APPIC holds 7th C.E. Conference

By Robert W. Goldberg, Ph.D., ABPP

APPIC held its Seventh Membership Meeting and Conference in Portland, Oregon, from April 16 to April 18, and it was a tremendous success. The conference theme was “Best Practices in Internship and Postdoctoral Training” with content focusing on the rapidly evolving consensus with respect to development and promulgation of a consistent system of professional competency appraisal from the beginning of graduate school to advanced practice. Despite the declining economy and precarious funding, a record 275 individuals were in attendance. Only the limits of the hotel’s fire occupancy code precluded additional registrants!

Starting off the conference, Stephen Behnke, J.D, Ph.D., of the APA Ethics Office, delivered an invited address on “Legal and Ethical Issues with Problematic Trainees,” a perennial topic of interest. The keynote address was given by Elizabeth Klonoff, PhD., ABPP, of San Diego State University, entitled “So We’re Not in Kansas Anymore, but Where Are We? Thoughts About the Future of Professional Psychology Training,” updating and extending Dr. Cynthia Belar’s

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APPIC honors executive director Hercey

Ms. Connie Hercey, MPA, was honored for her twenty years of dedicated high quality service as APPIC’s Executive Director, at the APPIC Membership Meeting held during the C.E. Conference in Portland. A specially prepared banner congratulating Ms. Hercey on this milestone was unfurled, after which Dr. Steve McCutcheon, APPIC Chair, summarized the many contributions Ms. Hercey has made toward the professionalization and operations of APPIC. Several other psychologists also contributed their kudos. Dr. Arnie Abels presented Ms. Hercey with a celebratory album of testimonial cards, letters, e-mails, and pictures from many, many people who value and cherish her contributions to APPIC and the professional relationships they have had with her.
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Remarks from the e-Editor
By Robert W. Goldberg, Ph.D., ABPP, FAACP

Submissions Solicited
This is another of my recurrent and perennial appeals for submissions to the Newsletter. Publication of the next issue will occur during the peak of intern ‘hunting season’ so articles on recruitment and selection, rule-in criteria for offering interviews, and new ways of managing the onsite applicant interviewing process would be particularly welcome due to their timeliness.

In addition, let me urge you to consider submitting manuscripts of projects you have completed. For example, during the April 2009 APPIC Continuing Education Conference, there were many presentations – qualitative, empirical, conceptual – which would be an excellent fit for the Newsletter. So look on the tops of your desks – not just in the bottom desk drawers! – for potential submissions. Many thanks in advance.

Associate Editors Wanted
We are seeking candidates for appointment to vacated Associate Editorships for Consortia, Forensic Psychology, Geropsychology, and Health Psychology. Candidates must be supervisors at an APPIC Member facility. If you are a potential candidate, please submit a paragraph statement of interest, accompanied by a curriculum vitae, to appic@aol.com, directing your materials to the attention of the Editor. Please consult the archived Newsletter issues on the APPIC website for an idea of the range of satisfactory column lengths and topics.
It is my pleasure to announce the winners of the APPIC Awards for 2009:

**APPIC Excellence in Training Award:**
Paul Robins, PhD
Children’s Hospital of Philadelphia

**APPIC Excellence in Diversity Training Award:**
Lynette Sparkman-Barnes, Psy.D.
University of Missouri-Kansas City Counseling Center

**APPIC Student Research Award:**
Tiffany O’Shaughnessy
Lehigh University

*Internship Site: University of California, Berkeley
Research Project: Lesbian & Gay Affirmative Therapy Competency, Self-Efficacy, and Personality. An Online Analogue Study*

There were a number of very worthy candidates for each of the awards this year which only underscores the quality of the individuals who are committed to training and to those students participating in these experiences. The Awards Committee would like to thank all of the candidates and their sponsors for their time and efforts.

The APPIC Board of Directors would like to remind all members that the awards will be presented at the APPIC Annual Business meeting which will be held on Thursday, August 6th, 8 to 10AM at the Intercontinental Hotel in Toronto, Canada in Ballroom A.

