



Psychology Internship Training Amidst COVID-19: Balancing Training Opportunities, Patient Care, and Risk of Exposure

Michelle B. Stein^{1,3} · Sheila O'Keefe¹ · Ryan Mace^{1,4} · Jacklyn D. Foley¹ · Allison E. White¹ · Jared R. Ruchensky² · Joshua Curtiss¹ · Eileen Moran¹ · Casey Evans¹ · Stuart Beck¹

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Abstract

The emergence of the 2019 novel coronavirus (COVID-19) has dramatically altered how psychologists deliver its training. At least for the time being, virtual care has become the primary method for delivering mental health services. This has allowed patients and clinicians to continue to access and provide services in a way that would have been impossible years ago. Not only has this shift impacted patients, but it has also impacted supervision and training. The impact has been especially profound on inpatient units where the psychiatric and medical acuity is high of patients and the therapeutic milieu is an important aspect of treatment. The purpose of this paper is to review the impact of COVID-19 on pre-doctoral psychology interns during their rotation on an inpatient psychiatry unit at the start of the pandemic (January to June of 2020) and use these experiences to onboard the next class of interns in the new academic year (July 2020 to June 2021) using a hybrid model of in-person and virtual training experiences. At the end of 2020/2021 rotation, we voluntarily asked interns to complete a questionnaire that was developed based on the qualitative experiences of the previous class to assess the effectiveness of this hybrid model. We also surveyed multi-disciplinary staff members who were essential personnel and required to work in person during this time about their experiences of safety and support. With this information, we explore and offer guidance to other inpatient training sites who are likely to encounter similar challenges during this time. In particular, we discuss the integration of virtual technology into this training experience, as well as the restructuring of clinical and supervisory experiences. We highlighted several short-term strategies that we have flexibly adapted to our inpatient unit. The lessons learned herein seek to guide supervisors and trainees alike in adapting their psychology training programs to meet the evolving demands of COVID-19.

Keywords Psychology internship · Inpatient psychiatry · COVID-19 · Training · Telemental health · Virtual care

The use of virtual technology in mental health care has increased over recent years. For clinicians, patients, and many insurance companies, it has become an accepted alternative to in-person psychotherapy, particularly for outpatient

care. Telemental health research has demonstrated that telemental health can increase access (i.e., due to physical/psychological limitations, geographical location, and/or socioeconomic factors such as transportation problems), reduce costs, and provide flexibility (Langanizadeh et al., 2017). However, disadvantages include the need for adequate technology, technological competencies, adequate internet access, insurance reimbursement, privacy and confidentiality, as well as challenges around perceptions of impersonality (Connolly et al., 2018; Langanizadeh et al., 2017). Most of this research has been limited to outpatient services. The emergence of the 2019 novel coronavirus (COVID-19) has pushed virtual care as the primary method (as opposed to in person visits) for delivering these vital mental health services while also striving to reduce the spread of COVID-19 (Perrin et al., 2020).

✉ Michelle B. Stein
mstein3@mgh.harvard.edu

¹ Massachusetts General Hospital and Harvard Medical School, Boston, MA, USA

² Department of Psychology and Philosophy, Sam Houston University, Huntsville, TX, USA

³ Psychological Evaluation and Research Laboratory (PEaRL), Massachusetts General Hospital & Harvard Medical School, One Bowdoin Square, 7th floor, Boston, MA 02114, USA

⁴ Center for Health Outcomes and Interdisciplinary Research, Massachusetts General Hospital and Harvard Medical School, Boston, MA, USA

Although telepsychiatry has been adopted in some rural inpatient settings for enhanced access (Grady & Singleton, 2011), historically the use of virtual technology in inpatient psychiatric care has been less prominent due to increased acuity and issues related to risk. Thus, not surprisingly, the research on telepsychiatry particularly inpatient psychotherapy is sparse. When COVID-19 emerged, there was an immediate need to integrate telemental health in inpatient care (with little to no existing frameworks available). Clinicians have forcibly struggled to identify best practices that incorporate the needs of the patient, trainee, supervisor, unit, and healthcare system, the balance of which has been quite delicate.

This pandemic has also had a profound impact on the structure of clinical training and provision of supervision across medical settings (Palitsky, Kaplan, Brodt, Anderson, Athey et al., 2021). While there continues to be a growing body of literature supporting the use of virtual technology in mental health care (Langarizadeh et al., 2017), there is little written about the role of telesupervision. These papers focus on providing telesupervision to trainees in underserved or rural areas (Jordan & Shearer, 2019; Tarlow, McCord, Nelon, & Berhaud, 2020) and emphasize outpatient settings.

Regardless, research has demonstrated a number of factors that foster effective telesupervision (see Hames et al., 2020). These include supervisee characteristics (e.g., autonomous, flexible, pragmatic, and assertive supervisees), supervisor characteristics (e.g., prior supervision and telesupervision experience), supervision characteristics (e.g., videoconferencing most appealing), communication strategies (e.g., slower speaking style, practice turn-taking, effective use of silence), technological considerations, environmental factors, prior in-person contact, and supervisory relationship

(e.g., accessibility of supervisor outside of supervision). In addition, there has been at least one paper that has been written about outpatient telesupervision during COVID-19 (Tarlow et al., 2020), which support the above tenets.

