors	
1. Attain skills in establishing and maintaining an optimal therapeutic alliance	Be able to understand and respect who you work with while developing bonds and expectations for treatment efficacy.
2. Attain skills in developing a collaborative approach with clients	Be able to reach consensus on symptoms/diagnoses, goals, and understand and address presenting problems. Be able to elicit and respond to feedback.
3. Attain skills in empathy, warmth, and genuineness	Be able to identify, understand, and communicate emotional experiences and perspectives based on presenting problems.
4. Attain skills in positive regard and affirmation	Be able to experience and express acceptance/support. Be able to validate and normalize experiences.
5. Attain skills in active listening and communication	Be able to use appropriate and facilitative nonverbal (e.g., eye contact, facial expressions, nonlexical encouraging utterances) and verbal cues (e.g., open-ended questions, clarifying questions, summary statements).
6. Attain skills in adaptation to relevant individual and cultural variables	Be able to adapt to varying developmental levels. Be able to adapt conceptualization and approach so it is acceptable and consistent with variable perspectives (i.e., individual and cultural).
C. Assessment	
1. Attain skills in diagnostic assessments	Be able to select and administer empirically validated structured interviews, rating scales, self-report measures, and collateral reports as relevant to presenting problems.
2. Attain skills in functional assessments	Be able to carry out functional analysis of presenting problems to understand the causal and functional relationships among symptoms, triggers, emotions, thoughts, behaviors, and consequences.
3. Attain skills in case conceptualization	Be able to formulate an integrated case conceptualization based on science-based treatment principles (e.g., cognitive-behavioral, psychodynamic) that link symptoms, problems, and life events and guide treatment plan development.
4. Attain skills in treatment planning	Be able to develop, collaboratively, an organized treatment plan with a hierarchy of treatment targets that is appropriate for presenting problems and goals.
5. Attain skills in measurement-based treatment	Be able to inform treatment planning and care on data collected throughout treatment. Understand the validity and sensitivity to change of different measures. Utilize routine outcome monitoring to inform treatment and adjust care as needed.
D. Intervention	
1. Attain skills in increasing motivation	Be able to effectively present rationale for intervention target skills. Be able to help clients resolve ambivalent feelings and insecurities that prevent change.
2. Attain skills in increasing awareness	Be able to implement mindfulness interventions that increase awareness of thoughts, emotions, and behaviors.
3. Attain skills in increasing distress tolerance	Be able to implement interventions that assist in effective management of emotional experiences (e.g., relaxation exercises, acceptance, crisis management).
4. Attain skills in increasing psychological flexibility	Be able to implement interventions related to cognitions (e.g., reappraise, reframe, restructure, defuse/distance) to modify beliefs and gain insight.
5. Attain skills in decreasing avoidance and increasing engagement	Be able to help clients recognize thoughts and emotions as internal constructs that should be acknowledged but should not be the basis of behavior. Be able to help clients construct a hierarchy of feared situations for both situational, imaginal, and interoceptive items and integrate into plan for exposure. Be able to help clients conduct exposures in order to learn fear/anxiety tolerance and re-evaluate anticipated consequences. Be able to help clients construct an activity schedule consisting of activities that bring pleasure and sense of mastery. Be able to help clients learn relationship of engaging in the activities and their mood.

Table 1 Continued

6. Attain skills in clarifying values	Be able to implement interventions that identify, clarify, and prioritize values and goals.
7. Attain skills in increasing interpersonal effectiveness	Be able to implement interventions that increase effective communication (e.g., assertiveness, validation).
E. Professional Values - Ethics	
1. Be knowledgeable and aware of ethical principles, guidelines, conduct, and behavior	Be familiar with clinical practice guidelines, relevant ethics codes, state laws, informed consent process, record keeping guidelines and rules for conduct for professional practice.
2. Attain skills in ethical conduct/behavior across new, exploratory, or complicated professional activities	Understanding of the limitations of various delivery methods of treatment. Understanding limits of confidentiality. Understanding methods for assessing effectiveness of intervention and using data in ongoing treatment planning.
3. Attain skills that improve ethical decision-making	Be able to use self-reflection for ethical dilemmas. Understand and use ethical decision-making models.
F. Professional Values – Diversity and Equity	
1. Be knowledgeable and aware of cultural competencies	Knowledge of relevant multicultural literature and APA guidelines.
2. Attain skills in cultural diversity	Be able to practice appreciation and humility for individual differences and diverse populations. Understand disparities in receipt, retention, and outcomes in services among ethnically diverse populations. Understand cultural models.
3. Attain skills in self-reflection and continued learning	Be able to reflect on potential blind spots. Understand the importance of commitment to life-long development. Be able to practice cultural self-assessment.
4. Attain skills in advocacy through knowledge and awareness of health disparities/systemic inequality	Be familiar with the factors (e.g., social, economic, and cultural) that impact access to services. Be able to identify specific barriers to help seeking or improvement. Be able to assist in self-advocacy.
G. Professional Values – Interdisciplinary Collaboration and Professional Consultation	Understand the roles within interdisciplinary teams. Be familiar with best practices for care coordination and interdisciplinary practice.
1. Attain skills in interdisciplinary collaboration	Be able to identify limitations in competencies and seek consultation when needed.
2. Be knowledgeable and aware of competencies	Be able to identify consultative resources.

for ML-HSP programs, and ensure that ML-HSP trainees are adequately equipped to deliver effective and efficient services, ultimately reducing the burden of mental health problems.

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Setting Standards for Supervision in a Clinical Science Training Clinic

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**denotes equal contribution*

OFTEN DESCRIBED as the "signature pedagogy" of clinical psychology (Goodyear, 2007), supervision is a complex and multifaceted clinical activity drawing on multiple distinct and interrelated competencies. In the past two decades, progress has been made in identifying the competencies central to supervision (e.g., American Psychological Association, 2015; Association of Social Work Boards, 2009; Falender et al., 2004; Falender et al., 2016) and to cognitive-behavioral supervision specificially (e.g., Newman, 2010; Sudak et al., 2016), which has fostered a growing awareness for defining and promoting standards of supervision quality in direct service contexts as well as training contexts (e.g., Mennen et al., 2018). Preconditions for the development of robust models for high-quality supervision involve not only establishing those standards, but also developing corresponding measurement and monitoring strategies to promote them. However, despite emerging consensus on several broad components of supervisory competency (e.g., diversity, ethics, establishment of a supervisory working alliance), there is currently no gold-standard measure that is used to evaluate supervisory competencies.

There have been some systems described in the literature for identifying and measuring specific supervisory competencies. For example, quality control features have been implemented for community supervisors seeking certification in the evidence-informed service system Managing and Adapting Practice (MAP).

Prospective MAP supervisors working within community mental health agencies must pass a performance review that includes self-evaluation of their own learning experiences and competencies as well as supervisee ratings of their performance on 15 supervisory competencies (Westman, Daleiden, & Chorpita, 2019). However, these models have largely been specific to service provision contexts and limited to the application of specific evidence-based practices. There remains a need for models that describe standards for supervisors and corresponding measurement practices within the context of graduate training clinics.

Although graduate training programs are likely to vary somewhat in their key supervisory competencies depending on discipline and training model, there may be some shared key strategies for articulating and measuring supervisory standards. We offer one example from the context of a clinical science training program in psychology, which includes both general competencies as well as some that may be specific to a clinical science context. The central tenet of the clinical science model is that mental health care services need to be grounded in science, and training in research and in practice are seen as fully integrated endeavors, with science at the center of both pursuits (McFall, Treat, & Simons, 2015). In this case study, we describe the process by which we established standards for supervisors in the context of a graduate training clinic, detail our operationalized standards and our mechanisms for measuring and promoting them, and provide a description of the subjective impact of these new processes on supervisors.

Methods

Context

The setting for the current project is a university-based training clinic in which students from the clinical psychology Ph.D. program obtain assessment and psychotherapy practicum experience prior to internship. The clinic serves individuals from the local community on a sliding-scale basis for a wide array of presenting concerns. The Ph.D. program has accreditation from both the American Psychological Association and the Psychological Clinical Science Accreditation System (PCSAS) and subscribes to a clinical science model. In the clinic, this model is embodied in several practices, including an emphasis on training in evidence-based assessment and psychotherapy practices, use of routine outcome monitoring, regular integration of data collection for research into clinic procedures (with client consent), and critical evaluation of treatment decisions utilizing both research and local evidence. The training clinic is led by the Clinic Director, an Associate Clinic Director, and two full-time staff members, in partnership with four tenure-track faculty and two graduate students on the Clinic and Placements Committee. At present, there are five tenured faculty who supervise therapy services in the clinic and an additional 43 supervisors from the community who, in exchange for providing supervision, receive unpaid appointments in the voluntary Clinical Faculty series and access to the library and online library resources. Approximately 40 students receive practicum training at the clinic each year, with specific training experiences determined by the student's year in the program and training goals. First-year students complete two comprehensive psychoeducational evaluations. In the second year, students carry a caseload of one or two individual adult cases and one child or family case, and conduct intakes. Advanced students carry caseloads ranging from one to five therapy and/or assessment cases.

The process of developing new standards for the initial appointment and review of supervisors began in 2015. Prior to that time, the guidelines for supervisory appointments and renewals had been guided by a document initially developed in 1988. The document provided a fairly limited description of the qualities supervisors would be expected to possess: an area of specialty needed by the clinic, 2 years of experience following the Ph.D., and licensure. The procedures for initial review detailed only an unspecified screening by the clinic director, recommendation by the Clinic and Placements Committee, and a vote by the full clinical area faculty. Review and promotion were determined primarily by the years since Ph.D., number of years of service as a supervisor, and unique contributions to the field for appointment as a full clinical professor.

Although the general nature of these criteria appeared to have the advantage of providing significant latitude regarding appointments, they ultimately led to the proliferation of idiosyncratic criteria in evaluating applicants who were seeking initial appointment as a supervisor. There was significant debate and little consensus about how to weigh various aspects of the backgrounds of potential supervisors, including degree type, research history, training history, and self-described approach(es) to practice. For example, a history of research productivity was a factor heavily favored by many faculty in making their decisions for initial appointment. This criterion both significantly limited the pool of potential supervisors in a way that presented challenges for our supervision-intensive program and also, at times, obscured other indicators that a supervisor might not be well aligned with our training model. As a result, the existing supervisory pool at the time this project began included several supervisors whose practice was a poor fit for the program's clinical science model (e.g., declined to utilize any routine outcome monitoring measures, practiced using an exclusively psychoanalytic approach). Perhaps this is not surprising given that a 2006 survey (Weissman et al.) found that only 56% of psychology Ph.D. programs, 33% of Psy.D. programs, and 38% of master's in social work programs met the gold standard of requiring both didactic and clinical supervision in at least one evidence-based practice (EBP). Therefore, neither degree type nor research history was an appropriate proxy for having received training in EBPs or using them as a primary form of practice. Furthermore, supervision was not readily recognized as an independent competency at the time that the initial standards were developed, and therefore expertise in this essential domain was not a clearly defined consideration. Finally, although students routinely rated their satisfaction with supervisors, there was no clear integration of student ratings into the process of evaluating and promoting supervisors.

