BULLETIN OF THE AMERICAN ACADEMY OF CLINICAL PSYCHOLOGY

Volume 21, Issue 1

Fall, 2021

Robert A. Moss, Ph.D., ABPP, ABN
Editor

In this issue

American Academy of Clinical Psychology Board Update

Gerard Rodriguez-Menendez, Ph.D., ABPP, MSCP

In this update the Academy of Clinical Psychology's (ACPP) current status and goals for 2021-2022 are reviewed in light of the actions of the Board of Directors (BOD) and the AACPP committees. The AACP currently has the following BOD members: Drs. Gerardo Rodriguez-Menendez, President; Larry Beutler, Vice President; Mary Ann Norfleet, Treasurer; Donna Ferguson, Secretary (outgoing); Joanne Babich, Member at Large; Nicholas Grant, Member at Large; and Alan Von Kleiss, Member at Large. At its last meeting of July 17th, the AACP BOD unanimously approved the formation of two new committees:

1. The Clinical Psychopharmacology Committee
2. The Diversity Committee

The rationale for the formation of a Clinical Psychopharmacology Committee is not new to the AACP BOD as our own Mary Ann Norfleet (2002) debated the RxP (Prescriptive Authority Movement for Psychologists) in the Journal of Clinical Psychology. Rather, numerous studies have identified that there is a mental health crisis in the United States (US), and in particular, there is a critical need for pharmacotherapy. Moreover, the COVID-19 pandemic has served to heighten health care disparities in the US. Long-standing inequities in health care due to socioeconomic depravation and systemic racism, impact health care access and utilization, increase rates of medical conditions, and shorten life expectancy, all of which are factors that escalate risk for COVID-19 exposure, illness, and mortality (SAMSHA, 2020). Since June 12, 2020, age-adjusted hospitalization rates in the US are highest among non-Hispanic American Indian/ Alaska Natives and non-Hispanic blacks, followed by Hispanics/ Latins, with rates between four and five times that of non-Hispanic whites (CDC, 2020). Data also suggest the homeless experience higher infection and hospitalization rates (Mosites et al., 2020). Furthermore, the resulting social isolation has led to increases of domestic violence, child abuse, and negative impacts to adolescents and older adults, as these groups are already at risk for depression or suicidal ideation (Galea et al., 2020).

Prior to the COVID-19 pandemic, there was a shortage of qualified professionals to meet the mental health care needs in the United States—in particular, psychiatric services—resulting in the need to recruit foreign physicians to the US to

Continued on page 2

meet the needs of over 300 million persons, with 40% of the workforce practicing in exclusive cash-only private practices, the second highest among medical specialties after dermatologists (National Council for Behavioral Health, March 28, 2017). The U.S. Department of Health and Human Services (2018) estimated that approximately 114 million Americans reside in mental health shortage areas. Nationally, about 60% of all counties, including 80% of all rural counties, do not have a psychiatrist and 40% of persons needing mental health care services go untreated (The New American Economy Healthcare Report, 2017). Despite the passage of the Mental Health Parity and Addictions Equity Act of 2008, nearly half of the 60 million adults and youth living with mental illness in the US go without any treatment (National Alliance on Mental Illness, 2017). The net effect is that predominantly the affluent can obtain pharmacotherapy in a time efficient manner, whereas patients from underrepresented sectors must wait weeks and months for appointment to receive needed medications. Additional threats to the practice of clinical psychology at the doctoral level include recent actions by the American Psychological Association's (APA) Commission on Accreditation's (CoA) approval of accrediting programs at the master's level, potentially blurring the distinction between doctoral and master level practitioners. Case in point, in Texas, Licensed Professional Associates (LPAs) a group comprised by master level practitioners, threatened to bring litigation against the Texas Board of Psychology. Today, LPAs can practice independently and conduct psychological assessment and evaluations without a licensed psychologist's supervision.

Most recently in August 2020, the APA Council of Representatives (COR) approved the application of the American Society for the Advancement of Pharmacotherapy, Division 55, recognizing clinical psychopharmacology as a specialty area, following a review by the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). Therefore, clinical psychopharmacology is now an APA recognized specialty area. Given the societal need, threats to the field of clinical psychology, and the recognition of clinical psychopharmacology as a specialty area, the BOD opines that clinical psychopharmacology represents an expansion of practice for clinical and other health service psychologists. Moreover, with the expansion of interstate rates afforded through the Psychology Interjurisdictional Compact (PSYPACT) psychologists can prescribe across state lines in participating states. For example, in the state of Illinois, by recently enacted state law, prescribing psychologists can prescribe using telehealth.

Similarly, the AACP BOD opined that following the social unrest stemming from the murder of George Floyd and other African Americans, and particularly given the US historical antecedents of race, power, privilege, prejudice and oppression, the Board opined that the AACP should have a committee dedicated to diversity. Hence, the Diversity Committee has been so named to represent two distinct elements of diversity: individual (gender, age, LGBTQ+, disability, etc.) and cultural diversity. The Diversity Committee will meet on a bimonthly basis and has the following aims:

1.Attract and retain underrepresented demographic sectors within the AACP for membership; and
2.Promote the development of multicultural competencies, and competencies for individual diversity within the Academy; and
3.Incorporation of diversity research and looking at the science behind race, ethnicity, and individual diversity.