It is important to note that research supports the effectiveness of outpatient telesupervision and telemental health care. However, there is limited research exploring telemental health and telesupervision in inpatient settings. There are inherent differences in treating patients and supervising interns in an inpatient setting (see Table 1). Based on these differences, adapting to virtual care in inpatient settings are not as straightforward as in traditional outpatient psychotherapy. Additional modifications are required when delivering clinical services and providing supervision virtually in inpatient settings.

In addition, research that has been conducted on telesupervision in inpatient settings (Jordan & Shearer, 2019) entails the supervisee conducting sessions in person on the unit and the supervisor being off-site. During COVID-19, the opposite phenomena is developing at many inpatient training sites. Physicians and licensed clinicians are essential employees who are required to work on site whereas trainees are non-essential and must work from home. To our knowledge, few if any studies exploring how the findings reviewed above translates to supervisors who are present on an inpatient unit and supervise trainees who are off-site. Furthermore, from a clinical and supervisory standpoint, there is limited guidance within the literature on how supervisors can adapt and create a virtual inpatient rotation where trainees can meaningfully engage in a variety of clinical activities that in some fashion mirror an in person inpatient rotation (i.e., how do we bring a therapeutic milieu to an iPad?).

Table 1 Differences in the treatment of patients and clinical supervision in outpatient and inpatient settings

	Outpatient	Inpatient
Treatment	<ol style="list-style-type: none"> 1. Pre-determined agreed upon day and time; most often weekly sessions 2. Specified office 3. Clinician and patient have access to technology and simultaneously sign on and conduct therapy in secure and confidential manner 4. In most instances, patients are able to find a private space to meet for therapy 	<ol style="list-style-type: none"> 1. Patients hospitalized and flexibility regarding time, day, and frequency of sessions 2. Space is often limited, room availability not as straightforward, clinicians find patients when it is time for therapy based on clinician availability and patient's involvement with other consultants 3. Patients do not have consistent access to secure media platform to conduct psychotherapy. Technology is provided by staff and said technology is limited 4. Finding a private space to conduct psychotherapy can be challenging due to having a roommate, limited rooms patients can go into without staff present due to safety concerns
Supervision	<ol style="list-style-type: none"> 1. Pre-determined agreed upon day and time and additional real-time supervision PRN 2. Assignment of patients happens in advance 3. Group sessions planned well in advance of day and time 4. No therapeutic milieu; navigating the multidisciplinary team present in select supervisions 	<ol style="list-style-type: none"> 1. Supervision happens in real time throughout the intern's shift 2. Assignment of patients occur during the shift due to turnover, patient needs, and clinical presentations 3. Group topics finalized during trainee's shift to ensure topic matches functioning level of unit 4. Navigating the therapeutic milieu and multidisciplinary team

Lastly, there is limited published work highlighting intern training experiences (Palitsky et al., 2021).

The focus of this paper discusses the impact that COVID-19 has had on inpatient training and supervision. In particular, we explore the challenges that pre-doctoral psychology interns and supervisor have faced during their inpatient rotation since the pandemic began. The lessons learned herein seek to guide supervisors and trainees alike in adapting their psychology training programs to meet the evolving demands of COVID-19. First, we provide an overview of this rotation prior to COVID-19. Second, we discuss how the rotation was restructured and integrated virtual technology to allow interns to continue their clinical training while working remotely. We explore perspectives of this transition from both the psychology interns and their supervisor. Third, we discuss how our multidisciplinary team has onboarded the next intern class (July 2020 to June 2021) including the development of an inpatient training questionnaire for quality improvement purposes and to maximize training efficiency. Finally, we asked members of the multi-disciplinary team who worked in-person during the pandemic about their experiences of safety and support via a 10-item questionnaire. Based on these experiences, we offer guidance to other inpatient training sites to adapt to select rotations.

Pre-COVID-19 Training

Thirteen pre-doctoral clinical psychology students with diverse clinical interests (Adult, Behavioral Medicine, Cognitive Behavioral Therapy, Child, Integrated Brain Health, and Neuropsychology) are accepted each year. While these interests have their own specialized training programs, as part of their core training, all psychology interns complete a six-month rotation on our medical psychiatric inpatient unit. The purpose of this rotation is to increase the intern's exposure to the evaluation and treatment of acute psychopathology. This four-hour per week rotation has historically consisted of interns attending patient rounds, seeing patients individually, and co-leading groups. In addition, they attend a weekly one-hour didactic seminar that covers a range of topics related to inpatient psychology and psychiatry. Interns also learn to provide consultation on behavioral management, psychotherapeutic interventions using a variety of modalities and empirically-supported treatments, and diagnostic clarification.