The initial response taken to try to rectify this growing awareness that supervision did not mirror the program's clinical science model was to attempt to recruit additional members of the tenure-track faculty to serve as supervisors. This approach seemed most in line with clinical science ideals, as students could directly observe faculty actively integrating their areas of research and clinical expertise (McFall et al., 2015). We surveyed all faculty regarding perceived barriers and advantages to supervising in the clinic and attempted to identify additional faculty supervisors. However, due to a combination of self-perceived boundaries of clinical competency, personal preference, and existing research and teaching commitments, these efforts were ultimately unsuccessful in yielding additional supervisors.

At that stage, the Clinic and Placements Committee members, along with the clinic leadership, began to design procedures that would allow us to better evaluate the fit of community-based supervisors with the competencies that the program at large had defined as most important for clinical training, and to monitor and encourage continuous growth in the application of these competencies.

Barriers

There were several important challenges that needed to be articulated and surmounted in order for this process of identifying and measuring supervisory competencies to be successful (Levine et al., 2017). An important philosophical barrier was a lack of consensus among stakeholders, including faculty, students, and clinic administration regarding the central competencies required for supervision in the clinic. An important practical barrier to identifying supervisors in line with the clinical science model was the relative paucity of graduates from clinical science programs given that only 43 programs are currently accredited by PCSAS (n.d.) and the fact that individuals who are in research-oriented positions often have little time for clinical supervision of students, particularly those who are affiliated with a different institution. In addition, there were organizational barriers, including the need to develop screening and review procedures that could be implemented consistently and fairly, and at low time and monetary cost for a fairly large group of supervisors. It was also important that any new procedures not create excessive time demands for supervisors, who serve in a volunteer capacity and are balancing their unpaid service to the clinic with many other professional obligations.

Approach

In the process of developing the new standards, we convened a workgroup of the non-tenure-track clinic leadership and tenured faculty on the Clinic and Placements Committee to develop and champion these new standards to the full academic department. At multiple points throughout the development and implementation process, we consulted with other workgroups of stakeholders, including focus groups with supervisors regarding their reactions to these new processes and review of student feedback on strengths and challenges with current supervisors (see Table 1 for full list of strategies used).

Our first step was to identify the philosophical and practical qualities that we felt were essential for supervisors to possess. This process led to the development of the five standards:

1. Supervisors must take a clinical science orientation to supervision and clinical practice. Rather than conflating the clinical science orientation with any one set of theoretical approaches, we determined that we wanted supervisors who followed the evolving evidence base (Chorpita, 2019) and grounded their practice in scientific epistemology (McFall et al., 2015). We operationalized this to mean that a detailed interview regarding supervisors' practices, including description of a recent case, would indicate that supervisors' clinical decision making involved hypothesis testing and disconfirmation through review of relevant evidence (including research literature and case outcome data).

2. Supervisors must possess expertise in one or more evidence-based treatment or assessment models. We presented a broad definition of how such expertise may be demonstrated, including publication of scholarly articles, invited or peer-reviewed presentations related to the area of practice, teaching of relevant coursework, board certification, supervised experience and coursework, and/or leadership roles in relevant professional organizations. Furthermore, we articulated that supervisors would ensure through proper evidence-based assessment that their expertise was appropriate to the case being supervised, in keeping with clinical science's focus on basing treatment decisions on evidence rather than strict adherence to a particular set of practices (McFall et al., 2015).

3. Supervisors must have training and/or experience with best practices in supervision. Recent guidelines for the practice of supervision have highlighted the importance of formal education and training in supervision (Falender et al., 2016). Given that only a minority of graduate and internship programs provide an opportunity to receive supervised experience in supervision (Lyon et al., 2008), we had to take a broad view of experiences that might qualify in this category, including coursework, meta-supervised practice, or continuing education of at least 6 hours duration in the past 5 years. We also provided existing supervisors with at least 5 years of experience in the clinic additional time as needed to obtain the formal training described in this standard.

4. Supervisors must be licensed in the state of California and possess a doctoral degree in the field of clinical, counseling, or educational psychology, psychiatry, or a related behavioral health degree.

5. Supervisors must commit to the process of continuous growth through participation in quality review procedures:

(a) Supervisors must meet expectations for the amount and type of supervision provided on a weekly or by-case basis. Supervisors of 1st years completing assessments were expected to live-observe both intakes and feedback sessions and to review videotape of testing. Supervisors of 2nd-year students were expected to watch their trainee's therapy session in full each week and meet with the supervisee for 1 hour. Supervisors of 4th- and 5th-year students were generally expected to provide 1 hour of supervision per trainee that includes video review. In addition, all supervisors were expected to provide thorough and timely review of notes and reports, and regular review of routine outcome monitoring measures.

(b) Supervisors were rated by supervisees, with data reviewed by the clinic director, on an annual basis. Supervisors were required to maintain an average score at or above the midpoint of the scale on each dimension of the student annual evaluation of the supervisor.

(c) Supervisors must participate in a review process (at least every 3 years or when a minimum of three student evaluations are gathered) that involves the supervisor's review of student evaluation feedback (de-identified and compiled by the clinic director), and a self-evaluation of strengths and areas for improvement, including the setting of performance goals for the next evaluation cycle.

Under these new guidelines, the initial review of potential supervisors consisted of a semistructured interview based on these five standards conducted by at least one member of the clinic administration and one faculty member of the Clinic and Placements Committee, in conjunction with a review of a self-statement describing one's approach to practice and a curriculum vitae. All other procedures regarding faculty review and vote were retained from the prior standards.

As alluded to in the fifth standard, we recognized that recommendations for reappointment or promotion in the clinical professor series would require data to both monitor that the supervisors are indeed

Table 1. Implementation Strategies Used in Setting Supervisory Standards

Implementation Strategy	Definition of Strategy (Powell et al., 2015)	Approach in Clinic
Identify and prepare champions	Identify and prepare individuals who dedicate themselves to supporting, marketing, and driving through a strategy, overcoming indifference or resistance that the intervention may provoke in an organization	Convened a workgroup of non-tenure-track clinic leadership and tenured faculty on the clinic committee to develop and champion the new standards to the full department
Use advisory boards and workgroups	Create and engage a formal group of multiple kinds of stakeholders to provide input and advice on implementation efforts and to elicit recommendations for improvements	Consulted with various workgroups of stakeholders throughout standard development and implementation including supervisors and students receiving supervision in the clinic
Revise professional roles	Shift and revise roles among professionals who provide care, and redesign job characteristics	Developed five standards for supervisors aligned with the specific needs and model of the clinic
Alter incentive/allowance structures	Work to incentivize the adoption and implementation of the clinical innovation	Appointed new supervisors and promoted existing supervisors based upon new standards
Develop and implement tools for quality monitoring	Develop, test, and introduce into quality-monitoring systems the right input specific to the innovation being implemented	Created student feedback forms and supervisor self-reflection forms with items reflective of the five developed standards and general supervisory competencies
Audit and provide feedback	Collect and summarize clinical performance data over a specified time period and give it to clinicians and administrators to monitor, evaluate, and modify provider behavior	Compiled student feedback forms to be reviewed by the Clinic Director and Clinic and Placement committee. Compiled anonymized aggregated feedback data and provided to supervisors.

implementing the practices they described during the period of initial appointment and to promote ongoing growth and continual learning. In order to do that, we created parallel self- and student-report forms of 20 items drawn from the five standards above and from best-practice consensus guidelines for supervision (Falender et al., 2016). Both versions use a 5-point Likert scale to rate the frequency and level of skill supervisors demonstrated when engaging in key supervisory practices (1 = *infrequent or ineffective demonstration*, 3 = *active implementation with room for growth*, 5 = *consistent and expert demonstration*). Clinic staff have collected these supervisory rating forms (SR-20; items shown in Table 2) from supervisees each year, and the compiled data were reviewed by the clinic director. Any supervisor with an average score falling below the midpoint of the scale on any item was reviewed by the Clinic and Placements Committee, whcih then recommended termination or remediation. When the clinic director had enough student feedback for a supervisor to provide an anonymized aggregate (at least three ratings), average scores on each item as well as paraphrased qualitative feedback were provided to the supervisor. In conjunction with that student feedback, supervisors were asked to complete a self-evaluation on a parallel version of the 20 items and to identify three goals for the upcoming training year. We determined that we would not collect supervisors' self-evaluations due to concerns that review of those scores would decrease supervisors' willingness to identify and reflect on areas of relative weakness, but we collected and periodically reminded supervisors of the goals they identified.

Results

Changes to the Supervisory Workforce

In the year prior to the creation of these new supervisory standards in 2016, there were 42 volunteer clinical faculty and five tenured faculty supervising in the clinic. Since the implementation of the new standards, an additional 20 supervisors have been appointed. It should be noted that these 20 additional supervisors were drawn from a much larger pool of individuals who contacted the clinic director to express an interest in supervising, approximately half of whom were determined not to meet our supervisory standards. Over that same period of time, 12 previous supervisors had their appointments terminated due to lack of fit with the new supervisory standards, and an additional 17 supervisors resigned from their positions for other reasons (e.g., retirement, relocation, new primary employment, family and health reasons), some of whom were both appointed and resigned during the time since the creation of the standards. At present, we have 43 volunteer clinical faculty and an unchanged number of tenured faculty supervising in the clinic.

Supervisory Rating Form (SR-20)

The SR-20 was collected for 198 therapist-supervisor dyads over the course of 3 academic calendar years between 2016 and 2019. Descriptive statistics for supervisee responses are provided in Table 2. Mean ratings were high for each of the items and supervisees utilized the full range of response options. Composite scores were calculated for each of the SR-20 submissions that did not contain missing data (N = 151, M = 4.26, SD = .67). Reliability estimates were conducted on composite scores and yielded a Cronbach's alpha value of .95 and an intra-class correlation coefficient of .31, indicating that SR-20 has high internal consistency and that 31% of the variance in composite scores is accounted for by supervisors.