Given the mission of the Diversity Committee, it

would be important to add advocating for the needs of unrepresented sectors who frequently experience health care disparities, thereby compounding their difficulties to access mental health care services. In 2013, there were 45,580 actively practicing psychiatrists in the US to meet the needs of over 300 million persons, with at least 40% of the workforce practicing in exclusive fee for service private practices, accounting for the second highest cash-only practice rate among medical specialties after dermatologists (National Council for Behavioral Health, March 28, 2017). Moreover, given the impacts of institutionalized racism that have been a central part of US history over the past several hundred years, it is of vital importance to add that as a profession, it behooves us to adopt the science-based model of race, and that to combat racism, the best approach is through education and advocacy.

Attract and Retain Professionals from Underrepresented Demographic Sectors

Based on the AACP Membership Survey that was circulated in 2019, it was found that the association is lacking membership based on gender, age, and racial/ethnic groups. For example, whereas females comprise 50.8% of the US population (US Census Bureau, 2019), and a 77.64% of students in HSP accredited doctoral programs (CoA, 2020), females only comprise 22.05% of membership in the AACP. Similarly, our membership survey revealed that we had more members among over the age of 65, then we had early career psychologists. Racial and ethnic underrepresented sectors included African American, Asian, and Hispanic/Latin representation. Hispanics/Latins and African Americans and Asians account for approximately 32% of the US population (US Census Bureau, 2019). Asians account for 5.9% of the US population, but only 0.79% of AACP members. Minorities now comprise 39.9% of the US population (US Census Bureau, 2019). In contrast, racial/ethnic groups in the AACP account for less than 8% of academy members. Therefore, the AACP BOD concludes that if we wish for our society to have access to health care services, then we must be culturally inclusive as an association and as exemplified in our membership.

Emphasis on Developing Multicultural and Individual Diversity Competencies

Multicultural and individual diversity competencies seek to promote the successful application of multicultural and culture specific abilities in human interactions in three broad cultural domains: (a) awareness; (b) knowledge; and (c) skills. Specifically, multicultural awareness entails the objective perception of one's behavior, and that of others, within a cultural context of circumstances. Examples include: (a) having an accurate awareness of oneself as a cultural being, and an awareness of one's own cultural values and biases; (b) being aware of how worldview and cultural backgrounds influence human interactions and may promote stereotypes; and (c) being aware of one's limits of competency and expertise (i.e., knowing when to refer a patient or client of a different culture to a practitioner with greater expertise).

Multicultural knowledge refers to acquiring factual information about specific cultures. Examples of multicultural knowledge competencies include: (a) being knowledgeable of one's racial and cultural heritage; (b) acquiring culture-specific knowledge about the racial and cultural heritage of the social groups one is providing clinical services for; (c) understanding the impact of racism, discrimination, oppression, power, and privilege on various social groups; (d) knowledge of the legal and ethical aspects of multiculturalism (e.g., Title VII of the Civil Rights Act of 1964, Health Insurance Portability and Accountability Act of 1996 [HIPAA], the APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations, among others); and (e) being knowledgeable about clinical resources and guidelines pertaining to the treatment of mental disorders in diverse populations. As an

example, many practitioners are not aware that the DSM-5 is published in a variety of languages. Therefore, practitioners providing services to multicultural populations (or supervising students providing services to such groups) should be familiar with available diagnostic, assessment, and treatment resources for these groups. Moreover, .it is incumbent for practitioners to learn and use the correct professional terminology (i.e., psychological jargon in a given language) when providing psychological services to non-English speakers.

Finally, multicultural skills refer to the successful application of multicultural competencies in human cross-cultural interactions. Specific multicultural skills entail: (a) seeking out educational, and life experiences to improve one's understanding and effectiveness in fostering positive interactions with persons of different cultural backgrounds; (b) actively seeking consultation from diverse groups served; (c) respecting the language preference of one's client and ensuring that accurate translations occur as needed; (d) examining traditional psychological practices for their cultural appropriateness; (e) modeling behavior that promotes the principles of tolerance, inclusion and pluralism: and (f) finding ways to engage in public advocacy to dismantle social obstacles as part of one's professional responsibilities.

Tie-In with Research

We understand the importance of following the science to prevent the spread of infection as a result of the COVID-19 pandemic. Similarly, with race and ethnicity, we should follow the science. Hence professional psychology would do well to adopt a science-based model of race, as opposed to a sociocultural model. The latter has generally prevailed in professional psychology. The weakness of the sociocultural model include that it is an arbitrary and archaic model and that it is largely based on classifying humans according to their phenotypical characteristics. As such, the sociocultural model was used to justify the existence of slavery based on these differences, and hence, the model is associated with oppression, power, and privilege. Apart from promoting stereotypes, the sociocultural model is historically inconsistent, uses the language of laypersons, and promotes high expressed emotion. In contrast, the science-based model of race is objective and verifiable. It focuses on genetic similarities, is historically accurate, and fosters the use of the language of science. Finally, a scientific model of race promotes reasoning and understanding. To facilitate this effort, the Diversity Committee will seek to disseminate high-quality, evidence-based research related to mental health care disparities, the causes of mental illness, and effective approaches for treatments.

In closing, it is evident that the world is getting smaller and that the acquisition of multicultural competencies will become a key life skill in the 21st Century. Therefore, the Diversity Committee will seek to provide the AACP with: (a) a body of recommended clinical resources and guidelines for providing psychopharmacology consultations and treatment to diverse populations; (b) disseminate this information among psychologists at the state and national level; and (c) place an emphasis on skills or competency development.