Each intern is assigned to one of four multidisciplinary teams that treat up to six patients at a time. The core multidisciplinary members consist of an attending psychiatrist, a medical resident (PGY1), a social worker (LICSW), and the patient's assigned nurse (RN). The purpose of psychology interns attending patient rounds is multifold. First, they acquire knowledge on psychiatric interviewing and

psychopharmacology (evaluation, treatment, and management of severe psychopathology). Second, some of our patients have concomitant medical conditions. As such, this rotation increases the intern's knowledge about medical comorbidities and how this is an important component to differential diagnosis. The third purpose of interns attending rounds is to help them learn how to be a psychology consultant. They learn how to communicate insights regarding the patient's psychological condition, introduce psychotherapeutic interventions and/or specific treatment modalities which may be indicated based on the patient's clinical presentation, as well as further assist with differential diagnosis. During this rotation, we spend a great deal of time on the interpersonal and emotional nuance (both a skill and an art to develop) that is required for the timing and delivering of these interventions to patients and team members. It also poses a challenge that interns come to the unit one day per week. That is, it takes longer for them to become familiar with navigating the milieu and patient acuity, feel integrated into the team, as well as feel comfortable communicating their expertise in real time.

A second component to the psychology intern's rotation is conducting individual and skills-based group psychotherapy. We use a "tapering" model to accommodate the range of backgrounds, therapeutic orientations, and familiarity working with acute psychopathology. The psychology intern starts by observing the supervising psychologist attend rounds and conduct psychotherapy. After the session, we review the session delivery, highlight relevant themes for case conceptualization, discuss treatment planning, and contextualize the experience within each intern's stage of training (see Stein & Jacobo, 2013). The second step in this tapering model entails the psychologist encouraging the intern to increasingly contribute to psychotherapy, such as by agreeing to lead certain topics or providing interventions in real-time (i.e., co-therapy), which we then process after the session. By the third step, interns primarily lead sessions while the supervising psychologist provides direct observation and may interject to further therapeutic techniques and training objectives. The last step in this model entails the interns conducting individual and group sessions independently. This staging process is applied flexibly to match intern confidence, skill, and training goals, as well as patient medical and psychiatric acuity, treatments, and characteristics. All interns are required to see patients independently by the end of the 6-month rotation.

Impact of COVID-19 on Inpatient Psychiatry Rotation

On March 16th, 2020 our psychology interns were 11 weeks into this core rotation when rising COVID-19 infection rates led to all non-essential hospital personnel being forced to work virtually from home. This included most trainees (psychology pre-doctoral and post-doctoral fellows, as well as medical students). A hybrid model, consisting of in-person and virtual care, was instituted for essential inpatient psychiatry staff, including a variety of consultants, to balance continued patient care with risk of exposure to COVID-19. Regarding the psychology service, we dropped down from 10 staff/trainees (psychologists: $N=3$; psychology interns: $N=7$) rotating on the unit weekly to one in-house psychologist (MBS, Director of Psychology on unit). The two other psychologists were also in leadership positions. They shifted their inpatient responsibilities to the outpatient department focusing on the policies, procedures, and logistics surrounding converting clinical care, supervision, training, and other relevant activities from in-person to virtual.

Modifications to Inpatient Psychology Rotation During COVID-19

This core rotation (with the exception of our weekly seminar) was temporarily paused for two weeks after the hospital enacted its “work from home” policy on March 16th 2020. During this time, our unit first prioritized the restructuring of operations across disciplines and contingency planning for COVID-19 before we could revamp our virtual training model. We were tasked with finding a technological solution that balanced the needs of the patients, unit, and trainee experiences, as well as burden on the team and supervisors. During these first two weeks, iPads were purchased for each attending psychiatrist for conducting in-person rounds while remaining team members participated virtually via secured video technology. Over time, a structure was instituted in which attendings, residents, and social workers alternated weekly between attending rounds in person and virtually, to limit exposure. Psychology interns remained on “work from home orders” for non-essential employees and continued their track-specific training held remotely. The multi-disciplinary team