Supervisor Responses

Current supervisors were asked to anonymously provide their perspective on receiving and incorporating feedback from the students they supervise as well as completing self-assessment and goal setting. Of the supervisors who responded to the online survey (n = 20), 15 indicated that they received a summary of SR-20 scores completed by their supervisees. Of those who received scores, 11 (80%) stated that this feedback positively impacted the way they supervise in the clinic. For example, one supervisor said, "It has helped me to address topic areas my supervisees felt were lacking in supervision. In addition, the positive feedback has been validating and rewarding, and made me feel my work has benefitted the students and clients served at the psychology clinic." Another supervisor reflected, "I have tried to focus more on regularly reviewing data, doing role-plays, and feedback to video observation." Three supervisors (20%) indicated that receiving feedback was reinforcing but not did not lead to behavioral change, with one commenting, "I have been encouraged by the feedback. It has not given me much specific new direction."

Of the supervisors who shared their perspective, 18 indicated that they completed the supervisor self-rating form and 19 indicated that they engaged in supervisor goal setting. Of those who completed the supervisor self-rating form, 16 (89%) reported that this form of self-evaluation positively impacted their supervision practice. For example, one supervisor stated, "This has made me more aware of my supervision style and think about ways to improve. I have tried to be more Socratic than didactic and let supervisees think about their decisions." Another supervisor remarked, "I have become more focused on tracking outcomes on multiple measures/variables." Two supervisors (11%) indicated that self-rating did not impact the way they supervise, with one supervisor responding that they were "pretty self-aware of where supervision has gone well and where I might do something better."

Of the 19 supervisors who indicated they engaged in goal setting, 17 (89%) reported that it positively impacted their supervision practices and two (10%) indicated that goal setting did not influence their supervision. For example, one supervisor explained, "Goal setting was an opportunity to select one area of my choosing to target a specific area of supervision. I was resistant as the process started as it felt like a remediation even though it wasn't presented in that way. But a year later, it provided a useful time point for reflection and review." In contrast, another supervisor said, "Did not find [goal setting] useful. Always actively involved in supervision, motivated to do my best. Goal setting seemed [like] just some more paperwork."

Discussion

We have drawn several conclusions from this experience of designing and implementing new supervisory standards for a clinical science graduate training clinic. First, we found that the process of articulating supervisory standards and corresponding measurement tools was useful both for the program and for our supervisors. These standards have reduced ambiguity and increased consensus in our process of supervisor appointment and promotion. Importantly, most supervisors reported positive reactions to these new processes of self- and student-evaluation and described making positive changes to their supervisory practices as a result. We attribute our ability to articulate and operationalize a successful set of standards for supervisors to the process of involving multiple stakeholders across various phases of the development process. Additionally, we were able to design procedures that placed relatively minimal burden on both students and supervisors. Finally, we found that it was feasible, even when relying on a volunteer supervisory workforce, to set high standards for supervisory competencies in line with a clinical science model while retaining a sufficient number of supervisors.

Findings from the student rating forms and the supervisor survey indicate that these other key stakeholder groups perceive the outcome of this process in a positive light. Total SR-20 scores, as well as ratings for most individual items, were generally high. These findings are encouraging and suggest that, in sum, supervisors are indeed engaging in the supervisory competencies identified in the five standards. However, supervisees did use the full scale across items. Given the overall high ratings, lower scores for individual items may be meaningful to supervisors. By design, items are worded in a way that provides behavioral guidance for supervisors seeking to improve their performance on a given competency. This appears to be substantiated by the feedback collected from supervisors, the majority of whom indicated that receiving feedback via the SR-20 positively impacted their supervision practices. Of note, the item related to active learning strategies (modeling, role-play, rehearsal) received the weakest endorsement. Active learning, specifically modeling and role-play, has been shown to be predictive of subsequent supervisee skill (Bearman et al., 2013), suggesting this set of competencies is a particularly important growth edge for our current supervisors and should be encouraged at a program level.

It is important to note that aspects of both our process and our measurement tools may not be applicable in other settings. Most important, the competencies we selected both for our standards and for the supervisor rating form may not fit with the model and goals of other programs, even other programs in the clinical science model. State-specific regulations about the degree type and licensure status of supervisors must also be taken into consideration. In addition, the desire to reduce the measurement burden on both students and supervisors led to a fairly concise list of measured competencies. Other programs may find that greater specificity within certain competencies is required or desireable. However, the notion that clear standards should be used in supervisory appointments and that supervisory competencies should be routinely measured may be useful for a wide variety of settings irrespective of the specific competencies that are foregrounded. Programs that rely primarily or exclusively on tenure-track faculty for supervision may also face a different set of challenges in incorporating supervisory standards into existing evaluation processes. We also recognize that we are fortunate to be situated in a large, urban area with a large pool of potential supervi-

Table 2. Student Responses on the Supervisory Rating Form (SR-20)

Item	Min	Max	Mean	SD
1. Measuring and reviewing client outcomes to guide decision making.	1	5	4.33	.98
2. Encouraging you to reference the research literature and/or evidence-based resources to guide practice (e.g., review of relevant research; use of online learning materials, written protocols, evidence-based manuals, structured interviews or standardized assessment procedures).	1	5	4.58	.79
3. Having a clearly articulated focus of each planned clinical activity (e.g., purpose of this assessment is to inform what decision? Aim of this treatment procedure is to address what target?)	1	5	4.62	.77
4. Encouraging a hypothesis-testing approach to care delivery.	1	5	4.40	.91
5. Assessing and ensuring your level of preparation prior to ending supervision	1	5	4.54	.85
6. Collaboratively assessing and monitoring your competence and training goals, identifying clear targets for ongoing supervisee growth (including supervisee self-assessment and supervisor feedback).	1	5	4.41	.91
7. Using role play, modeling, rehearsal, or other experiential exercises designed to foster procedural knowledge and skill acquisition for identified supervisee goals.	1	5	4.13	1.05
8. Observing directly (e.g., live or recorded observation) to provide behaviorally-anchored feedback on competencies and identified supervisee goals.	1	5	4.34	1.09
9. Timely and thorough feedback on reports, case notes, and documentation.	1	5	4.48	.89
10. Attending to the ethical and legal aspects of clinical practice including appropriate boundaries, informed consent, and confidentiality.	1	5	4.83	.49
11. Attending to contextual (e.g., age, socioeconomic, geographic, community, and diversity) factors in clinical practice.	1	5	4.69	.69
12. Clarifying and ensuring understanding of supervisee roles and supervisor expectations (through a formal orientation, syllabus, or supervisory contract).	1	5	4.33	1.01
13. Attending to personal factors or emotions that may impact the therapeutic work; inquiring about challenges, supervisee disengagement, or burnout; creating an environment where you feel supported.	1	5	4.55	.89
14. Creating a professional climate where you feel safe disclosing weak areas, mistakes, challenges, or uncertainty.	1	5	4.71	.77
15. Providing ongoing constructive feedback using labeled praise (including encouragement of self-praise or peer praise).	1	5	4.61	.86
16. Identifying problems with the supervisory relationship and addressing them as appropriate.	1	5	4.43	.97
17. Seeking out, reflecting on, and incorporating feedback from supervisees.	1	5	4.46	.97
18. Dependability: comes to supervision on time and prepared	1	5	4.62	.89
19. Accessibility: can be reached in times of crisis or when needed for clinical questions or emergent concerns	1	5	4.63	.81
20. Overall rating of supervisor	1	5	4.26	.63

sors that enable us to have a high degree of selectivity. Additionally, although we feel optimistic about the utility of the SR-20 as a quality control procedure and tool for promoting supervisor growth, we caution that it has not been validated against objective measures of supervision behavior (such as coded observations) and recognize that it is likely subject to some of the biases, such as leniency bias, that are evident in supervisors' ratings of supervisees (Gonsalvez & Freestone, 2007).

There are several goals for the supervisory standards and evaluation process as it moves forward. First, we plan to continue program evaluation to ensure that we are moving towards growth in supervisory performance, both by improving within-supervisor performance and by attracting and retaining supervisors who excel in the identified competency domains. Additionally, we plan to examine the ways that supervisors are meeting (or not) the criteria and evaluate whether shifts need to be made to the way in which these standards are operationalized and measured. Finally, we strive to use this data to identify systematic ways to support the ongoing and continuous growth of our supervisors on our desired competencies.

In sum, the current project demonstrates the feasibility, acceptability, and utility of developing a set of standards and corresponding measurement procedures for supervisors practicing in the context of a clinical science graduate training clinic. Although the specific competencies measured and the procedures for doing so may vary, program-specific adaptations of this approach may prove useful in other clinical settings. As greater empirical attention is paid to the practice of supervision, we

hope there will continue to be advancements in the measurement of supervision competencies that can inform future revisions of these processes.

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teaching online

What You Need to Know to Run Your First Online Class

Daniel Beck, LICSW

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■ https://www.youtube.com/watch?v=9pes7yQvygY&feature=youtu.be

Navigating the New Landscape of Value-Based Care: An Example of Increasing Access, Improving Quality, and Reducing Costs Using the Unified Protocol

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IN 2015, the U.S. Congress passed one of the largest reforms of federal healthcare payment policy since the creation of Medicare/Medicaid and the passage of the Affordable Care Act. MACRA (the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015) was designed to reimburse healthcare providers based on the value of their service, not the volume of patients treated. Termed *value-based care*, this policy aligns with a population health model focused on the "health outcomes of a group of individuals including the distribution of such outcomes within the group" (Kindig & Stoddart, 2003). Starting in 2019, the law applied to clinical psychologists that met particular benchmarks based on service to Medicare patients.[1]

Value-based care is designed to shift financial risk from insurance payors to healthcare providers by financially incentivizing providers with upside (i.e., reward) and/or downside (i.e., penalty) contingencies linked to improved access to care and outcomes and reduced healthcare costs. Patient outcomes are weighed relative to the severity of presenting problems using the Centers for Medicaid and Medicare Services' hierarchically coded condition modifier so as not to disincentivize providers from treating patients with complex or severe presentations (Centers for Medicaid and Medicare Services, 2019). However, the increased uncertainty around yearly reimbursements may lead providers to treat fewer Medicare patients, leave the marketplace, or join larger practices. This shift in provider concentration could disproportionately impact areas with fewer behavioral health resources unless new providers or larger practices fill these gaps.