**Conference Continued from Page 1**

classic 1997.appraisal. Perspectives on concepts of competency was provided by Nadya Fouad, Ph.D. the Plenary Speaker, who updated the group on “Benchmarks in the Sequence of Psychology Education and Training.” In addition to the omnibus events, the jam-packed schedule of concurrent sessions included 4 paper presentation sessions, 4 workshops, 9 setting-related breakout sessions (for Training Directors from similar institutions), 24 poster presentations, 3 panel discussions, 1 symposium, and 1 demonstration (of the new ‘AAPI Online.’).

Formal sessions and informal discussions provided an opportunity for officials of many psychology organizations to share concerns and compare approaches. These included: from APA: Dr. Catherine Grus (BEA office); Dr. Susan Zlotlow (Office of Program Consultation and Accreditation), Dr. Nancy Elman (Chair, Commission on Accreditation), and Dr: Nina Levitt (Advocacy); from ABPP: Dr. David Cox (Executive Officer); from ASPPB, Dr. Emil Rodolfa (Chair); and from the National Register, Dr. Judy Hall.

The day prior to the conference, APA conducted workshops on Self Study Preparation and on Accreditation Site Visitor Training. In addition, APPIC conducted it’s now-traditional Workshop for New Training Directors.

That day, the APPIC Board of Directors also held a Board Meeting, discussing some principles and procedural matters in executive session, after which the meeting was opened to Board Liaisons and other invited guests to provide information and conduct discussion on the match imbalance and progress in developing the electronic online AAPI, to be employed in the 2010 Match. Decisions from the Board Meeting, and the status of other APPIC projects and initiatives, were conveyed to the entire convention during the subsequent public APPIC Membership Meeting and its lively question-and-answer session. At that meeting, Executive Director Ms. Connie Hercey was also recognized for her twenty years of service to APPIC.

Dr. Arnie Abels was Chair of the Conference Planning Committee, which also included APPIC CE Coordinator Dr Sharon Berry, Drs. Eugene D’Angelo, Ira Grossman, Jeanette Hsu, Amy Wagner, and Steve McCutcheon, as well as Executive Director Ms. Connie Hercey.

While formal feedback data had not been analyzed at this writing, it was the consensus of attendees that this was the most consistently theme-focused, highest quality, collegial, and best-executed conference that APPIC has yet mounted. Can APPIC top this? Prepare now to register for the next Conference, to be held in Orlando, Florida, next February 10-13, 2010!
We are pleased to report that 2,752 applicants were successfully matched to internship positions. A total of 45% of all applicants who obtained a position matched to their first choice internship program, approximately two-thirds (66%) received one of their top two choices, and nearly four-in-five (78%) received one of their top three choices.

A total of 846 applicants were not matched to an internship position, while 299 positions remained unfilled. This is the highest number of unmatched applicants to date, slightly exceeding the 842 unmatched applicants from the 2007 APPIC Match.

Compared to the 2008 APPIC Match, the number of registered applicants increased by 66 (1.8%) to a record 3,825 applicants, while the number of internship positions decreased by 7 (0.2%) to 3,051 positions. It should be noted that on September 30, 2008, initial 2009 Match registration figures showed an encouraging increase of 243 registered positions as compared to the same date in 2007. However, this increase was not sustained over time as the economic downturn worsened in the months leading up to Match Day, resulting in positions being removed from the Match due to a loss of (or uncertainty regarding) funding.

Here are the changes in numbers of applicants and positions as compared to the 2008 APPIC Match:

<table>
<thead>
<tr>
<th>Category</th>
<th>2008</th>
<th>2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants</td>
<td>3,073</td>
<td>3,825</td>
<td>+752</td>
</tr>
<tr>
<td>Withdrawn or did not submit ranks</td>
<td>231</td>
<td>227</td>
<td>-4</td>
</tr>
<tr>
<td>Matched</td>
<td>2,410</td>
<td>2,752</td>
<td>+342</td>
</tr>
<tr>
<td>Unmatched</td>
<td>432</td>
<td>846</td>
<td>+414</td>
</tr>
<tr>
<td>Positions offered in Match</td>
<td>2,752</td>
<td>3,051</td>
<td>+299</td>
</tr>
<tr>
<td>Filled</td>
<td>2,410</td>
<td>2,752</td>
<td>+342</td>
</tr>
<tr>
<td>Unfilled</td>
<td>342</td>
<td>299</td>
<td>-43</td>
</tr>
</tbody>
</table>