Table 2 Pre-doctoral psychology interns experience of rotation modifications

Clinical activity	Advantages	Disadvantages
Virtual rounds	<ol style="list-style-type: none"> 1. Develop novel ways to contribute and greater access to in-moment resources (information related to diagnosis, medication, medical record, online resources) 2. Attain more “fly on the wall” perspective 3. Teaches us to be succinct; assertiveness building 4. Patients willing to include and interact with us virtually and patient’s response to video technology informs us clinically 5. Increased discussions with team in between seeing patients 6. Our face is not covered with a mask and goggles 	<ol style="list-style-type: none"> 1. Have to abandon many “soft skills” (in person) we have accrued throughout our training 2. Miss non-verbal cues, see patient’s upper body only 3. Extra burden is placed on in-person team members to coordinate and act as a liaison to the unit 4. Connection issues, low volume, hard to hear people 5. Sometimes people would forget to introduce us 6. Harder to contribute and feel a sense of belonging and active member the team 7. Increased distractions at home; harder to focus
Co-psychotherapy	<ol style="list-style-type: none"> 1. Confidence building 2. Learn in-vivo from supervisor’s style and receive moment-to-moment feedback 3. Patient benefits from multiple perspectives 4. Deeper dive into clinical presentation in supervision 5. Helps us observe important cues that we might have missed when conducting therapy alone 6. Patients can see our faces and associated expressions 	<ol style="list-style-type: none"> 1. Less opportunity to see range of patients that we would typically see 3. Hinders independence 4. More challenging to find individualized therapeutic identity and build confidence as inpatient psychologist 5. Hard to hear patients during session and intuited session content based on supervisor’s interventions 6. Can be challenging to bounce off each other in session
De-emphasizing groups	None	<ol style="list-style-type: none"> 1. Miss out on learning about the structure and content of inpatient groups and ways to manage patient’s behavior/verbalizations (i.e., redirection) in group
Weekly seminar integrating case conference format	<ol style="list-style-type: none"> 1. Problem solved ongoing difficulties transitioning to telehealth 2. Direct relevance to what is occurring on unit in real time 3. Developed case conceptualization skills 4. Increased sense of belonging and feeling more integrated and valued team member 	<ol style="list-style-type: none"> 1. Miss out on learning about theories of psychopathology

remained committed to the intern's teaching and did not opt out of their training responsibilities.

Shifting from an in-person to virtual rotation impacted all clinical (i.e., rounds, individual and group psychotherapy) and supervisory (i.e., weekly seminar and individual supervision) activities. In this next section, we discuss the specific adaptation required. In addition, we highlight the lessons we learned, positives and negatives, which are summarized for the reader in Table 2.

Virtual Rounds

Psychology interns re-joined rounds remotely once a week starting in late March 2020 and were met with several challenges. Upon their return, each intern assimilated to a new treatment team—a switch that occurs halfway through the inpatient rotation to foster new learning opportunities and a change to interact with different multidisciplinary providers. Some interns found it difficult to develop relationships with their new team members and reported feeling disconnected from rounds. Also, the census dropped during the hospital's initial response to COVID-19, and the admitted patients were more acutely ill. While this provided novel exposure and increased education surrounding acute psychiatric illness, interns had less exposure to patients that would typically benefit from psychological interventions during rounds. As such, they participated less during rounds. The high patient acuity compounded technological barriers, such as low volume, unstable connection, and image quality, making it even more challenging for interns to meaningfully contribute.

We supported the intern's acclimation and contribution to virtual rounds in individual supervision and during our weekly seminar. In addition, the supervising psychologist checked in with team members (i.e., attending, PGY1, LICSW) regularly to see how psychology's participation was being experienced. We worked collaboratively and creatively to identify the advantages and disadvantages of attending and participating in rounds virtually and when possible, developed workarounds (i.e., team more explicitly asking for intern input and increases in intern self-assertion). Interns found novel ways to contribute, and they continued to broaden their understanding and treatment of patients (see Table 2). Overall, the psychology interns appreciated being part of the multidisciplinary team and the unit's efforts to keep them involved during this time, as not all hospital trainees had the opportunity to do so (medical and nursing students). Some interns opted to attend virtual rounds more frequently, which assisted them in feeling more integrated within the team, enhance their training, and support the hospital-wide response to COVID-19. Some interns did not feel impacted by attending rounds virtually as opposed to in-person. Looking back, we would have omitted the team switch

if we knew that they would continue with stay at home orders for the remainder of this rotation. This would have reduced at least one of the initial challenges. Positively, they adjusted to this challenge, and the teams were committed to helping them integrate into rounds and share their clinical wisdom. In sum, if we have to convert to virtual rounds again in the future, we will keep the psychology interns on their respective teams. In addition, we will ask the treatment teams to make sure the iPad is on Gallery as opposed to Active Speaker View (ideally during and between patient rounds though at least between patient rounds) to foster the psychology intern's participation and integration within the team as well as problem solve with the teams to find ways to optimize iPad volume. We would continue to offer the psychology interns to attend rounds more frequently if they so desired.

Individual Psychotherapy

Two weeks after virtual rounds began (April 13th 2020), we secured an iPad and re-introduced individual psychotherapy into the rotation. This is the component of this rotation where we needed to be most thoughtful about balancing training needs with patient care. We knew that the interns would be part of the individual psychotherapy session via video technology; however, a number of questions were raised by leadership prior to its execution. First, would the supervising psychologist, psychology intern, or combination of both conduct the session? Second, if the psychology intern conducted the session, would the supervising psychologist be present, or would the intern video in independently? Third, what is the preferred method for session delivery (e.g., virtual, in-person, or hybrid)? Fourth, what are the interns' level of comfort and preference in taking the lead, interjecting, or purely observing the individual psychotherapy session held virtually, as some interns had more experience with telehealth than others? Fifth, if the intern conducted the session independently, who would arrange the zoom session and provide the patient with an iPad? In addition, is the patient safe to independently meet with the intern virtually? How would we know when the session was complete and who would procure the iPad following the session?