A Contract Between Military and Civilian

Bryce Lefever PhD. ABPP

My uncle served in the famed 10th Mountain Division in World War II. Growing up, I was aware that he had been wounded (a bullet or shrapnel had torn apart his right ear). He was back in combat in a few weeks. He told me only one story about his war experience and I now regret that I had not asked him to tell me more. His squad was clearing farmhouses near the end of the war. This was very dangerous work. While on patrol, a sniper shot and killed one of two brothers serving on his team. The squad circled around and captured the sniper, a young German boy of approximately 14 years of age. An officer took the boy behind a barn and shot him. This was traumatic for my uncle and probably for every soldier present.

When my uncle returned from the war, he reunited with his family (my mother was his only sibling—just a year younger). My uncle talked through the night as the family listened. However, my grandfather concluded that there was something mentally wrong with him, deceived him into seeing a psychiatrist, and the result was that my uncle was given a series of electroconvulsive shock treatments.

As an active-duty military psychologist, I treated many service members for their reactions to the traumatic and life altering events that so frequently result from exposure to war. Often, these warriors will remark that they don't talk about these experiences or tell me that I am one of the few whom they have told. I ask them why. They tell me that others don't understand. I asked one man, suffering from anxiety, flashbacks, and nightmares whether he has discussed his experiences with his wife. He said "no." I asked why. He says, "she doesn't understand."

In order to make a couple of vital points, I am going to make some sweeping generalizations—so I apologize to all those great Americans who handled the return of their loved ones with patience, skill and care. I also want to assure you that my observations are based on contact with a huge number of combat and trauma survivors including those from every war including and since the national ordeal that was World War II. Here are the generalizations:

1. After World War II, Americans wanted America to return to normalcy. They wanted prosperity and life as good or better than it had been before the war. Recall that, unlike subsequent wars, virtually every American had been directly affected and involved in the war effort through loss of friends or loved ones, rationing, recycling, purchasing war bonds and performing voluntary service. It was not that the returning soldiers did not talk about their experiences, it was that when they began to talk, they got the very strong message from family and friends to "get back to normal." In public and private, others did not want to hear about the realities of their heroic and often terrible ordeal. All war is hell and America did not really want to hear about what it took to get the job done.

2. During and after Viet Nam, the public disliked the war and did not see its purpose. Those who fought the war were treated as if they had done something wrong and they were shunned, mistreated and sometimes vilified. Again, the message from the public

was "I don't want to hear about your experiences."
3. In other wars, there are probably mixtures of these two messages, but they have too often been received as "I don't want to hear about it—can you get back to a normal life, a normal marriage, and be a normal person?"

Americans have willingly gone to war and experienced hardships, pain, death, physical and psychological trauma, loss, and the guilt that comes with surviving. In war, strengths and weaknesses that make us human are exposed. And, in the midst of all of this, these humans have accomplished great things under terrible circumstances on our behalf and in defense of America and freedom. These Americans will tell us that they are not heroes, but they are.

Clearly, we don't want them to suffer any more than necessary and we don't want their suffering to last a lifetime—in silence no less. But what can we do about it? We can do a lot. First, one of the largest and most unaccounted factors or causes of chronic trauma reactions or PTSD is that the warrior feels unappreciated for what he has endured and for what he has done. The first remedy is for us to frequently show our appreciation by telling him that we will never let him forget how aware we are of his sacrifice. The second remedy is similar. It is to show warriors how much we care by making every effort to listen to them and to ask that they share with us their experiences.

This is the contract between the receiving public and the returning warrior: "Please tell me what you did, and I will listen. I will listen for as long as you want to talk and as many times as you want to tell me. You are a hero, and I cannot imagine what you have endured. I will never stop listening to you and I will never cease in my effort to understand." In this way, our brave American warriors can be accepted. In this way, they can help us to understand. In this way, they can help us to understand. In this way, they can be fully appreciated.

[The photograph below is of Dr. Lefever deployed to Afghanistan in 2002.]

Clinical Training in PsyD programs during the COVID-19 pandemic: Challenges and Implications

Priscilla Dass-Brailsford, EdD MPH*, Linda J. Baum, PhD, Michelle S. Schultz, PsyD, and
Amy L. Young PsyD, MSEd, HSP

*Corresponding Author: 1015 15th St. NW #400, Washington DC, pbrailsford@thechicagoschool.edu

In March 2020, the federal government issued stay-at-home orders due to the COVID-19 pandemic. This once-in-a-century pandemic forced U.S. educational institutions to adhere to federal lockdown and shelter-place orders. Higher education institutions began to teach remotely, and many practicum and internship sites shut down. Not surprisingly, these severely affected students' ability to deliver face-to-face therapeutic services and to participate in in-vivo classroom activities, presenting major problems for the long-term consequences of practical training in clinical psychology. In this brief paper we discuss some of the challenges of the COVID-19 pandemic on the practical training of students in clinical psychology programs in the United States, and the strategies that programs initiated to overcome them.