Following is a seven year comparison of the 2002 and 2009 Match statistics:

<table>
<thead>
<tr>
<th>Category</th>
<th>2002</th>
<th>2009</th>
<th>7-YEAR CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Sites</td>
<td>610</td>
<td>666</td>
<td>+56 (+9%)</td>
</tr>
<tr>
<td>Positions Offered</td>
<td>2,752</td>
<td>3,051</td>
<td>+299 (+11%)</td>
</tr>
<tr>
<td>Positions Filled</td>
<td>2,410</td>
<td>2,752</td>
<td>+342 (+14%)</td>
</tr>
<tr>
<td>Positions Unfilled</td>
<td>342</td>
<td>299</td>
<td>-43 (-13%)</td>
</tr>
<tr>
<td>Registered Applicants</td>
<td>3,073</td>
<td>3,825</td>
<td>+752 (+24%)</td>
</tr>
<tr>
<td>Withdrawn Applicants</td>
<td>231</td>
<td>227</td>
<td>-4 (-2%)</td>
</tr>
<tr>
<td>Matched Applicants</td>
<td>2,410</td>
<td>2,752</td>
<td>+342 (+14%)</td>
</tr>
<tr>
<td>Unmatched Applicants</td>
<td>432</td>
<td>846</td>
<td>+414 (+96%)</td>
</tr>
</tbody>
</table>

Note: A “training site” can offer more than one “program” in the Match. Each “program” was identified in the Match by a separate 6-digit code number.

MATCH RESULTS

<table>
<thead>
<tr>
<th>Category</th>
<th>2009</th>
<th>7-YEAR CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positions Filled</td>
<td>2,752</td>
<td></td>
</tr>
<tr>
<td>Remaining Unfilled</td>
<td>299</td>
<td></td>
</tr>
<tr>
<td>Programs Filled</td>
<td>984</td>
<td></td>
</tr>
<tr>
<td>With Unfilled Positions</td>
<td>162</td>
<td></td>
</tr>
</tbody>
</table>

Note: 39 programs at 35 sites submitted fewer ranks than the number of positions available. As a result, no ranks were submitted for 77 positions, which remained unfilled.

APA or CPA Accredited Positions:

<table>
<thead>
<tr>
<th>Category</th>
<th>2009</th>
<th>7-YEAR CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filled</td>
<td>2,242</td>
<td></td>
</tr>
<tr>
<td>Remaining Unfilled</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,322</td>
<td></td>
</tr>
</tbody>
</table>

Non-Accredited Positions

<table>
<thead>
<tr>
<th>Category</th>
<th>2009</th>
<th>7-YEAR CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filled</td>
<td>510</td>
<td></td>
</tr>
<tr>
<td>Remaining Unfilled</td>
<td>219</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>729</td>
<td></td>
</tr>
</tbody>
</table>

Non-accredited positions represented 73.2% of all unfilled positions.

RANKINGS

Average Number of Applicants Ranked Per Position Offered for Each Program:

<table>
<thead>
<tr>
<th>Category</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs Filling All Positions</td>
<td>8.4</td>
</tr>
<tr>
<td>Programs With Unfilled Positions</td>
<td>2.5</td>
</tr>
<tr>
<td>All Programs</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Each Registered Applicant was Ranked by an Average of 5.3 Different Programs

APPLICANTS

Participation

<table>
<thead>
<tr>
<th>Category</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants Registered in the Match</td>
<td>3,825</td>
</tr>
<tr>
<td>Applicants Who Withdraw or Did Not Submit Ranks</td>
<td>227</td>
</tr>
<tr>
<td>Applicants Participating in the Match</td>
<td>3,598</td>
</tr>
</tbody>
</table>

(match includes 42 individuals who participated in the Match as 21 “couples”)

MATCH RESULTS

<table>
<thead>
<tr>
<th>Category</th>
<th>2009</th>
<th>7-YEAR CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants Matched</td>
<td>2,752</td>
<td></td>
</tr>
<tr>
<td>Participating Applicants Not Matched</td>
<td>846</td>
<td></td>
</tr>
</tbody>
</table>

Match Results by Rank Number on Applicant’s List:

(percentages may not total to 100 due to rounding errors)

CONTINUED ON NEXT PAGE
**PART 2: SUMMARY OF PROGRAM RANKINGS**

The following report contains additional statistics on how successful programs were, on average, in matching with applicants. There are several important issues that must be considered in attempting to analyze program success based on the rank numbers of matched applicants.