Given the influence of Medicare reimbursement policies on commercial insurance, value-based care models are expected to proliferate across the U.S. (Sharp et al., 2019). Clinical psychologists, especially those with training in (a) empirically supported, transdiagnostic, and process-based treatments (Hayes & Hofmann, 2018), (b) research methods, and (c) program evaluation are well-suited to lead the implementation of behavioral interventions in the new era of value-based care. We will outline the three primary goals of value-based care and discuss the role of clinical psychologists in achieving these goals. We conclude by describing how the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2018) is a candidate treatment to implement in settings accountable to value-based incentives.

Improving Behavioral Healthcare Access and Quality

In contrast to traditional reimbursement models based on the frequency of patient visits, value-based care incentivizes providers to demonstrate the best outcomes for the lowest cost. It is not possible to accomplish this goal without improving access to healthcare services. Access can be defined by the population receiving necessary behavioral healthcare. For instance, although 56% of Americans require behavioral health services at some point in their lives, 38% cannot access care due to barriers outside their control (e.g., transportation, long waitlists; Cohen Veterans Network, 2018). Even patients who do access care may be limited by the availability of evidence-based interventions (Gunter & Whittal, 2010). Time-limited, evidence-based interventions may be one way to increase access. Although evidence-based behavioral health treatments are often brief (e.g., 12–16 sessions; American Psychological Association [APA], Division 12), patients typically attend fewer than five sessions (Minami et al., 2008). This discrepancy highlights the need for very brief treatments. One promising approach is modular treatments, consisting of individual skills that each achieve their intended effects (Chorpita et al., 2005). Although current implementations of modular treatments may not outperform more holistic treatments per-session (Barlow et al., 2017), individual skill modules may be more easily sequenced to maximize early treatment gains (Sauer-Zavala et al., 2019). Brief treatments can be further optimized by implementing homework assignments based on a thorough functional assessment of target symptoms or incorporating technology such as smartphone-supported apps.

Enhancing Quality Through Integrated Care and Transdiagnostic Treatments

High-quality care is commonly operationalized and assessed by symptom improvement (Quality Payment Program).[2] Clinical psychologists can confer value in this domain by providing leadership to systems about how to identify, routinely administer, and interpret the most appropriate outcome measures in interdisciplinary medical settings to demonstrate the quality of care. Given clinical psychologists' scientific training, they are expertly placed to provide, supervise, disseminate, and evaluate assessment strategies and identify evidence-based interventions to further increase quality in value-based care models.

[1]The law will apply to clinical psychologists, or their practice groups, who bill at least $90,000 in a year to Medicare or who treat at least 200 patients with Medicare insurance. Providers who do not meet this Low Volume Threshold (LVT) may opt in to MACRA but will not be required to participate.

[2]To incentivize providers to use electronic medical records, document patient progress in qualified clinical data registries, and avoid patient claims, these are also evaluated as indicators of care quality.

Of course, clinical psychologists are not the only providers responsible for patients. In value-based care models, providers are incentivized to collaboratively treat patients' physical and behavioral health needs in an integrated care framework. In such models, providers may collaborate on treatment planning and outcome monitoring, using electronic medical records to implement protocols for stepped care. Integrated care models have been shown to be efficacious for certain disorders (e.g., depression) for nearly two decades (Unützer et al., 2002), and MACRA is expected to accelerate their proliferation. Providers can facilitate the use of integrated care by establishing typical care pathways for patients with particular clinical presentations. That is, each clinical presentation can be defined by a pathway to deliver evidence-based interventions known to change specific psychological mechanisms.

One of the largest barriers to developing care pathways, however, is the gap between patients' common diagnostic presentations and the treatment research literature. Patients often present for treatment with a variety of comorbid diagnoses (Al-Asadi et al., 2015), but most evidence-based psychological treatments are designed to target specific disorders (APA, Division 12). These treatments may be ineffective for providers because they require expertise in a different treatment for each disorder, placing an unreasonable training burden on providers.

A parsimonious solution to this problem is to implement transdiagnostic treatments that target a range of disorders by intervening on the shared features thought to contribute to their etiology and maintenance. The development, implementation, and evaluation of such treatments represent important ways clinical psychologists may demonstrate leadership.

Evidence-Based Psychological Interventions: Impact on Healthcare Costs?

A primary goal of value-based care models is to reduce healthcare costs. A recent meta-analysis indicated that patients hospitalized for a somatic complaint with psychiatric comorbidity incurred higher medical costs, were more frequently rehospitalized, and had longer lengths of stay than those without a psychiatric comorbidity (Jansen et al., 2018), suggesting effective treatment of psychiatric disorders could reduce system-wide healthcare costs. There is support for the greater cost-effectiveness of brief treatments, including cognitive-behavior therapy (CBT) for depression, relative to pharmacotherapy (Ross et al., 2019), and for similar levels of cost-effectiveness relative to longer treatments for particular conditions and populations (e.g., Slade et al., 2017). Studies evaluating collaborative care models have also demonstrated cost-effectiveness compared to usual care among patients with depressive (Jacob et al., 2012) and anxiety (Goorden et al., 2014) disorders. Given these results, it is reasonable to suggest that brief, transdiagnostic interventions could help reduce costs in value-based payor models.

An Example of Psychological Treatment in Value-Based Care

To accomplish the primary goals of value-based care, behavioral health providers might consider care models based on treatments that target common mechanisms maintaining behavioral health disorders. These treatments could be flexible and modularized, using clinical research to guide their implementation. Evaluation of behavioral health interventions will require psychometrically valid, brief, easily accessible (e.g., free) measures of change (e.g., symptoms, functional impairment) that patients routinely complete.[3] Interventions and assessment measures that fit these criteria may best align with the contingencies of value-based care.

One transdiagnostic intervention that may confer value in the era of value-based care is the UP. The UP is a transdiagnostic cognitive-behavioral treatment for mood, anxiety, and related disorders. It is designed to facilitate an accepting and willing attitude toward the experience of strong emotions to reduce reliance on avoidance-based coping strategies. An accumulating body of evidence suggests the UP is efficacious for multiple clinical presentations, including anxiety, mood, obsessive-compulsive, and related disorders (Sakiris & Berle, 2019).

Treatments such as the UP are well poised to meet the goals set forth by MACRA. The UP can increase patient access to care because it is a time-limited (8–16 session) protocol that consists of five core modules (understanding emotions, mindful emotion awareness, cognitive flexibility, countering emotional behaviors, interoceptive exposures). Preliminary data suggests these modules achieve their intended effects when delivered in isolation (Sauer-Zavala et al., 2017) and in a personalized order to match patients' strengths, which may lead to more rapid symptom improvement (Sauer-Zavala et al., 2019). Thus, even if patients only attend three to four sessions, they could still learn meaningful skills to improve their symptoms.

Standardized outcome monitoring is also embedded in the UP. Brief (five-item) assessments of functional impairment related to anxiety, depression, and "other" emotions (identified by the patient and therapist) are administered before each session and tracked throughout treatment. Because providers can directly compare patient progress on these metrics to the growing body of research on the efficacy of the UP (Sakiris & Berle, 2019), the UP may be a good choice for providers who seek to demonstrate treatment quality.

Finally, the UP has the potential to be cost-effective. Although no researchers have evaluated its cost-effectiveness to date, the UP has demonstrated efficacy across multiple primary disorders (Barlow et al., 2017) and comorbid conditions (Sauer-Zavala et al., 2020) comparable to single-disorder treatments, suggesting that it can be incorporated into care pathways for many diagnostic presentations. Providers could thus implement one treatment to (a) reduce training costs (McHugh & Barlow, 2010), (b) save providers' time preparing for sessions, and (c) potentially enhance provider competence in and fidelity to the treatment with repeated delivery. Investigation of the cost-effectiveness of the UP represents an important next step for the field.

Future Directions

The advantages of the UP in a value-based care model should be considered in light of its limitations. First, the standard form of the UP lasts 8–16 sessions, longer than many patients can complete (Minami et al., 2008). Ultra-brief versions of the UP may need to be adapted (Bentley et al., 2017) to enhance dissemination in community settings. Although ultra-brief

[3]For instance: https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019#measures *and* https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

transdiagnostic treatments may result in similar outcomes as more specialized or holistic treatments, providers may save on training costs by learning only one treatment. However, empirical data concerning the effectiveness of such dissemination efforts is currently lacking. Further, the UP has primarily been tested with anxiety or obsessive-compulsive disorders. Although these patients may comprise a large portion of cases (Delgadillo et al., 2014), especially among those who provide generalist care, comparisons of the UP to more holistic, evidence-based treatments for comorbid conditions is notably limited, albeit currently under investigation (Sauer-Zavala et al., 2020). Finally, the best method(s) for personalizing the UP (i.e., which skills, for whom, in what order; Sauer-Zavala et al., 2019) also requires further study.

As mental health providers adjust to the realities of value-based care, the need for high quality, cost-effective interventions accessible to the population they serve will only increase. We believe the UP is an example of one potential intervention, although further rigorous studies of its economic effectiveness are needed. We encourage clinical psychologists to take a leading role in the changing landscape of healthcare by studying, developing, implementing, and supervising brief, modular, transdiagnostic interventions to improve population health. This may involve explicit graduate instruction in the economic and structural impact of healthcare policies, such as value-based care. It may also involve more emphasis in clinical training aligned with value-based models of real-world care, including (1) prioritizing direct patient care using brief, modular, transdiagnostic treatments, (2) providing more training in supervisory and administrative roles (e.g., learning about finance, management, etc.), (3) practicing program evaluation and quality assessment using clinical science methods and principles, (4) using novel approaches for brief and cost-effective behavior change that integrate digital health assessment and intervention, (5) training nonbehavioral healthcare providers in strategies to manage behavioral health problems to offset medical costs, and (6) developing competence in wellness and prevention interventions. This breadth of training would equip new generations of clinical psychologists to apply their unique clinical and scientific talents to promote population health by increasing access to high-quality, evidence-based behavioral health interventions.