Virtual Instruction

Educators quickly found solutions to the challenge of providing students with continued education as seamlessly as possible using technology platforms such as Google Classroom, Zoom, and WebEx. Some of these virtual and technological platforms were free and others had extensive cost but appeared to be the most plausible solution to transitioning and offering classes via remote instruction. Didactic aspects of training have historically been widely and efficiently offered virtually in higher education (Seaman et al., 2018); additionally, the online format of education is convenient and reduces excessive travel time to the institution.

However, graduate training in clinical psychology is governed by the American Psychological Association (APA) Commission on Accreditation (CoA), which is recognized as the primary accrediting body in the United States by both the U.S. Department of Education and Council of Higher Education Accreditation. The Standards of Accreditation (SoA) in Health Service Psychology provide specific guidelines that accredited clinical psychology programs are mandated to follow (APA, 2015). A doctoral education delivered substantially or completely online is not compatible with the SoA (see Implementing Regulation C-11 D). Fortunately, the CoA announced permission for virtual teaching until July 1 (that timeline has now been extended).

SoA Implementing Regulation (IR) C-10 D specifies the importance of 'identifying' the student, yet in the virtual world it is possible to remain anonymous or manipulate one's identity. It thus becomes important for instructors to ensure that students are completing their assessments and assignments on their own. While some programs may have used the virtual format in the past and have documented guidelines related to student privacy and identifying students in a virtual environment, other programs may have suddenly switched to this format based on the

demands of the pandemic. For the latter, it is critical to continuously document how the program adhered to IR C-10 D. Examples include the security of technology systems used, as well as policies regarding their use such as requiring students to use their cameras during class lectures and/or virtually administered exams.

It was further critical to follow CoA guidelines which require the evaluation of trainees' competence in each required profession-wide competency as an integral part of the curriculum. The assessment of many clinical competencies, evaluations are partly based direct observations (APA, 2015). Thus the direct observation of student competencies became a complex issue since the restrictions of the COVID-19 pandemic complicated the implementation. Moreover, some practicum sites switched to a fully virtual format within a short frame of time, which did not allow sufficient time to develop a structured framework and policies for the direct observation of student trainees.

A specific area of student training that was most affected by the observation imperative was psychological assessment. In-person observation of student administration of several assessment tests (intelligence, personality, and other performance-based tests) is required in graduate training; unfortunately, the pandemic conditions did not allow this to occur. In addition, students could not practice administration, due to pandemic social distancing regulations. To manage this challenge programs adopted a variety of strategies. Some chose to revise and restructure the academic curriculum so that assessment courses that required direct observation (primarily cognitive assessment) occurred later in the course sequence when pandemic restrictions were lifted and in-person administration became possible. Others chose to delay teaching practical elements of intelligence test administration and training, requiring students to demonstrate competency in the administration of the test informally, just prior to the start of an assessment training practicum.

Even though it is unlikely that one semester or evaluation period without direct observation would have a major impact on a student's clinical training, it is important that adjustments to the evaluation process of student training are well documented. It is also imperative that academic programs offer sufficient and additional opportunities for the observation of student performance, so that training programs are confident of the clinical competence of their students. Socialization, peer interaction, and faculty role modeling that require face-to-face interaction are some areas compromised by virtual teaching . Virtually mediated communication does not allow for nuances of non-verbal communication or engagement in multiple conversations in a group context. To foster socialization under pandemic conditions, some programs have organized virtual opportunities for students, staff, and faculty to engage outside of the classroom. For example, programs have organized virtual cafes or coffee hours, happy hours, and drop-in lounges conducted through video-conferencing platforms, virtual work groups, and social discussions via video sharing on mediums such as flipgrid (e.g., sharing short videos on holiday traditions). These endeavors have required the investment of time, resources, and planning.

Tele-supervision

Tele-supervision is another virtual learning opportunity that is constrained by the SoA (see IR C-13). Many training programs that did not have a tele-supervision policy prior to the pandemic, needed to quickly pivot towards this format. Faculty had to be proactive in documenting how student training

experiences changed due to the pandemic. If this format continues in the future developing clear tele-supervision policies is important. Practicum site supervisors must be trained and have full awareness of the limitations that tele-health policies may have on student training experience so that they can make adaptations accordingly. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides clear guidance on federal requirements for maintaining the security of client data (Luxton, et al., 2016). Academic programs must ensure platforms are HIPPA-compliant and take every step to maintain compliance.

Academic Programs with Training Clinics

Programs with training clinics that offered assessment and therapy services to clients from the community on their campus locations experienced unique challenges. While some universities were closed, and unable to maintain service provision, others were able to pivot to a tele-health model of service delivery. However, this required changes in virtual platform access which came with unplanned costs to academic programs. An example of a HIPAA-compliant platform used by campus clinics is LYSSN, a web-based platform that allows students to easily engage in telehealth services; speech-to-text transcription allows for the recording of client sessions and gathering of material that can be shared for supervision. LYSSN utilizes Artificial intelligence (AI)-enabled technology to recognize skills and techniques from evidenced-based practices and produces data summaries that can be later reviewed in student supervision. Fortunately, the stimulus bill referred to as the Coronavirus Aid Relief, and Economic Security (CARES) Act was passed in March 2020, which could be accessed to provide funding to offset some of these unpredictable expenses.