**DEFINITIONAL PROBLEMS:** Because each applicant submitted a single Rank Order List in order to match to a single position, it is easy to identify his or her “first choice,” “second choice,” etc. However, for an internship program, determining first or second choice applicants is a far more difficult and complex task. First, many programs attempt to fill several positions; if a program has three positions to fill, an applicant ranked third by that program can in effect be considered a “first choice” for purposes of the Match.

Furthermore, a significant number of sites submitted multiple Rank Order Lists for a single program, sometimes ranking the same applicant on different Lists with different rank numbers.

Also, the reversion of unfilled positions between lists adds a further complication to this analysis.

We worked closely with National Matching Services in an attempt to resolve these difficulties and to develop a reasonable method of presenting this data.

**STANDARDIZED RANKINGS:** For the purposes of this analysis, we converted each site’s rankings to a “standardized rank.” This is best explained by example: if the number of positions to be filled from a Rank Order List was three, then the first three applicants on this List were considered to be “first choice” applicants and given a standardized rank of 1. The next three applicants on that List were defined as “second choice” applicants and given a standardized rank of 2. And so on.

Match Results by Standardized Rank Number on Internship Program List (percentages may not total to 100 due to rounding errors)

<table>
<thead>
<tr>
<th>Standardized Rank</th>
<th>Number of Applicants Matched</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,021 (37%)</td>
</tr>
<tr>
<td>2</td>
<td>711 (26%)</td>
</tr>
<tr>
<td>3</td>
<td>506 (18%)</td>
</tr>
<tr>
<td>4</td>
<td>269 (10%)</td>
</tr>
<tr>
<td>5</td>
<td>116 (4%)</td>
</tr>
<tr>
<td>6</td>
<td>59 (2%)</td>
</tr>
<tr>
<td>7</td>
<td>33 (1%)</td>
</tr>
<tr>
<td>8</td>
<td>11 (0%)</td>
</tr>
<tr>
<td>9</td>
<td>5 (0%)</td>
</tr>
<tr>
<td>10 or higher</td>
<td>21 (1%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,752 (100%)</strong></td>
</tr>
</tbody>
</table>

To interpret this chart: of all positions that were filled in the Match, 37% were filled with “first choice” applicants (as defined above), 26% with “second choice” applicants, and so on.

Furthermore, 63% were filled with “first” or “second” choice applicants, while 81% were filled with “third choice” applicants or better.

Of course, comparing these numbers to applicants’ Match statistics should be done with extreme caution, given the significantly different ways in how “first choice”, “second choice”, etc. were defined in each analysis.

**PART 3: STATISTICS FOR COUPLES**

This year, a total of 42 applicants participated as 21 “couples.” Sixteen of these couples had both partners successfully matched to an internship program, while five couples had one partner who was not matched.

For five couples, both partners matched to programs at the same internship site.

Following is a specific breakdown of the Match results for the 21 couples based on distance between matched programs:

<table>
<thead>
<tr>
<th>NUMBER OF COUPLES</th>
<th>DISTANCE APART</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Same City</td>
</tr>
<tr>
<td>4</td>
<td>Less than 50 miles apart</td>
</tr>
<tr>
<td>2</td>
<td>50-100 miles apart</td>
</tr>
<tr>
<td>0</td>
<td>100-150 miles apart</td>
</tr>
<tr>
<td>1</td>
<td>150-500 miles apart</td>
</tr>
<tr>
<td>0</td>
<td>500-1000 miles apart</td>
</tr>
<tr>
<td>0</td>
<td>Over 1000 miles apart</td>
</tr>
<tr>
<td>5</td>
<td>One partner unmatched</td>
</tr>
</tbody>
</table>