From a clinical and educational standpoint, we opted for the supervising psychologist to be present in the session and in most instances lead the session. While this decision reduced opportunities for interns to treat patients independently, it preserved their clinical hours and created opportunities for co-therapy with a licensed psychologist. Also, from a supervisory standpoint, it would have created increased burden to procure virtual technology for patients and manage logistics surrounding interns independently seeing select patients.

We wanted the interns to actively participate in the session in some fashion. Initially, we attempted to do this organically where the intern could chime in during an optimal moment (as with in-person co-therapy). This proved challenging given the placement of the iPad, interaction complexities for both verbal (e.g., patient has a soft voice and was required to wear mask, which muffled sound even further) and nonverbal information (e.g., patient and on-site psychologist wore a mask), and technological difficulties (e.g., video lag). The supervising psychologist increased intern participation by selecting portions of the session, such as natural breaks in the conversation or when relevant to individual training goals, to elicit input on what has been discussed so far. At the end of the session, the supervising psychologist asked the intern for any final thoughts or observations to share with the patient. There were a few instances when the supervising psychologist requested that the intern lead the session, mostly when it was on an area of intern expertise (i.e., Exposure Response Prevention for Obsessive Compulsive Disorder). From a supervisory perspective, patients have responded well to this approach to individual psychotherapy and include the interns in the session.

The interns had varied responses to the changes in psychotherapy. There were some interns for whom their experience pre-and post-COVID-19 did not change. That is, if they felt they could learn different things by observing, working together, and working independently, the restructuring and use of technology did not impact them as much. Likewise, for interns who were less likely to conduct psychotherapy post-internship (e.g., those specializing in assessment or research), this restructuring took some of the pressure off seeing patients independently. However, the changes had more of an impact on interns who were interested in increasing their independence, confidence and competence, as well as building their inpatient psychotherapy skill set during this rotation. That is, after internship training and certainly after post-doctoral training, having the opportunity to identify how to treat high acuity patients under close supervision (and within the containment of an inpatient unit) becomes less and less. While interns reported enhanced knowledge about inpatient psychotherapy and the various ways to conceptualize and employ interventions, they had fewer opportunities to apply this skillset and to develop their identity as an inpatient psychologist (see Table 2). As such, finding ways select interns can virtually see select patients independently is indicated.

Groups

We opted to minimize the intern's role in co-leading inpatient groups during this time for a few reasons. First, it was challenging to hear all participants via video. Second,

psychology groups often occurred at the same time as team rounds. Interns quickly transitioned from rounds, to debriefing with their supervisor, to co-leading group before COVID-19, all of which was not feasible over video. We did not want to do this when they were participating virtually because the interdisciplinary exchanges were already reduced for the interns when we went virtual. As such, it was decided for interns to participate in all of rounds, and the sacrifice would be decreasing exposure to psychoeducational skills-based groups. Overall, for interns who were looking for increased experiences running inpatient groups, this was an overall negative to the restructuring of the rotation (see Table 2).

Weekly Seminar

The final modifications that were made to this rotation focused on the structure and content of our weekly seminar. The seminar resumed with the same curriculum that was planned prior to COVID-19 with adaptations for video (e.g., screen sharing PowerPoint presentations). Over time however, we observed that while interns were continuing to gain team experiences in rounds and conducting co-therapy, they were missing out on the impromptu interpersonal exchanges with staff. In addition, they were missing out on clinical observations that occur within the general milieu and seeing medical, psychiatric, and psychological phenomena in-person as opposed to on-screen. Certain topics, while all relevant to their inpatient psychology rotation, were more challenging to directly observe and apply to one's clinical work. As such, we shifted our seminar from predominantly didactic to a case conference format beginning the week of May 18th 2020. The revised goal was to discuss symptom, psychological, personality, milieu, and system factors during course of hospitalization. We invited the PGY1's and PGY2 psychiatry trainees currently rotating on the unit, as well as other disciplines, as it related to the case discussion. This created opportunities to gain collaborative experiences and to explore different philosophies to inpatient care conceptualization and treatment between disciplines. The supervising psychologist prioritized cases that had been seen by most interns. In most cases, the psychology service played an integral role during the patient's hospitalization.

Overall, the psychology interns had positive experiences of the shift in format from didactic to case presentation. They felt like it fostered collaboration and sense of cohesion with psychiatry residents. Additionally, it further developed their case conceptualization skills (see Table 2).

Telesupervision

Supervision during this time shifted from in-person to virtual. Psychology interns used their personal computer and the supervisor used an iPad. Unlike in-person supervision, telesupervision entailed meeting at a specified time every shift, discussing their experience of rounds and then who we were going to see individually that day and the approach to the session. Afterwards, we processed the session. The biggest barrier to telesupervision occurred during the individual therapy session. That is, interns were able to hear the supervisor clearly, but in many instances had extreme difficulty hearing the patient. So, co-therapy proved more challenging than intended. In the future, if interns are required to work from home again, it may be advantageous to have the patient hold the iPad instead of the supervisor (see Table 2).