Positive experiences with tele-supervision during the COVID-19 pandemic will motivate some training sites to continue with this modality in non-pandemic times, given that research has demonstrated the benefits of tele-supervision (Inman, Soheilian, & Luu., 2019; Jordan & Shearer, 2019). It is therefore important that student coursework focuses on telehealth models of service delivery in the future, especially for programs with training clinics. However, offering assessment services in the virtual context remains a major challenge. Some guidance regarding the adaptation of assessment into the virtual format was provided by the Society of Personality Assessment with the caveat that not all assessments can be validly administered virtually.

Embracing the benefits of tele-health approaches to instruction will keep campus training clinics competitive with community agencies. It will give clients from more diverse backgrounds options to receive services at campus clinics and play a role in dismantling stigma associated with receiving mental health services for many disenfranchised communities (Bell et al., 2020).

Socioeconomic Status Considerations

Access to technology has been essential to maintain academic performance and communication when shelter-in-place orders were instituted. Students with financial hardships may have been unable to purchase needed computer hardware or access internet connectivity, preventing them from fully engaging with the educational process. In some cases, the whole family shared one computer, which quickly evolved into family crises as well as a major educational stressor for doctoral students.

Students with economic hardship may have

experienced additional problems as well. Poor internet connectivity interfered with students' ability to provide psychological services and obtain the necessary clinical experience hours crucial to training. Confidentiality and privacy are core tenets in clinical psychology programs. Students are trained to maintain the confidentiality of their clients but they themselves also have a right to confidentiality. Using audio-video technology caused students to disclose private information they typically would not report in educational and clinical settings (e.g., when using virtual platforms such as Zoom, students may disclose their living conditions; living spaces may be not always be well-furnished, or clean, causing some students embarrassment). In small apartments, the bedroom and bathroom may be the only rooms with doors to offer some privacy. Neither is ideal for maintaining professionalism in a virtual setting.

American with Disabilities Act (ADA)

Accommodations for students with ADA concerns increased dramatically during the pandemic. Comorbid pre-existing conditions that classify such students as 'high risk' and other related stressors affected student education and training during the pandemic. Even during non-pandemic conditions, people with disabilities are challenged in attaining equity, despite strong advocacy from the ADA (Pappas, 2020). Many clinical programs advocated for students who were immune-compromised or had other health concerns to be given accommodations at training sites that required face-to-face service delivery; however, these adjustments to training must be clearly documented. While students are able to limit direct exposure to the virus with tele-health, not all sites offered services in this format. Residential facilities, such as inpatient hospital settings and correctional facilities required students to continue to offer direct services to clients. These are also sites that offer good training opportunities in terms of constant and consistent caseloads (clients do not have barriers to attending sessions since they are already on site) and offering students the opportunities to acquire a higher number of face-to-face training hours with patients with more serious mental health issues. Unfortunately, students with disabilities that include immunocompromise were unable to take advantage of these unique training opportunities.

Internship

The process of matching with a pre-doctoral internship in clinical psychology is the final stage of doctoral training in clinical psychology and was similarly affected by the pandemic. The Association of Psychology Postdoctoral and Internship Centers (APPIC) quickly made changes to the application process in light of the pandemic. The application for predoctoral internships transitioned to a virtual format, with video instructions and information about the APPIC Application for Psychology Internships (AAPI) linked to an online discussion board. APPIC further recommended that internship interviews occur virtually, allowing for greater access to internship sites during a time when travel was restricted.

Quarantine, stay-at-home orders, and site closures led to a decrease in experience hours for some students, which led to less competitive applications and compromised ability to match with an internship site. To add to these challenges, APPIC recently reported that the greatest disparity in the student to position ratio since 2015 occurred in March, 2021, with 364 more students applying for internship than available positions. This gap is likely the result of the inability of sites to operate at normal capacity because of the pandemic. It is unclear if this problem will persist into future internship

interviews occur virtually, allowing for greater access to internship sites during a time when travel was restricted.

Quarantine, stay-at-home orders, and site closures led to a decrease in experience hours for some students, which led to less competitive applications and compromised ability to match with an internship site. To add to these challenges, APPIC recently reported that the greatest disparity in the student to position ratio since 2015 occurred in March, 2021, with 364 more students applying for internship than available positions. This gap is likely the result of the inability of sites to operate at normal capacity because of the pandemic. It is unclear if this problem will persist into future internship match seasons.

Licensure

Licensure is an area in which complications can be anticipated in the future. Training departments must encourage students to have a stringent record-keeping process. Because supervision often adopted a virtual format in March 2020, and perhaps remained virtual, students need to keep detailed records about their supervisory experiences, so that they can offer appropriate explanations for adaptations made to training during the pandemic in the future when they seek licensure. To assist with this process, on November 3, 2020, the Association of State and Provincial Psychology Boards (ASPPB) provided guidance on logging changes in training experiences. An ASPPB COVID-19 workgroup released four forms, to track modifications made to education, practicum training, internship training, and postdoctoral training.

Conclusion

The pandemic made virtual and remote education the only safe, accessible and acceptable means of education for many students, and several technology platforms (ZOOM, WebEx) made this possible. This article identified some of the challenges and the changes made to adjust to pandemic conditions, with specific attention to clinical training which mandates face-to-face interaction among student trainees, clients and supervisors. The ripple effects of these adjustments to student clinical training during the COVID-19 pandemic will be felt for many years as programs slowly return to on-ground education and make decisions on which aspects of training will remain virtual, especially aspects which were found it to be effective during shelter-in-place conditions (Bell et al., 2020). For example, it is important, especially for programs with training clinics, to include training in telehealth models of service delivery in curricula.