CONTINUED ON NEXT PAGE
The number of applicants from Canadian schools who participated in the APPIC Match this year increased by 24 (20%), while the number of positions in Canada rose by 2 (2%). The APPIC Match successfully placed 19 (20%) more applicants from Canadian schools as compared to last year, while the number of applicants from Canadian schools that were not matched remained the same as in the 2008 Match. A total of 18 applicants from Canadian schools remained unmatched, and 17 Canadian positions remained unfilled. Here are the changes in numbers of applicants from Canadian schools and positions in Canada as compared to the 2008 APPIC Match:

<table>
<thead>
<tr>
<th>Applicants</th>
<th>Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered for the Match</td>
<td>Offered in the Match</td>
</tr>
<tr>
<td></td>
<td>Matched</td>
</tr>
<tr>
<td></td>
<td>Filled</td>
</tr>
<tr>
<td></td>
<td>Unfilled</td>
</tr>
</tbody>
</table>

**RANKINGS**

Average Number of Rankings Submitted Per Applicant:
- Matched Applicants: 6.1
- Unmatched Applicants: 4.3
- Overall: 5.8

**INTERNSHIP PROGRAMS IN CANADA PARTICIPATION**

<table>
<thead>
<tr>
<th>Positions Offered in the Match</th>
<th>Match Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filled</td>
<td>112 (86%)</td>
</tr>
<tr>
<td>Unfilled</td>
<td>129</td>
</tr>
</tbody>
</table>

**MATCH RESULTS**

- To Canadian Programs: 95 (85%)
- To U.S. Programs: 17 (15%)
- Participating Applicants Not Matched: 18 (14%)

**Note:** 1 program at 1 site submitted fewer ranks than the number of positions available. As a result, no ranks were submitted for 1 position, which remained unfilled.

**MATCH RESULTS**

- Applicants Matched: 112 (86%)
- To Canadian Programs: 95 (85%)
- To U.S. Programs: 17 (15%)
- Participating Applicants Not Matched: 18 (14%)

**MATCH RESULTS**

- Positions Filled By Applicants from Canadian Schools: 95 (85%)
- Positions Filled By Applicants from Non-Canadian Schools: 17 (15%)

**INTERPRETATION NOTE:** A paired Rank Order List submitted by a couple could have been very lengthy, particularly when a couple chose to submit most or all possible combinations of programs. Eight couples had Rank Order Lists that exceeded 100 pairs of programs, while two couples ranked more than 300 pairs of programs. One should not directly compare the results above with the results achieved by individual applicants (e.g., because 45% of individual applicants received their first choice, and 33% of couples received their first choice pairing, one should NOT conclude from this data that individual applicants “do better” than couples).

**PART 4: SURVEY OF APPLICANTS FROM CANADIAN SCHOOLS**

The number of applicants from Canadian schools who participated in the APPIC Match this year increased by 24 (20%), while the number of positions in Canada rose by 2 (2%). The APPIC Match successfully placed 19 (20%) more applicants from Canadian schools as compared to last year, while the number of applicants from Canadian schools that were not matched remained the same as in the 2008 Match. A total of 18 applicants from Canadian schools remained unmatched, and 17 Canadian positions remained unfilled. Here are the changes in numbers of applicants from Canadian schools and positions in Canada as compared to the 2008 APPIC Match:

**Applicants:**
- Registered for the Match: +24 (+20%)
- Withdrew or did not submit ranks: +5 (+56%)
- Matched: +19 (+20%)

**Positions:**
- Offered in the Match: +2 (+2%)  
- Filled: +8 (+8%)
- Unfilled: -6 (-26%)

**APPLICANTS FROM CANADIAN SCHOOLS PARTICIPATION**

- Applicants Registered in the Match: 144
- Applicants Who Withdrew or Did Not Submit Ranks: 14
- Applicants Participating in the Match: 130
  (includes 0 individuals who participated in the Match as a “couple”)

**MATCH RESULTS**

<table>
<thead>
<tr>
<th>Applicants Matched</th>
<th>112 (86%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To Canadian Programs</td>
<td>95 (85%)</td>
</tr>
<tr>
<td>To U.S. Programs</td>
<td>17 (15%)</td>
</tr>
<tr>
<td>Participating Applicants Not Matched</td>
<td>18 (14%)</td>
</tr>
</tbody>
</table>