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The Importance of Empowering Nonbinary Psychology Trainees and Guidelines on How to Do So

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Nonbinary is used as an umbrella term for those who do not exclusively identify as men or women and is also used by some as a gender identity label itself (Matsuno & Budge, 2017). There are several different identity labels and experiences that fall under the nonbinary umbrella. For example, some people experience an absence of gender (e.g., agender, genderless), others experience a presence of multiple genders (e.g., bigender, pangender), others fluctuate between different genders (e.g., genderfluid, genderflux), or identify with third gender in-between or outside the gender binary (e.g., genderqueer, neutrois; Matsuno & Budge, 2017). Additionally, some nonbinary people may partly identify with being a man or woman (e.g., demiboy, demigirl; Barker & Richards, 2015). Some nonbinary people identify as transgender (referring to their assigned sex not aligning with their gender) whereas others do not. However, nonbinary people are often conceptualized as a subpopulation within the greater trans umbrella and are often distinguished from trans men (men assigned a female sex at birth) and trans women (women assigned a male sex at birth; Webb et al., 2017). Trans and nonbinary people (TNB) have often been grouped together in research due to the many shared experiences between them; however, it is worth examining the unique experiences of nonbinary people that may differ from trans men and trans women.

Nonbinary people experience substantial mental health risks, potentially greater than trans men and trans women (Lefevor et al., 2019; Reisner & Hughto, 2019). Minority stress theory posits that experiencing adverse conditions, such as identity-based rejection, discrimination, and victimization, contributes to the negative mental health outcomes found among sexual and gender minorities (Hendricks & Testa, 2012; Meyer, 2003). Research suggests that nonbinary individuals experience higher rates of minority stressors, such as harassment, family rejection, sexual abuse, and other traumatic events, compared to trans men and trans women and cisgender sexual minorities (Lefevor et al., 2019; Reisner & Hughto, 2019), which may explain the emerging findings on the mental health risks found among nonbinary people.

Nonbinary graduate students experience nonbinary-related minority stressors such as frequently being misgendered, being outed or harassed, and experiencing discrimination within their school contexts while also managing the typical challenges of a graduate program (Budge, Domínguez, & Goldberg, 2019; Goldberg, Kuvalanka, & dickey, 2018). In addition to experiencing minority stress, nonbinary

graduate students may lack adequate mentoring, role models, social support, and other resources to help them navigate their professional role as a nonbinary person, making their path to a graduate degree even more difficult. Although many college campuses have support systems in place for TNB undergraduate students, many campuses overlook the needs of graduate students, further isolating nonbinary graduate students (McKinney, 2005). Additionally, pervasive experiences of minority stress may limit the opportunities that nonbinary students have in applying for and choosing graduate programs by limiting their choices to programs and/or geographic locations that will be safe enough for them to survive and succeed (Goldberg, McCormick, Virginia, & Matsuno, 2020). Minority stress may also impact nonbinary graduate students' opportunities for practicum, internship, and postdoctoral placements later on in their training.

To understand the unique experiences of nonbinary graduate students, it is essential to consider the impact of intersecting systems of oppression. Intersectionality theory asserts that experiences of privilege and marginalization associated with one's social identities are not simply additive, but rather co-constructed and interdependent (Crenshaw, 1989; Meyer, Schwartz, & Frost, 2008). Research in this area has found having multiple marginalized identities does not necessarily implicate additional risk for health disparities (e.g., Meyer et al., 2008). Rather, holding multiple marginalized identities may lead to exposure to unique types of minority stressors, but also help build distinctive types of resilience processes (McConnell et al., 2018).

The goal of this article is to offer insight into the unique, intersectional challenges that nonbinary psychology trainees face and provide recommendations on how to create more affirming environments that can empower nonbinary psychology trainees. We hope this article can benefit faculty members/advisors, clinical supervisors, training directors, administrators, graduate student peers, and anyone involved in graduate student training in psychology. The recommendations we provide stem from the psychological literature as well as from our own personal experiences and engagement in nonbinary community advocacy and activism. We will provide a positionality statement about the authors, outline the common challenges faced by nonbinary psychology trainees, and provide concrete recommendations for supporting and empowering nonbinary trainees.

Positionality Statement

The authors all identify as nonbinary trainees in psychology, represent a range of training levels (master's level through postdoctoral), and are located in a variety of geographic locations and political landscapes across the United States. Most of us identify as people of color and each represent a different ethnic background. Three of us are children of immigrant parents. Two of us identify as first-generation college students from working-class backgrounds. Two of us were socialized as male and three were socialized as female. Our various intersectional experiences allow us to bring together a diverse collection of nonbinary trainee perspectives. Our collaboration on this topic began by participating together on a panel featuring nonbinary graduate students for a webinar hosted through APA divisions 44 and 35. The recording of the webinar and the subsequent infographic can be found online.[1]

Unique Challenges of Nonbinary Trainees

Feeling Isolated

Given that nonbinary individuals make up a small percentage of the population and face many barriers to entering higher education, nonbinary students are often one of a few or the only TNB person in their graduate program (Goldberg et al., 2018). This experience can feel isolating when others cannot directly relate to the challenges they face. Cisgender students may have more opportunities to bond with other students in the program who share identities or gendered experiences, whereas nonbinary individuals may not have this sense of kinship within their cohorts. Additionally, resources aimed at building community and social support for LGBTQ students broadly are often targeted to undergraduate and sexual minority students (McKinney, 2005) and, therefore, nonbinary graduate students may lack community support in their programs, on their campus, and sometimes in their local community as well.

Being Tokenized

As a consequence of "being the only one" or one of few who identify as nonbinary, faculty often ask nonbinary students to educate the department on transgender issues without compensation. Educating others about one's own marginalized identity can be emotionally taxing and generally time consuming. Additionally, nonbinary students often receive subtle messages that they are meant to speak on behalf of all nonbinary individuals, despite having a unique individual experience. Placing the responsibility of improving the academic environment for TNB students, solely on TNB students themselves, may feel burdensome and tokenizing.[2] Previous research has found that TNB students are often tokenized in classroom settings (Nicolazzo, 2017; Robles et al., 2019). In addition to feeling tokenized, nonbinary students may feel pressured either implicitly or explicitly to focus on TNB populations in their research or clinical practice. For example, a clinical supervisor may assign a nonbinary supervisee several TNB clients without the supervisee ever indicating an interest in specializing with this population. These assumptions take away nonbinary students' ability to make their own decisions about the direction of their career path.

Invalidation and Misgendering

One of the most hurtful forms of stigma about nonbinary people is belief that nonbinary people do not exist, are going through a phase, are mentally ill, or are otherwise invalid (Chang & Singh, 2016). Nonbinary students may feel invalidated

[1]The webinar can be accessed at: https://register.gotowebinar.com/recording/viewRecording/5435226123245411075/2275216511764203011/klump@msu.edu?registrantKey=6707494117973903373&type=ATTENDEEEMAILRECORDINGLINK
The infographic can be accessed at: https://create.piktochart.com/output/38939812-non-binary-students

[2]The concept of being a "token" within the sociological literature often refers to people who are hired or admitted because of their marginalized identity to serve as proof that the organization does not discriminate against such people (Zimmer, 1988). In other words, tokenizing is the action of including marginalized people for the appearance of inclusion without doing the work to actually be inclusive.

through experiencing microaggressions that reinforce these false beliefs, or more explicit aggression and harassment. For example, nonbinary students may feel invalidated when nonbinary identities are excluded from conversations about gender and from course curriculum generally.

Misgendering is another invalidating experience that occurs when a gendered word (e.g., name or pronoun) is used for an individual that does not correctly reflect their gender (McLemore, 2015; McLemore, 2018). Research suggests nonbinary people are misgendered at a higher frequency than trans women and trans men (Goldberg et al., 2018; McLemore, 2015). Like other microaggressions, misgendering may appear to be harmless or trivial, yet emerging research suggests that misgendering is psychologically distressing and may have implications for physical and mental health outcomes (McLemore, 2018). Particularly, feeling stigmatized as a consequence of misgendering is associated with increased negative affect, less favorable feelings about appearance, decreased feelings of "being trans enough," and increased perception of trans people as stigmatized (McLemore, 2015). When done publicly, nonbinary individuals may feel humiliated and exposed. Furthermore, using the wrong pronoun publicly may encourage misgendering by others who witnessed the original microaggression, creating a potentially hostile and pervasively invalidating environment. Misgendering can occur in other ways, such as incorrectly grouping people together by gender. For example, graduate students in applied psychology may be matched by the wrong gender with clients in clinical agencies (e.g., a nonbinary person being matched with a female client looking to work with a female therapist).

Although correcting others may seem like an easy solution for nonbinary people who are misgendered, doing so carries risks. There can be social consequences, such as colleagues distancing themselves because it is "too difficult" to change gendered language or learn new pronouns. Elsewhere, there can also be negative professional consequences when correcting those with greater levels of power (e.g., a supervisor), such as receiving a negative evaluation. Nonbinary graduate students may feel that correcting someone is not worth jeopardizing a job, losing their student status, or being further stigmatized. Furthermore, several states lack legal protections from discrimination on the basis of gender identity, making these confrontations even riskier.

Navigating Disclosure

Another common challenge experienced by nonbinary individuals is navigating disclosing their identity to others. "Coming out" is an ongoing, often daily process for nonbinary individuals, that can include decisions about whether to correct others when they make gendered assumptions or deciding whether or not to share one's pronouns during an introduction (Nicolazzo, 2016; Nicolazzo, 2017). These decisions are typically made by evaluating one's sense of safety, which can be emotionally taxing and stressful, especially when anticipating being rejected based on one's marginalized identity (Rood et al., 2016). It can be stressful to both disclose one's identity and to choose not to disclose. For example, after disclosing their nonbinary identity, individuals may be asked to educate the other person about nonbinary identities or, worse, be invalidated or rejected as a result of their disclosure (Siegel, 2019). On the other hand, nonbinary individuals may feel like they are compromising their authenticity when choosing not to disclose their identity, even if doing so protects them from harm.

Pronouns can pose additional stress when others assume one's gender identity based on the pronouns they use. The use of they/them as a singular pronoun is becoming increasingly popular and is recognized by larger organizations, including American Psychological Association (APA; e.g., APA, 2020; Publication Manual – 7th edition). However, given the frequent and public use of pronouns, nonbinary individuals who use they/them pronouns may feel that they have less control over who is aware of their identity. For example, it is not very common to reference someone's sexual orientation in conversation with others, whereas using someone's pronouns is commonplace. This can lead to feelings of hypervisibility and vulnerability among those who use they/them pronouns. On the other hand, nonbinary individuals who use she/her, he/him, or alternate between pronouns (e.g., use she/her pronouns on some days and he/him on other days), may feel a sense of invisibility, because others may assume that they identify within the gender binary. Assumptions made based on pronouns may lead nonbinary psychology trainees to struggle with the decision about whether or not to disclose their pronouns to clients in a therapy setting. It can be difficult to disclose pronouns that may lead a client to be uncomfortable, especially when the nonbinary person is in a helping role and encouraged to build rapport and make the client feel comfortable.