Attaining Clinical Proficiency

While all interns successfully adapted from in-person to virtual care, it was less clear how these changes and challenges impacted learning relative to traditional training experiences. Unavoidably, the range of clinical experiences reduced during this time (during this rotation and the internship more broadly). We have less information surrounding the development of their professional identity and if/how this was affected by the pandemic. In addition, we have less information as to if/how this impacted their transition to a post-doctoral fellowship or academic position. While quantitative data is not available, our evaluation data did not change. All psychology interns successfully graduated and most often continued to exceed expectations. As a cohort of 13, 11 progressed to post-doctoral fellowships at MGH or Harvard affiliated institutions. Two interns attained academic positions in university-based settings.

Development of a Hybrid Model

July 1, 2020 marked the beginning of the new academic year. Clinical internship sites were trying to find a delicate balance between virtual and in-person training. Without prior scaffolding, such as touring the unit and meeting with unit staff, we imagined that an entirely virtual rotation posed further training challenges of inpatient training sites. This is different than what has been presented in this paper thus far as both psychology interns and supervisor were 11 weeks into their rotation before COVID-19 altered their training/supervisory experiences. However, in parts of the country COVID-19 rates were significantly increasing just as the academic year approached. As such, the safest option for these sites were to begin inpatient rotations virtually. Positively, in our area restrictions regarding working from home, particularly in healthcare professions, were slowly lifting as

the new academic year was approaching. As a result, this allowed leadership to entertain discussions about the percentage of time psychology interns can be on and off site during their internship year, how this relates specifically to their inpatient rotation, and personal safety.

Based on this, the 2020–2021 academic year consisted of the following

1. Clinical activities were predominantly held in-person. This included patient rounds, seeing individual patients, and co-leading groups. There were two interns who for medical reasons conducted between 5 and 7 weeks virtually and either resumed or initiated in-person care after vaccination. In addition, if one of the fellows was asked to consult for a patient due to their particular area of expertise and it was outside their shift, then this would be completed virtually (as for many of the interns, this was the only in-person rotation during their internship year).
2. Each intern had different level of comfort re-initiating in person care, as this may very well be the first time since COVID-19 emerged that they will be seeing patients on site. Similar to our “tapering” model in approaching individual therapy, we have tried to balance the requirements of the rotation with the intern’s comfort level. The Director of Psychology Internship Training Program reached out to the incoming class to get a sense of their comfort level and associated concerns about returning to in-person care for this rotation. Based on this, both she and the select intern collaboratively decided who would be rotating on this unit the first half versus second half of the academic year.
3. We continued to have our weekly seminar virtually throughout the academic year.
4. We flexibly re-introduced virtual activities (i.e., rounds, individual and group psychotherapy) as needed based on intern’s level of comfort (i.e., increased COVID+ patients on unit), and other reasons that precluded them from attending a select shift or portion/remainder of the rotation in person (i.e., waiting for COVID test results following time off and/or possible exposure).
5. All interns were trained on how to use PPE. They were required to wear surgical masks and goggles for all patient exchanges and when navigating the unit. Additional PPE was required for patients on COVID+ precautions. In these instances, interns had the option to participate or decline meeting with patients during rounds who were COVID+ or an exposure risk based on their comfort level. For these patients, individual therapy was conducted by staff psychologists.

Experiences of the Hybrid Model

Clinical activities during the July 2020 to June 2021 were primarily held in person. Eight interns opted to complete this questionnaire. They reported that the pandemic minimally impacted their ability to participate in this rotation in person ($M = 1.9$; $SD = 0.64$; 1 = all in person & 5 = all virtual). The mean number of virtual rotations was 1 ($SD = 2.4$; Min and Mode = 0; Max = 7). They felt safe navigating clinical activities ($M = 4.75$; $SD = 0.46$; 1 = not safe & 5 = completely safe) and they experienced minimal anxiety regarding COVID-19 exposure ($M = 1.25$; $SD = 0.46$; 1 = no anxiety & 5 = extreme anxiety). For those that completed this questionnaire, only two participated in at least one virtual shift. As such, we couldn't analyze data further. However, there was space at the end of this questionnaire to provide qualitative information regarding the integration of virtual technology into this rotation. Analysis of these comments reveal similar experiences to the March to June 2020 intern cohort when engaging in virtual care (technological barriers such as sound and internet connection at times) and optimizing/structuring patient/multi-disciplinary team interactions when interfacing with primarily in-person team as the dominant themes.