References

American Psychological Association. (2015, November). *Commission on accreditation: Implementing Regulations.* Bell, D. J., Self, M. M., Davis, C. III, Conway, F., Washburn, J. J., & Crepeau-Hobson, F. (2020). Health service psychology education and training in the time of COVID-19: Challenges and opportunities. *American Psychologist, 75*(7), 919-932. http://dx.doi.org/10.1037/amp0000673https://www.apa.org/ed/accreditation/section-c-soa.pdf

Association of Psychology Postdoctoral and Internship Centers (2020c, March 24). *COVID-19 resources for the training community*. https://www.appic.org/News-Articles/ArtMID/1931/ArticleID/6/COVID-19-Resources-for-the-Training-Community

Bell, D. J., Self, M. M., Davis, C. III, Conway, F., Washburn, J. J., & Crepeau-Hobson, F. (2020). Health service psychology educa tion and training in the time of COVID-19: Challenges and opportunities. *American Psychologist, 75*(7), 919-932. http://dx.doi.org/10.1037/amp0000673

Goghari, V. M., Hagstrom, S., Madon, S., & Messer-Engel, K. (2020). Experiences and learnings from professional psychology training partners during the COVID-19 pandemic: Impacts, challenges, and opportunities. *Canadian Psychology/ Psychologie Canadienne*, *61*(3), 167–189. https://doi.org/10.1037/cap0000250

Inman, A. G., Soheilian, S. S., & Luu, L. P. (2019). Tele-supervision: Building bridges in a digital era. *Journal of Clinical Psychology, 75*, 292–301. https://doi.org/10.1002/jclp.22722

Jordan, S. E., & Shearer, E. M. (2019, September 16). An Exploration of Supervision Delivered via Clinical Video Telehealth (CVT). *Training and Education in Professional Psychology*. Advance online publication. http://dx.doi.org/10.1037/tep0000245

Luxton, D. D., Nelson, E., & Maheu, M. M. (2016). *A practitioner's guide to telemental Health: How to conduct legal, ethical, and evidence-based telepractice*. American Psychological Association.

Pappas, S. (2020, Nov. 1). *Despite the ADA, equity is still out of reach.* American Psychological Association. https://www.apa.org/monitor/2020/11/feature-ada

Seaman, J., Allen, I. E., & Seaman, J. (2018). *Grade Increase: Tracking Distance Education in the United States.* Babson Survey Research Group. http://www.onlinelearningsurvey.com/highered.html.

With each newsletter we will strive to provide information developed in clinical practice from our members. These may be useful to the practicing clinicians in addressing issues they encounter and may provide avenues for future applied research studies by our member academicians and students.

Clinical Implications of Internal Self-Talk: The Verbal Interpreter and the Unconscious

Robert A. Moss, Ph.D., ABPP, ABN

In two high-powered experiments, Orvell, Vickers, Drake, Verduyn, Ayduk et al. (2021) confirmed that a subtle shift in language promotes emotion regulation. That involves "distanced self-talk" which is silently referring to oneself using one's own name and non-first person-singular pronouns. I have used this concept for years in clinical practice based on a brain theory, the Dimensional Systems Model (DSM; Moss, 2006), in which emotional processing primarily involves the right cerebral cortex and the source of internal self-talk (i.e., the "verbal interpreter") involves the left lateral inferior frontal cortex (i.e., in and around Broca's area). The most comprehensive discussions of the DSM and the applied Clinical Biopsychological Model are in an open-access article (Moss, 2020a) and a more detailed book (Moss, 2020b). I wanted to briefly discuss how the Orvell et al. (2021) findings can be explained based on this theory and other implications of the verbal interpreter concept related to psychotherapy.

The DSM posits that all cognitive functions involve multiple circuits of cortical columns (i.e., the binary digits, or "bits"). There are serial circuits in which all columns are directly connected in-line and it is proposed that some cognitive tasks (e.g., mirror drawing) can be done by a single circuit of columns from the point of sensory input to the behavioral response. If a cognitive task involves multiple serial circuits that do not directly connect, these are in parallel. In that case, the different circuits project to one or more distant common areas (often called "hubs") as the information is combined and a response is formed. While serial circuit columns may be directly consolidated into memory via reentrant processes (Edelman & Gally, 2013), parallel circuits require the involvement of the hippocampus to become bound and consolidated into a complex memory involving all the circuits (Moss, 2016). Thus, if there is damage to the hippocampi, then the person can learn to improve performance with mirror drawing but lack the ability to verbally state they have ever done the task in the past. This is due to the parallel verbal interpreter circuitry not being bound in memory with the mirror drawing circuitry. Obviously, this specific example is more relevant to clinical and cognitive neuropsychologists, but it serves to demonstrate the result of what is behaviorally observed with circuits that do not directly connect. In that case if the verbal interpreter circuitry does not directly connect with other circuits, then there can be a lack of verbal awareness that those circuits are involved in ongoing cognitive tasks. The lack of verbal awareness is typically called "unconscious" by our psychodynamic colleagues.