Binary Structural Systems

In addition to interpersonal struggles, there are many structural challenges that nonbinary students must contend with in academic institutions. One prominent challenge is nonbinary students' lack of access to safe and affirming bathrooms on college campuses (Flint et al., 2019). Even in progressive academic settings, this gendered separation of a universally necessary public space can cause daily stress. For nonbinary students, there is not only the fear of confrontation when using public bathrooms, but also potential ambivalence about which gendered facility to use. As a result, students may travel great distances across campus to find gender inclusive, single stall, or low-traffic bathrooms. Nonbinary students may also struggle with how to best interact with colleagues in these gendered spaces and worry about whether using a gendered restroom will result in misgendering, particularly for those who use they/them pronouns.

Methods for collecting and storing student information can be another manifestation of cisnormativity (i.e., the notion that being cisgender and identifying within the gender binary is expected and preferred) in higher education. In her brief report, Nowicki (2019) notes that "SIS [student information systems] and data policies are almost always built by and for cis people," and as a result, "... trans and nonbinary students are often mis-gendered or dead-named[3] when well-meaning administrators only have access to legal name and sex data" (pp. 5-6). Additionally, binary expectations and policies around professional attire are yet another aspect of graduate education that can cause stress for nonbinary students. Professionalism in academia is often used as a way to minimize expressions that differ from cisgender and White standards of appearance or behavior (Spade, 2010). As a result, psychology graduate programs often have formal or informal guidelines for appropriate attire "for men and for women" as it applies to attending conferences, interviews, meetings with clients, and other pro-

[3] Use of someone's birth name when they go by another name.

fessional activities. This kind of explicit binary language suggests that nonbinary students do not exist and forces them to compromise their gender expression in order to meet program expectations.

Intersectional Stressors

In addition to the uncertainty surrounding professional attire, acquiring appropriate clothing can be a daunting expense for nonbinary students. Nonbinary students may have to shop at specialty stores to find clothes that fit their gender expression and body size/shape (e.g., feminine style shoes that fit larger feet or button-down shirts that accommodate different chest sizes). Professional attire is just one of many unexpected expenses that graduate students incur, which can cause additional stress for nonbinary students who are often at a financial disadvantage. TNB individuals in the U.S. are more than twice as likely to live in poverty than the general adult population (James et al., 2016). This statistic is likely influenced by TNB individuals experiencing family rejection, struggling to maintain employment due to discrimination, and high out-of-pocket medical costs if their insurance refuses to cover gender affirming medical services (James et al.). Financial stress can require nonbinary students to work while in school, attend school part time, forgo opportunities to attend conferences, or turn down internships in other cities, all of which can significantly hurt the trajectory of one's education and career.

Nonbinary graduate students of color may also experience the challenges that come with attending predominantly White institutions, such as encountering racism from faculty, administrators, and other students (Levin et al., 2013); a lack of culturally responsive curriculum (Yuan, 2017); and the need to code-switch (i.e., switch languages or the manner of communicating) to fit into the culture of higher education (Elkins & Hanke, 2018). Some students of color may also experience conflicts between the individualistic culture of higher education and their more collectivistic home cultures. The culture of higher education prizes a "monkish devotion" to intellectual pursuits, and leaves little time for family, community, or a work-life balance (Springer et al., 2009). As a result, nonbinary graduate students of color with partners, children, or strong ties to their families may struggle to uphold their familial roles due to the high demands of graduate programs. This can further put nonbinary graduate students of color at risk for mental health concerns as family and community support has been shown to buffer the negative impact of minority stress (Trujillo, Perrin, Sutter, Tabaac, & Benotsch, 2017), and can play a particularly important role if students feel alienated from LGBTQ communities on campus that are predominantly White (Nicolazzo, 2016).

Conversely, communities of color that affirm a nonbinary student's cultural background may not be affirming of their gender identity or gender expression. For example, communities of color may associate LGBTQ identities with "being White" and westernized (Han, 2007) and as a result may reject nonbinary people of color. Additionally, nonbinary students of color may experience misgendering through their own culturally specific gendered language. For example, Black nonbinary students may struggle with being referred to as "brother" or "sis" in Black communities and Latinx nonbinary students may not be respected within their community if they try to use gender neutral "-e" or "-x" endings such as the term Latinx (Merodeadora, 2017). These intersectional stressors can lead nonbinary students of color to feel as though their social identities are in conflict with each other and can create further isolation and stress (Sarno, Mohr, Jackson, & Fassinger, 2015).

Guidelines to Change Harmful Environments and Empower Nonbinary Trainees

Become Educated and Open to Feedback

Rather than expecting nonbinary students to advocate for what they need, we suggest that individuals within psychology programs invest time and resources in challenging deep-seated narratives surrounding gender and that programs require gender diversity trainings for faculty and staff. It is important not to assume that nonbinary students wish to conduct gender diversity trainings, especially with faculty members in their own programs, as this can put nonbinary students in a vulnerable position. Consulting with a university or community LGBTQ center is often a useful way to find gender diversity trainings for faculty and staff. However, it can be empowering to ask a nonbinary student if they would be interested in conducting a gender diversity training provided that they have previously expressed interest in such topics and are adequately compensated for their labor. We encourage individuals and institutions to take advantage of resources available, such as the APAGS guide for supporting trans and gender diverse students[4] (Maroney et al., 2019) and the APA Division 44 non-binary fact sheet[5] (Webb et al., 2017) and other educational materials related to working with nonbinary clients, such as "A Clinicians Guide to Working with Transgender and Gender Nonconforming Clients"[6] (Chang, Singh, & dickey, 2018).

In addition to seeking education, it is important to embrace cultural humility. Tervalon and Murray-Garcia (1998) define cultural humility as a process of lifelong learning and critical self-reflection that is other-centered regarding various aspects of cultural identity. Cultural humility involves taking responsibility for mistakes rather than making excuses and being open to learning from others with different identities and potentially less power or professional experience. One way to practice cultural humility is by inviting feedback and receiving feedback in a nondefensive manner. For example, saying "Thank you for correcting me" or "Thank you for bringing this issue to my attention. I will bring this up with the leadership team during our next meeting" can make nonbinary students feel respected and valued.

Relearn Gender as Nonbinary

It is important to become aware of binary assumptions and actively relearn gender as nonbinary. Given the range of possibilities of any individual's gender and the fact that gender identity is self-defined, we encourage individuals not to assume someone's gender based on their appearance. We believe it is helpful to use they/them pronouns with all people whose pronouns are unknown and when asking for pronouns may not be appropriate. Nonbinary people have differing reactions to being asked about their pronouns. Some feel validated and respected whereas others

[4] https://www.apa.org/apags/governance/subcommittees/supporting-diverse-students.pdf

[5] https://www.apadivisions.org/division-44/resources/advocacy/non-binary-facts.pdf

[6] https://www.amazon.com/Clinicians-Guide-Gender-Affirming-Care-Nonconforming/dp/1684030528/

may experience the question as a microaggression when it seems that the other person wants to put them in a gender category for their own peace of mind rather than to be respectful. These varying reactions often depend on the context in which the question is asked. A general guideline for evaluating whether asking about pronouns is appropriate is to consider whether it is necessary to know and to not only ask people that have gender-nonconforming expressions (UCSB Resource Center for Sexual and Gender Diversity). It is important not to use they/them pronouns in instances when someone has expressed using she/her, he/him, or other sets of gender-neutral pronouns such as ze/hir pronouns as doing so may be experienced as misgendering.

Additionally, it is important not only to practice using someone's correct pronouns, but to practice conceptualizing their gender as nonbinary. Being affirming of nonbinary individuals goes beyond replacing pronouns to truly seeing and understanding someone as nonbinary. This involves noticing when binary gender assumptions are occurring about a nonbinary person and actively fighting against conceptualizing that person through a gendered lens. It can be helpful to consume media with and by nonbinary people to begin to understand gender as a spectrum rather than a binary. Examples of popular nonbinary figures include Alok Vaid-Menon, Angel Haze, Indya Moore, Janelle Monae, Maxi Glamour, and Sam Smith.

When relearning gender as nonbinary, mistakes are inevitable. Apologizing when mistakes happen is important and indicates an effort at respecting nonbinary people. However, becoming aware of mistakes or microaggressions can be anxiety inducing and can elicit a number of responses including feeling defensive and offering excuses. We encourage individuals to not offer excuses (e.g., "I did not have the same access to resources young people have nowadays!"), get defensive (e.g., "Well, we are still figuring it out!"), attempt to justify actions (e.g., "It is a long and complicated process to change demographic information on forms, so we just keep it how it has always been!"), or apologize profusely (e.g., "Wow, I am so, so, so sorry for misgendering you. I feel so bad!"). These types of apologies can make nonbinary students feel like a burden and may put the nonbinary person in a position to take care of the person who made the mistake. Instead, we suggest making apologies direct, concise, and specific, and to cope with feelings of guilt, anxiety, or defensiveness privately or with others.

Be an Advocate and Ally

It is crucial that people in positions of power or privilege (i.e., instructors, supervisors, cisgender peers) engage in advocacy for nonbinary students. When advocating for nonbinary students at the institutional level, an important starting point is incorporating gender identity and expression in university nondiscrimination policies and explicitly communicating these nondiscrimination policies in program handbooks (Case, Kanenberg, Erich, & Tittsworth, 2012; Goldberg et al., 2019). Another important campus policy is providing student health insurance that covers gender-affirming medical procedures. Most student health insurance plans do not cover gender-affirming medical care, which can prevent access to care due to substantial financial concerns and can increase the incidence of mental health or medical health challenges for TNB people (Padula & Baker, 2017). Finally, universities should conduct a review of paperwork (i.e., application materials, intake forms, handbooks, syllabi, website and faculty pages, student evaluations) to ensure that documents are TNB inclusive (e.g., replacing "he or she" with "they"). Some important points of consideration are providing space for both legal and current name, current gender identity, and pronouns. It is advisable to either have write-in options or provide nonbinary options for gender identity and pronouns (see Knutson et al., 2019; Maroney et al., 2019). It can be helpful to start with making internal changes within the program's paperwork, while also advocating for larger university-wide changes.