Current Experiences & Existing Research on Telemental Health and Telesupervision

COVID-19 has forced psychology training sites to shift from in-person to virtual rotations within a matter of days to weeks. Fortunately, the research on telemental health and telesupervision has been growing in recent years. However, most of this research has focused on outpatient settings and it is unclear how advantages and disadvantages directly translate to inpatient settings. The main purposes of this paper were to highlight the psychology challenges and opportunities accounted for when adapting an inpatient rotation from in-person to virtual to using a hybrid model. We hope to help others benefit from our experiences. Our experienced-based lessons may be especially relevant given the limited research on telemental health and telesupervision in inpatient settings. In addition, the work that has been completed in inpatient settings usually entails the trainee being on site and the supervisor being off site and there is no research that we are aware of that depicts how to bring the inpatient rotation and specifically an inpatient milieu experience to an iPad. Our experiences indicated that environmental and technological factors (see Hames et al., 2020) were the biggest barriers to both telemental health and telesupervision. This is not surprising given the differences noted above in treating inpatients versus outpatients, increased patient acuity, and the existence of a general milieu. Based on this, we suggest that additional training sites describe and share their experiences from a trainee and supervisory perspective to

collectively identify creative and flexible ways we as a field can maximize the treatment of inpatients and training of psychology interns during this time. While the impetus for this paper focused on the training challenges associated with COVID-19, there will likely be other situations we face that will require inpatient units to incorporate virtual training into select rotations. As such, the utility of this paper reaches beyond COVID-19.

Multi-disciplinary Team Experiences of Working in Person

While the psychology interns and more broadly trainees were afforded the opportunity to work from home, there were numerous multi-disciplinary team members who were not afforded the opportunity to work either fully or partially from home. As such, we felt it important to capture the multi-disciplinary team's experience of safety and support working during the pandemic in person. A ten-item survey was created and distributed via an online survey. This survey was sent three times over the course of 16 days. Nine out of the ten questions focused on the two time periods corresponding with the academic calendar (March to June 2020 & July 2020 to June 2021). The final question focused on one experience that stood out working on this unit during the pandemic. This question covers the entirety of the pandemic (March 2020 to March 2022; see Table 3).

23 multi-disciplinary team members responded to this survey. Numerous disciplines were represented (i.e., Attending psychiatrists, Administration, Medical Students, Nursing, Occupational Therapy, Personal Care Assistants, Pharmacy, Psychology, Spiritual Care, and Social Work).

52% of staff members who completed this survey worked in person on this unit between March 2020 to June 2020. 41% of these staff members felt safe coming to work and 14% did not. 36% of staff members felt supported compared to 18% who did not. 41% of staff members felt more comfortable as the pandemic went on and 18%'s level of comfort fluctuated based on emerging variants (Fig. 1).

87% of staff members who completed this survey worked in person on this unit between July 2020 to June 2021. 52% of these staff members felt safe coming to work, 30% of staff members' comfort fluctuated based on emerging variants, and 4% did not feel safe coming to work. 74% of staff members felt supported compared to 13% who did not. 65% of staff members felt more comfortable as the pandemic went on, 17% level of comfort fluctuated based on emerging variants and 4% of people did not find their level of comfort increased as the pandemic went on (Fig. 1).

Overall, staff member's experience of safety increased 11% over these two time periods. Staff member's experience of support increased 38%. The people who did not feel supported decreased by 5%. People's level of comfort as the

Table 3 Multi-disciplinary team survey assessing staff's level of comfort and safety working in-person during the COVID-19 pandemic

1. Multi-disciplinary team member
a. Attending
b. Nursing
c. PCA
d. Social Work
e. Other
2. Did you work on unit during March-June 2020 (beginning of pandemic);
If no, choose N/A for items 3 to 5
a. Yes
b. No
3. Did you feel safe coming to work?
a. Yes
b. No
c. N/A
4. Did you feel supported?
a. Yes
b. No
c. N/A
5. Did your comfort level increase as the pandemic stretched on?
a. Yes
b. No
c. Fluctuated based on emerging variants
d. N/A
6. Did you work on the unit during July 2020-June 2021?
If no, choose N/A for items 7 to 9
a. Yes
b. No
7. Did you feel safe coming to work?
a. Yes
b. No
c. Fluctuated based on emerging variants
d. N/A
8. Did you feel supported?
a. Yes
b. No
c. N/A
9. Did your comfort level increase as the pandemic stretched on?
a. Yes
b. No
c. Fluctuated based on emerging variants
d. N/A
10. What is one experience that stood out for you working on this unit during the COVID-19 pandemic?

pandemic stretched on increased by 24%. Interestingly, those staff members whose level of comfort fluctuated based on emerging variants remained relatively the same across these two time periods (18% and 17% respectively). One way to interpret these findings is that familiarity with COVID-19