There are many naturally occurring disconnected

cortical circuits with this being best demonstrated in hemispheric asymmetry of functions. I began using the term "interpreter" instead of saying "verbal-thinking" after reading a chapter by Gazzaniga (2002) on consciousness. He defined the "interpreter" as a device or mechanism in the left cortex that seeks to explain why events occur. He discusses how split-brain research supports the fact that the interpreter can provide an erroneous explanation of the right hemisphere's actions based on stimulus input provided only to the right cortex. In other words, the interpreter uses its own sphere of knowledge from the left cortex to provide the most logical explanation of actions controlled by the right cortex, despite it being factually wrong in many situations.

I discussed evidence that the right posterior cerebral cortex preferentially handles non-detailed emotional stimulus input and processing, while the right frontal cortex controls emotional responses (Moss, 2020a, b). I proposed that there is a right "emotional interpreter" and interhemispheric connections connect it with the left verbal interpreter to coordinate vocalized responses. The emotional interpreter provides the planning for the emotional communications of speech, such as volume, inflections, prosody, and single word emotional expressions (e.g., profanity). However, there are no direct connections between the right posterior cortex and the left verbal interpreter. This means there can be complex emotional sensory processing that occurs without verbal awareness. That right cortical sensory processing can activate subcortical areas (e.g., amygdala, hypothalamus) which result in physiological responses (e.g., increased muscle tension, panic symptoms) and the verbal interpreter may be unaware of why those responses have occurred.

It is common that the verbal interpreter claims to have the emotional reactions (i.e., "I feel"), alt-

.though the DSM posits that the right cortex is responsible for feelings. Accordingly, if the third person pronoun is used then it is an accurate statement because the verbal interpreter is not the source of the emotional reaction. Consistent with the Orvell et al. (2021) findings, as I have patients say "he/she feels" instead of "I feel" in session, they typically find it leads to more perceived peace based on this accurate statement. It acknowledges the right hemisphere's processing and allows the verbal interpreter to console and assume responsibility for dealing with the situation leading to the emotional response. I equate it with an adult (left cortex) looking out for the well-being of his/her child (right cortex) in which the adult intervenes and either resolves the problem or removes the child from the problem. In either case, it reduces the hurt for the child and makes the child (right cortex) feel more secure in the relationship with the adult (left cortex). For many patients, this is facilitated by simply explaining that it is allowing the left cortex to protect the right, just as they as parents would intervene and protect their own children.

Based on the foregoing discussion, I hope it is apparent why I recommend psychological treatment address both the right and left cortices, as well as their congruence (i.e., verbal thinking and emotional thinking are aligned). As I summarize the Clinical Biopsychological approach in an upcoming workshop as:

We each have a brain. We each have two minds, as does everyone with whom we have a relationship. We verbally think and form verbal memories. We emotionally think and form emotional memories. Verbal and emotional processing occurs independently, but

each can influence the other internally, and by controlling the external world perceived by the brain. It is possible to use a brain model to guide assessment, conceptualization, and treatment with patients.

References

Gazzaniga, M.S. (2002). Consciousness. In V.S. Ramachandran (Ed.), Encyclopedia of the human brain (Volume 2, pp. 31–35). New York: Academic Press.

Edelman, G. M. and Gally, J. A. (2013) "Reentry: a key mechanism for integration of brain function." *Frontiers in Integrative Neuroscience* 7, 63.

Moss, R. A. (2006). Of bits and logic: Cortical columns in learning and memory. *The Journal of Mind and Behavior, 27,* 215-246.

Moss, R. A. (2016). A theory on the singular function of the hippocampus: Facilitating the binding of new circuits of cortical columns. *AIMS Neuroscience, 3,* 264-305. doi: 10.3934/Neuroscience.2016.3.264

Moss, R. A. (2020a) Psychotherapy in pain management: New viewpoints and treatment targets based on a brain theory. *AIMS Neuroscience, 7(3),* 194-270. doi: 10.3934/Neuroscience.2020013

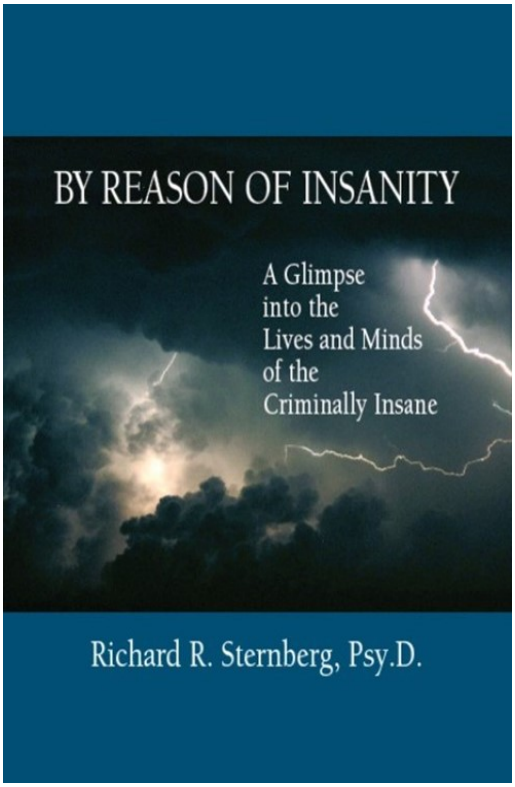
Moss, R. A. (2020b) *Psychotherapy in Pain Management: New Perspectives and Treatment Approaches Based on a Brain Model.* Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK: Cambridge Scholars Publishing.