Advocacy can also occur on an interpersonal level, such as when microaggressions occur. One of the best ways to be an advocate is to be supportive in a collaborative manner that gives nonbinary students power to decide what will make them feel safe and comfortable. For example, it can be helpful to check in with nonbinary students privately about whether they would like you to use their pronouns in all contexts, as many nonbinary individuals "code switch" and use different pronouns in different contexts depending on their perception of safety (Goldberg et al., 2018). It is important to validate nonbinary students' decisions about whether or not they want to be out to others and follow their lead rather than pressuring the student to conform to the individual's own values. Additionally, it is helpful to ask nonbinary students whether they want allies to correct others on pronouns before doing so. Correcting others without consent of the student can potentially "out" them and unintentionally create negative consequences for the nonbinary student. However, it can still be helpful for allies to challenge binary assumptions when they are made broadly (e.g., letting someone know that stating "men and women" does not represent all genders).

Advocacy for nonbinary students can also include challenging program culture that prioritizes productivity over self-care. Although individuals cannot always prevent minority stressors from occurring, it can lighten the burden on nonbinary students to acknowledge the impact of minority stress and allow graduate students to take care of their well-being. This could involve extending a deadline, allowing for mental health days similar to traditional "sick days," working with students to help them set boundaries, and connecting them to resources. It can also be helpful to check in with nonbinary students to see how they are doing after witnessing a microaggression occur or when trans-antagonistic events happen in the larger societal context.

Finally, another way to be an ally to nonbinary students is by providing the opportunity to share pronouns during introductions, normalizing this process, and then using the correct pronouns for students. Instructors (especially if cisgender) can share their pronouns on the first day of class, explain the purpose of sharing pronouns, and invite students to share their pronouns as part of their introduction if they are comfortable doing so. It is important not to require students to share their pronouns, as nonbinary students may not feel comfortable disclosing their pronouns due to safety concerns. Having this process occur as classes commence normalizes pronoun disclosure, gives nonbinary students the opportunity to share their pronouns before misgendering occurs, and removes the stress of being only student to disclose pronouns. Similarly, providing pronouns as part of an email signature or at the top of syllabi also communicates the importance of pronouns and may help cultivate a space that feels safer for nonbinary students.

Conclusion

As the field of psychology shifts from a pathological view of TNB people to a more

affirming stance on gender diversity, it is imperative to bring more nonbinary people into the profession and its leadership. Promisingly, there are increasing numbers of nonbinary graduate students in psychology (Matsuno, 2019). However, many psychology graduate programs are ill-equipped to support nonbinary students, creating additional stressors for nonbinary students. We urge cisgender psychologists to educate themselves about the lives of nonbinary people, reflect on their own privileges, and use their power to empower nonbinary individuals. We hope these guidelines are a useful educational tool to begin this process.

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Reflections on Supervision in a University Counseling Center Utilizing a Brief Treatment Model

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THE TRANSITION from "in-house" training clinics to an external placement with a large caseload tends to be a challenging experience for clinical psychology. However, the transition into a setting that provides very brief treatments can provide additional challenges not typically faced in long-term psychotherapy settings. In this piece, we—Author JMG and Author JFH, two advanced clinical psychology graduate students—reflect on our training experience in a university counseling center, University of California, Los Angeles (UCLA) Counseling and Psychological Services (CAPS), which utilizes a brief treatment model. Specifically, after outlining the structure of the training program, we discuss the unique benefits and challenges of the brief treatment model and the specific elements of supervision that helped us adapt to our new training setting and develop professionally.

UCLA CAPS is one of the nation's largest and most highly utilized counseling centers, serving a highly diverse student body with regards to demographic background and presenting concerns. In an effort to address the high demand for services, therapists at UCLA CAPS see clients with student health insurance for approximately 6 sessions per academic year, and for 3 additional sessions during the subsequent summer. Furthermore, UCLA CAPS houses a large training program that enables a larger workforce to address the needs of the university. Specifically, psychology trainees completing a 1-year practicum at UCLA CAPS spend approximately 16 hours per week on-site and carry a caseload of about 10–12 active clients at a time.

One of the hallmarks of the UCLA CAPS practicum experience includes comprehensive supervision of all clinical activities. Practicum students receive 2 hours of individual supervision per week from a licensed clinical psychologist and from a psychology intern and attend weekly group supervision with other practicum and graduate trainees (UCLA CAPS, n.d.). Given the relatively large caseload and brief treatment model along with the diversity of cases covered, the clinical work and supervision during our practicum provides a unique, challenging, and enriching training experience.

My experience (JMG) transitioning to a high-demand, brief treatment therapy setting proved to be a valuable learning experience. As my 2nd year of training consisted of only two to four long-term psychotherapy cases, with 2 hours of weekly supervision, the transition to a large caseload was initially daunting. Prior to each of my early supervision sessions at UCLA CAPS, the main question in the forefront of my mind was, "What should I do in the next session with each client?" With an active caseload of approximately 10 clients, it became evident that the thorough session planning I had grown accustomed to was not going to be feasible. With the guidance of my supervisors, I had to restructure my approach for session planning by refining my case conceptualization skills to conduct conceptualization-driven intake assessments.

Much of the literature regarding treatment supports the need for strong conceptualization skills to guide treatment planning (Hinkle & Dean, 2017; Kendjelic & Eells, 2007; Persons, 2006); however, there

is considerable variability with regard to the degree to which supervisors provide instruction and guidance in the case conceptualization process. One of my supervisors dedicated supervision time to discussing various ways to conceptualize clients, based on different treatment modalities (e.g., CBT versus ACT) and variations within those modalities. To assist my learning during this phase, she used conceptualization worksheets, and walked me through the process of using the information gathered from the intake to complete each sheet. Throughout the course of our supervision, my supervisor encouraged me to use these worksheets to determine which orientation's conceptual approach felt like the best fit for each client, and subsequently guided me in developing treatment plans in line with our joint, working conceptualization. As my skills in case conceptualization began to develop, I utilized the worksheets during intake sessions to maximize the efficiency of my questions and initiate treatment planning prior to the client leaving the intake.

The benefits of conducting conceptualization-driven intakes in a brief-treatment center were threefold. First, as aforementioned, quick conceptualization aided in rapid, intentional treatment planning as I was able to more readily identify a client's unique treatment needs and develop plans accordingly. Second, for those clients eligible for fewer sessions due to insurance limitations, conceptualization-driven intakes were useful for guiding my decision-making for targeted referrals. Finally, having a solid conceptualization of each client helped me maximize my time in supervision so that I could instead focus on the mechanics of how to deliver interventions, rather than focus on what to deliver.

Learning to deliver evidence-based interventions also proved to have a steep learning curve. As our caseloads varied in presenting problems, chronicity, and severity, I had to learn a variety of clinical skills and interventions to effectively target each of my client's treatment needs. In this setting, it is also not feasible to deliver complete, manualized evidence-based protocols, which often require a minimum of 10–12 sessions. Therefore, my supervisor and I often elected a modular approach to treatment, which involved consulting the literature and focusing on specific practice elements that would best target my client's primary presenting problem (Chorpita & Daleiden, 2014). In a recent research trial comparing manualized, evidence-based protocols to a modular treatment for youth mental health problems, those who received modular treatments showed faster recovery and required significantly fewer treatment sessions than standard EBTs as typically implemented in the community (Chorpita et al., 2017). This translated into brief and effective courses of psychotherapy. For example, for a client who presented with a history of severe depression currently in remission, my supervisor and I elected to focus on mood monitoring and relapse prevention planning, including elements of behavioral activation and goal setting. However, for a client who presented with severe social anxiety, we focused primarily on psychoeducation and targeted social exposures.

In focusing on specific practices that co-occur in a variety of treatment protocols (e.g., cognitive restructuring), my supervisor helped me to refine the delivery of these skills, often through the use of in-session modeling and role-plays. Modeling, in which the supervisor demonstrates the practice, and role-playing, in which the trainee demonstrates the practice with the supervisor playing the client, are considered active supervision practices. Active supervision practices are considered gold-standard practices of evidence-based supervision, and have been shown to be the strongest predictors of whether a trainee uses a newly learned skill with a client (Bearman et al., 2013; Beidas & Kendall, 2010). To increase my comfort with learning a new skill, the supervisor first modeled the delivery, often using examples from my own life to illustrate the process. This allowed me to identify with the client's perspective and highlighted what made the delivery of the intervention most potent (Hinkle & Dean, 2017). Afterwards, I often role-played my own delivery of the intervention, maintaining openness to feedback for how to improve. The use of modeling and role-playing was perhaps the greatest enhancement of my learning at UCLA CAPS, as it allowed me to view the interventions from both the therapist and client perspectives, which further increased my desire to continue practicing and refining my delivery to provide my clients with the best care possible.

Similar to JMG, the transition to a new training environment entailing a larger caseload and fewer sessions with each client presented a number of challenges to me (JFH) that would have been difficult to confront without skilled supervision. One of the most impactful supervisor actions during my training at UCLA CAPS included my supervisor's strong emphasis on collaboration, with other professionals as well as with my clients. One of my first cases during practicum was a client concurrently treated by a psychiatrist of the UCLA CAPS staff. Although I was able to review the psychiatrist's notes in my client's chart, my supervisor suggested that I seek a brief in-person consultation with the psychiatrist. My supervisor validated my initial hesitation (the fear that I might unnecessarily use the psychiatrist's time) as developmentally appropriate and conveyed that she too had encountered similar worries, yet had found consultation with other UCLA CAPS staff highly valuable. By helping me schedule a meeting with the psychiatrist during our supervision time, I was able to follow up immediately on her suggestion and learn the administrative procedures involved in such situations at my new training site.

In addition, my supervisor helped me appreciate the value of collaboration between therapist and client, arguably one of the best and most reliable predictors of outcomes (e.g., Horvath, Del Re, Fluckinger, & Symonds, 2011). Specifically, my supervisor helped me involve my clients in active treatment planning by openly discussing the UCLA CAPS session limit at the outset of treatment and by collaboratively deciding on major treatment goals that would be realistic targets within this limited time frame. Furthermore, when taking on new cases for which it was evident from the beginning that a client's needs could not be met within the 6-session model, my supervisor helped me to either advocate for extended session limits or, if longer-term treatment was needed, to provide the client with outside referrals. More important, my supervisor provided a warm and comfortable space during supervision meetings, and invited me to process my own emotions surrounding such decisions. For example, she helped me evaluate the risks of carrying out certain treatments without the adequate amount of time or sessions needed to achieve the best outcomes and thereby provided guidance in my ethical decision-making process (Gilbert 1992). Additionally, she validated arising feelings of helplessness and self-disclosed that she too sometimes struggled when confronted with situations in which she felt her clients truly needed longer-term treatment.