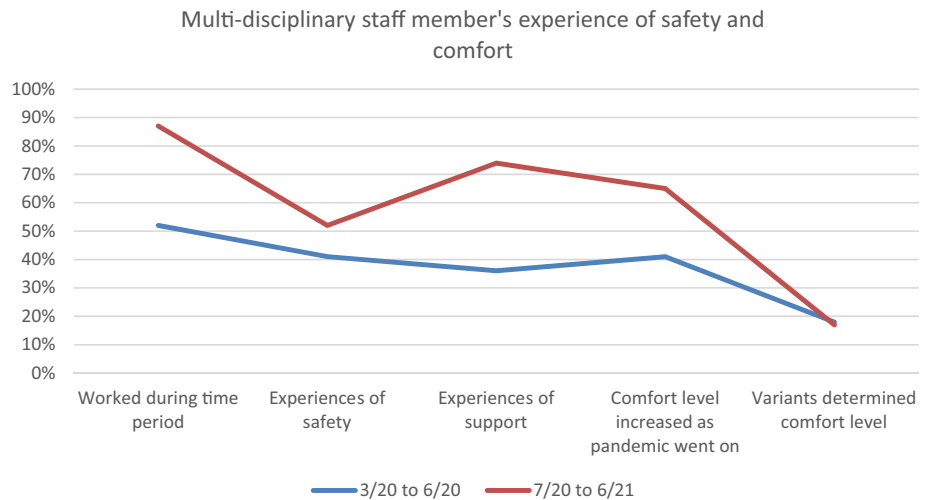
reduced staff member's level of current distress but did not impact their degree to future (anticipatory) anxiety. Overtime, staff feel more comfortable working within a COVID-19 environment and at the same time experience fear and worry related to future mutations.

The last question focused on one experience of working during the pandemic in-person that stood out for each staff member. Four main themes emerged. Two of the themes focused on experiences of unity, collaboration, and group cohesion. The other two themes focused on systemic barriers that resulted in experiences of dissonance. Specifically, one of the experiences that staff members spoke about focused on everyone's *commitment to patient care*. Examples of this included everyone doing their best to integrate virtual technology (use of iPads so COVID+ patients can continue to safely participate in groups) and make physical adaptations to the unit to reduce social isolation while maintaining social distancing. Another common experience focused on staff feeling a *strong sense of community and belonging*. This entailed staff feeling like they were part of a team. Staff felt supported one another and experienced a reduced sense of isolation. In some situations, staff members felt more understood by their fellow colleagues than family and/or friends who were able to work from home. A third theme highlighted the difficulties *navigating the frequently changing guidelines on PPE and precaution requirements*. Staff communicated precautions, policies, and updates efficiently and supported one another. However, this was particularly challenging when high acuity patients who were COVID+ were unable to comply with quarantine rules. The last theme focused on *varying expectations surrounding which disciplines had the opportunity to work remotely as well as which staff/trainees entered COVID+ rooms*. That is, certain disciplines had the flexibility of working from home whereas others did not (i.e., hybrid models were new, certain staff would not be able to perform their duties if they were not in-person, each multi-disciplinary team member's department policies and procedures were evolving in real-time). Certain staff members experienced ambivalence about working in-person versus home, with pros and cons on either side. There were also varying expectations as to who was responsible for going into COVID+ rooms. While there were some exceptions, the nursing staff held most of this burden compared to other disciplines. This was experienced at times in the form of added responsibilities, emotional toll, and at times a decreased sense of collaboration. This was most prominent in the first wave.

Concluding Thoughts

COVID-19 has created a sudden and dramatic shift how we deliver mental healthcare and subsequently will have an ever-changing impact on clinical training. Positively, video

Fig. 1 Multi-disciplinary staff member's experience of safety and comfort



technology allowed interns to continue their inpatient rotation, which would have not been possible years ago. There is no right way of delivering care to patients, as well as there is no right way to provide supervision to pre-doctoral psychology interns during this time. In fact, it takes active collaboration and frequent feedback among the supervising psychologist, psychology interns, and the unit to successfully make these modifications work for all parties involved without sacrificing training experiences, patient care, staff/unit burden, and increasing exposure risk.

This paper also sheds light on multi-disciplinary staff members reporting of safety and comfort as well as experiences that uniquely stood out to them working in-person during the pandemic. The findings gleaned from this survey provides an opportunity to highlight the emotional and interpersonal strengths we possessed as a unit. These findings also provide us with an opportunity to more thoroughly understand and explicitly work on the logistical challenges multi-disciplinary team members faced when adopting a hybrid in-person/virtual model in the setting of the COVID-19 pandemic.

To summarize, this paper highlights short-term strategies that we have flexibly adapted to our inpatient unit and how this information informed the next academic year. Many of these fundamental processes can be applied to most trainees rotating on inpatient units. We encourage other psychology training rotations and disciplines to do the same as we all establish our new normal way of providing clinical care, training our interns, and communicating across and within disciplines. In this way, we can work on best practices and begin conducting qualitative research on training under pandemic conditions.

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Declarations

Conflict of interest Michelle B. Stein, Sheila O'Keefe, Ryan Mace, Jacklyn D. Foley, Allison E. White, Jared R. Ruchensky, Joshua Curtiss Eileen Moran, Casey Evans and Stuart Beck declare they have no conflict of interest.

Ethical Approval This was a quality improvement project and not part of a research study.

Human and Animal Rights This article does not contain any studies with human or animal subjects performed by any of the authors.

Consent to Participate Voluntary as part of quality improvement project aimed at maximizing the effectiveness and safety of training during COVID-19.

Consent for Publication We consent to publishing this article upon acceptance.

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