Orvell, A., Vickers, B. D., Drake, B., Verduyn, P., Ayduk, O., Moser, J., ... & Kross, E. (2021). Does Distanced Self-Talk Facilitate Emotion Regulation Across a Range of Emotionally Intense Experiences? *Clinical Psychological Science*, *9*(1), 68-78.

Article:

Andersen, D. T. (2021). Reflections on 48 years of mindfulness practice. *Journal of Humanistic Psychology, 61,* 650-654.

New Books Written By AACP Fellows and Members



RICHARD R. STERNBERG received his doctorate in clinical psychology from Long Island University/CW Post in 1995. He received a postdoctoral certificate in psychoanalysis and psychotherapy from Adelphi University's Derner Institute of Advanced Psychological Studies in 2004, and a postdoctoral certificate in marital and couple therapy from that institute in 2007. Currently an adjunct professor of psychology at Adelphi, Dr. Sternberg is also a clinical supervisor for Long Island University's doctoral program in clinical psychology and a past supervisor for the New York University-Bellevue Medical Center internship in clinical psychology. He was a staff psychologist at the Kirby Forensic Psychiatric Center from 1996 to 1999, and By Reason of Insanity is based on his experience in that setting. A diplomate of the American Board of Professional Psychology in clinical psychology, Dr. Sternberg has been recognized by the National Institute of Health Service Providers in Psychology and maintains a private practice in psychoanalysis and clinical and forensic psychology in Hewlett, NY

This is an excellent book, a solid, well-written and very smart work. I couldn't put it down. It is superb. Dr. Sternberg is an excellent story-teller and a serious scholar, thinker and writer.

—Lewis Aron, PhD, Director, NYU Postdoctoral Program in Psychotherapy & Psychoanalysis

This unique volume offers a rare glimpse into unfamiliar—in a sense, even, forbidden—territory for most psychoanalysts and other mental health professionals. The stories are fascinating and sensitively rendered; the writing is as crisp, accessible and compelling as a strong piece of fiction. I recommend this for anyone hungry to explore the darkest recesses of the human mind. I can state with certainty that I have never read anything like it.

—Steven Kuchuck, President, International Association for Relational Psychoanalysis and Psychotherapy, Faculty, NYU Postdoctoral Program in Psychotherapy and Psychoanalysis, author of *The Relational Revolution in Psychoanalysis and Psychotherapy*

IPBOOKS.net International Psychoanalytic Books

By Reason of Insanity: A Glimpse into the Lives and Minds of the Criminally Insane

Richard R. Sternberg, Psy.D, ABPP (2020) IPBooks.net

Click here for information available at the publisher's website

Purpose of the CEU Committee: The Committee's goal is to encourage high quality lifelong learning opportunities for Clinical Psychologists and colleagues who are engaged in the delivery of professional psychological services. The Committee can facilitate learning by providing courses and access to seminars that are supportive of state-of-the art approaches for diverse populations. By doing so, the Committee will be supporting ongoing improvements in clinical modalities, so as to help our clients heal even more while adding to the science of our psychology profession.

Presently, the Academy has no continuing education modules or events planned. Our Continuing Education Committee continues to explore programs that meet membership needs. We are also developing a list of APA Approved Sponsors of Continuing Education programs that will offer our Members and Fellows discounts.

IAt present, we are pleased to let you know that we have obtained a discount for CE programs offered through *Professional Resource Press, Bookshelf to Couch,* and *TZK Seminars*. You may access the programs as follows:

Professional Resource Press

The discount code to apply is: **AACP20**

Bookshelf to Couch

The discount code to apply is: **AACP30**

TZK Seminars

The discount code to apply is: **tzk20**

Professional Resource Press , Bookshelf to Couch, and TZK Seminars are approved by the American Psychological Association to sponsor continuing education for psychologists. Professional Resource Press and TZK Seminars maintain responsibility for the programs and content.

Board of Directors

Please encourage your colleagues and students to join the American Academy of clinical psychology. Presently, we are waving the 2021 membership your dues, as part of our membership campaign for this year. As you may know, we offer for levels of membership: Fellow (for Fellows of the American Psychological Association and psychologists who are Board Certified through the American Academy of Clinical Psychology, Member, Emeritus Fellow (Fellows who are no longer earning income from professional services), and Student (graduate students in clinical psychology).

APPLICATION

(print clearly)

Name _____ Degree_____

Address _____

Address_____

City _____ State_____ Zip_____

Telephone _____ email _____

Board Certified? ____Yes ____No

Fellow of APA or Certified Specialist through ABPP? ____Yes ____No

Licensed? ____Yes ____No

License Number and State _____

Name as you would prefer on certificate_____

Would you like to serve on an Academy Committee? ____Yes ____Not at this time

Professional Membership Organizations:_____

_____

_____

FEE WAIVED FOR MEMBERSHIP YEAR 2021.

Please submit application to: contact@aacpsy.org

Please pass the application along to colleagues and students who may have been interest in joining the Academy

Call for Submissions

We encourage our membership to submit news about professional activities that you would like to share with membership, recent list of articles, books published by our membership, book reviews, as well as contribution to our new section, *Insights and Procedures from Clinical Practice.* In this section, we will strive to provide information developed in clinical practice from our members. These may be useful to the practicing clinicians in addressing issues they encounter and may provide avenues for future applied research by our member academicians, practitioner, and students

Please submit to Bob Moss, clinicalbiopsychology@gmail.com

Telephone: 813-321-5635
www.aacpsy.org