Several aspects of my supervisor's actions are supported by the supervision literature as being conducive to promoting a high-quality supervisory relationship and optimal outcomes for trainees' professional

development. First, my supervisor combined facilitating attitudes, behaviors, and practices, which have been shown to positively impact the supervisor-trainee relationship and increase the likelihood a trainee will open up about insecurities and questions to their supervisor (Falender & Shafranske, 2004). She confronted my initial hesitations with empathy (Nerdrum & Ronnestad, 2002), warmth, and understanding (Hutt, Scott, & King, 1983), making me feel comfortable to disclose such worries and leading me to feel comfortable in continuing to do so. Second, with regards to professional consultations, my supervisor underscored the value of forming and maximally utilizing networks of colleagues, a concept referred to as communitarianism (Johnson et al., 2014). Communitarianism has been identified as desirable for transforming psychology's individualistic focus on competence given the dynamic and contextually based nature of this competence. Furthermore, communitarianism is beneficial not just with regards to enhancing treatment and client care but also with regards to treatment increasing providers' job satisfaction and decreasing stress-related burnout (Epstein & Hundert, 2002). Third, by highlighting that she herself often made use of consultation with other professionals and by self-disclosing struggles around set session limits, my supervisor was able to model professionalism and teach me knowledge, skills, and attitudes associated with professionalism. The teaching and modeling of professionalism is highlighted as a major competency in Guideline 1 of Domain D of the American Psychological Association's (APA) Guidelines for Clinical Supervision in Health Service Psychology (APA, 2015).

In summary, both the overall training and supervision structure at UCLA CAPS as well as the specific actions our supervisors engaged in throughout the year were conducive to our development as professional psychologists. With regards to the overall training structure, we benefited from the amount and regularity of supervision offered, which have been shown to be important aspects related to positive psychology trainee outcomes (APA, 2015). In addition, with regards to the specific supervision experiences and actions described above, our supervisors aided us in overcoming the unique challenges associated with working in a brief treatment model college counseling center. Specifically, we believe that both of our experiences highlight the ways in which supervisors enabled us to gain increased self-efficacy and confidence in our clinical skills by adjusting their supervision techniques to our developmental level at any given time point. For example, whereas our supervisors initially performed certain actions for and then with us (e.g., filling out case conceptualization sheets and scheduling consultation appointments with other professionals), less guidance was provided over time. These active modeling techniques (Bearman et al., 2013) allowed us to learn new skills, practice them under the guidance of our supervisors, and then incorporate these abilities into our ongoing clinical competencies. Our supervisors' actions thereby enabled us to gain heightened independence, preparing us well for increasingly challenging training and working environments.

We are confident that the clinical skills and confidence we gained through the help of our supervisors at UCLA CAPS will continue to be useful to us throughout our professional development during training and beyond, and will be applicable in a variety of settings beyond a brief treatment model college counseling center. We hope that other trainees and supervisors can learn from the experiences we described.

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The Instructions That Would Not Load

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"*Please unsubscribe me from this listserv*"
—Many users, in variations of this quote

Dr. Merovingian arrived for his continuing education (CE) training session on time, as recommended on the ticket stored in his iWallet. This was the new neuroCE, which advertised as follows:

> This CE will be a uniquely immersive experience in the full panoply of empirically supported methods, and how to craft these into evidence-based practices. Full integration of knowledge into the clinician's existing armamentarium of clinical skills fully guaranteed, with no decay of knowledge for up to two years. Plan on being at the CE immersion center for approximately 1 hour.

Dr. Merovingian was gob-smacked when he read the description in the CE advertisement that arrived in his email inbox. In one hour, he was going to have all the available empirically supported treatments available to him immediately?? And the capacity to integrate this knowledge seamlessly into client-focused and tailored evidence-based practice? This seemed too good to be true! True, the cost was pretty high, at $895 plus the CE filing fee with his state, but this one hour would cover all of his CE requirements for two full years! The medical waiver at the bottom seemed strange to him, but he nonetheless took the plunge.

When he arrived at the CE immersion center, three lab technicians greeted him. They said nothing, only scanned his ticket on his phone, and gestured toward the door across the foyer. When he entered, he saw that there was what appeared to be an infinite row of doors, with one opened. Upon entering the room, he saw a reclining chair, a computer console with a device connected to it that consisted of a long prong at the end. One of the technicians who greeted him at the door entered, and wordlessly gestured toward the chair. Dr. Merovingian sat. At last, the technician spoke:

"I am the designer. You would like to know all the empirically supported protocols?"

"Yes, I would like that. I mean, that was what I signed up for," Dr. Merovingian said.

"Okay, but I must ask you a few questions first."

"Okay, go ahead."

"We have conducted a background check, and it is clear that you earned your doctorate, are licensed, and have never had any complaints against you. Can you tell me the last CE course you completed?" the technician asked.

"As required, I enrolled in an ethics refresher course last month. It was a webinar, and was two hours in length."

"Good. And, please tell us how often you post questions on social media about practice matters," the technician queried.

"Well, I'm online a lot, intermittently between clients, and sometimes I'll post lengthy questions about complex clinical matters. The discussions can get fairly intense. I guess if I can just estimate, I probably post around five to six times a week, but comment on other posts far more often."

"Okay, we see that in our background check as well," the technician noted.

"Wait, you have that information? I thought those groups were private."

"We need to check these things to determine how immersive we need to be for this CE. While you were told to reserve an hour, some other clinicians need longer. For example, if someone primarily practices non-evidence-based approaches, we need much more time, sometimes three or even four hours. And we have to prep people more, since it can be painful for that kind of re-orientation when we upload you into the system," the technician explained.

"Hold it, 'upload me into the system'?" Dr. Merovingian asked.

"Of course! How did you think we would cram all that information into you, by talking really fast? Why else would we have all the medical waivers? Oh, wait, I have a note here." The technician grew somber, and a grave look washed over his face. He pressed the intercom.

"Dr. Smith, can you rush in here?"

"What? What is going on?" Dr. Merovingian asked. Sweat started beading on his forehead.

Dr. Smith entered, a tall woman with a lab coat and an unmistakable small patch of blood on the lapel.

"What is it? I have another one in the other room who can't follow simple instructions. Blood all over the floor, I have no idea how long it will take to clean up, but I can guarantee that doctor will know how to 'follow' a post from now on, without posting 'following' as a comment on a thread." Dr. Smith was flustered, and did not look at Dr. Merovingian.

"Dr. Merovingian, this is Dr. Smith. She pioneered the immersive CE experience."

"Dr. Merovingian." Dr. Smith made eye contact, and proceeded grimly, "We see here in our background information that you have often sent out large group emails requesting to unsubscribe from several listservs, is this correct?"

"Um, yes," Dr. Merovingian replied, sheepishly. He did not like the sound in her voice. He was sweating profusely.

"It shows in our background checks that you have done this numerous times, long after the moderator posted the instructions for how to unsubscribe. Correct?"

"Yes, but I just thought I would have the moderator do it for me."

"Okay, so here is the thing. We have found that our immersive experience works best when the subject's neural system does not have the pesky impeding neural circuitry that comes from not following instructions. When the circuits that controls not following instructions are in place this firmly, we have to blast past them, and this makes it harder to get the full range of CE information loaded. You understand?"

"No, not entirely . . . " Dr. Merovingian said, in a near whisper.

"Of course you don't. We have seen this same profile five times in the last week, and everyone says the same thing. Okay, let me state it more simply. We are going to insert a prong into your brain stem and tendrils will spider out into your midbrain and up through to your cortex. That part you will feel, and the pain will be transient albeit intense. What will follow will be a radical re-ordering of neural circuits. The early part of the experience will blow out the cir-

cuitry that activates when you encounter easily followed computer instructions but that you promptly ignore. We have found that subjects typically bleed from the nostrils for around 8 to 10 minutes from that, but the full procedures takes around 5 hours given the severity of your case. After that, we can then upload the CE materials you signed up for. You'll need to clear your schedule for the day. What is your blood type?" Dr. Smith finished saying all this while working the computer console and wiping the prong down with alcohol.

"Hold it, seriously??? And . . . uh, I'm O+." Dr. Merovingian was rising up in his seat.

"Where are you going? This is important. You need to have this problem fixed. And after all, at the end you will be a trafficker in CE information," Dr. Smith stated, with a somewhat reassuring voice. And then, before Dr. Merovingian could finish getting up from the seat, the prong was inserted into his brain stem, and he was pinned to the chair. Eyes closed, grimacing but apparently unconscious, the corrective process began in earnest. Blood trickled from his nostrils.

— after the procedure —

"You can try to stand now." It was the technician, standing over Dr. Merovingian.

"What? Are you sure? I feel so dizzy," he said.

"Yes, the procedure worked. For the past two hours you have been babbling on and on about the hexaflex in Acceptance and Commitment Therapy, applications of interoceptive exposure for various anxiety conditions, and behavioral activation for complex depression. And occasionally, you snuck in a jibe about the inefficacy of equine therapy, which we filmed and posted to our social media accounts since it just seemed more than a bit gratuitous at this point."

"What time is it?" Dr. Merovingian asked, sitting up on the side of the chair.

"Three o'clock, Wednesday." Dr. Merovingian remembered that he arrived at 9:00 a.m. on Monday.

"We had a lot of work to do on those circuits. In addition to the missing unsubscribe circuit, we had to rework your regular re-asking of questions on Facebook groups that were just asked one or two days previously. We received notes of thanks from several colleagues that we repaired that. Our social media has been blowing up. No doubt your colleagues are going to appreciate the new you." The technician was now smiling broadly.

"So, you mean, I won't be doing that anymore?"

"Oh no, we blew that circuit out entirely. You'll actually use the search function, which we learned you have never once used! Our work here was far more necessary than we dreamed, and since we like to 'experiment' on ourselves with the equipment, we have some pretty outrageous dreams!" The technician turned and left the room.

As Dr. Merovingian left the CE immersion center, he noticed in the waiting room several colleagues. He checked his email, and his inbox had several messages from people in this very same waiting room, and all said the same thing: "Please unsubscribe me from this list."

"Poor bastards," Dr. Merovingian mumbled, as he got in his car.

. . .

No conflicts of interest or funding to disclose.

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This award recognizes outstanding individuals who have shown exceptional dedication, influence, and social impact through the promotion of evidence-based psychological interventions, and who have thereby advanced the mission of ABCT. Importantly, the goal of the award is to identify individuals who translate the impact of research into community health and well-being outside of the scope of their job requirements. Individuals who perform this function as part of their normal job (clinical or research) will not be considered for the award. Champions may not be members of ABCT at the time of their nomination.

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