**RANKINGS**

Average Number of Rankings Submitted Per Applicant:
- Matched Applicants: 6.1
- Unmatched Applicants: 4.3
- Overall: 5.8

**INTERNSHIP PROGRAMS IN CANADA PARTICIPATION**

<table>
<thead>
<tr>
<th>Positions Offered in the Match</th>
<th>Match Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filled</td>
<td>112 (87%)</td>
</tr>
<tr>
<td>Remaining Unfilled</td>
<td>17 (13%)</td>
</tr>
<tr>
<td>Programs Filled in the Match</td>
<td>49 (79%)</td>
</tr>
<tr>
<td>With Unfilled Positions</td>
<td>13 (21%)</td>
</tr>
</tbody>
</table>

**Note:** 1 program at 1 site submitted fewer ranks than the number of positions available. As a result, no ranks were submitted for 1 position, which remained unfilled.

**MATCH RESULTS**

- Positions Filled By Applicants from Canadian Schools: 95 (85%)
- Positions Filled By Applicants from Non-Canadian Schools: 17 (15%)
A slightly different perspective

By Pat DeLeon, J.D., Ph. D.
Former APA President

I 

very much appreciated the honor of receiving your Meritorious Service Award during your 40th anniversary ceremony at our annual convention in Boston. It was especially moving to stand alongside Robert Zeiss, who has done so much for psychology within the Department of Veterans Affairs. As I listened to the reflections of a number of your previous chairs and officers, including such visionaries as Ron Fox and Cynthia Belar, I could not help but think that APPIC has come such a long way over the years in developing the foundation for psychology being able to effectively address society’s most pressing problems, while systematically ensuring that our next generation of colleagues will have access to the highest quality “hands-on” training experiences.

Over the three and a half decades that I have served on Capitol Hill, I have come to appreciate at the policy level that the federal government will appropriately recognize and ultimately reimburse those healthcare professions which it helps to train. And further, that it is up to psychology’s leaders to make the case for why their trainees should be recognized under various federal initiatives. Mary Beth Kenkel has consistently emphasized that oftentimes, this can best be accomplished by patience, persistence, partnerships, personal relationships, and a long term perspective for the field. In all candor, when I hear the concerns raised by APAGS and your membership regarding the availability of internship slots or stipends, I suspect that rather than there really being a shortage of resources or opportunities, those speaking out are unfamiliar with the larger policy picture and thus are not seeking access to those ongoing federal programs that would be applicable.

Children’s Hospitals Graduate Medical Education Payment Program. Established under President Clinton, the Children’s Hospital GME initiative supports graduate medical education training in freestanding children’s teaching hospitals. Payments are made directly to the individual hospitals. According to the HHS Fiscal Year 2009 budget submission, payments are made to these hospitals to enhance their financial viability and to help maintain ongoing GME programs. There are approximately 60 children’s hospitals nationwide that are considered freestanding teaching hospitals and thus eligible for the program. In FY’2008, $301,646,000 was provided by the Congress; in FY’2006, 5,243 medical residents on and off-site were supported. The authorization for this program is located within the Public Health Service Act, which is under the jurisdiction of the Senate Health, Education, Labor, and Pensions (HELP) Committee, chaired by Senator Kennedy (D-Ma); the ranking member being Senator Enzi (R-Wy). It is important to understand that this program is quite distinct from the Medicare GME initiative of the Senate Finance Committee, which is often mentioned in the APA Monitor on Psychology and Practice. In considering the earlier FY’2006 appropriations level (ultimately $296,795,000), the House of Representatives noted: “The Committee believes this program is vital to restoring the reimbursement inequity faced by pediatric hospitals, which provide very high quality care to children with difficult and expensive conditions.”

Without question, children are more than “merely little adults” and have their own unique needs, responses to clinical interventions, and family system dynamics. Accordingly, we would rhetorically ask: How can Quality Care truly be provided without addressing the critical psychosocial-cultural-economic component of healthcare? Psychology’s clinical and research expertise must be an integral component. The principal focus of the Children’s Hospital GME initiative must be to ensure the availability of quality care. Psychology’s leaders must work with their natural allies (and especially with the families of those requiring these specialized services) to ensure that these teaching hospitals have the flexibility to utilize the federal GME funds to support students (including post-doctoral fellows) from whichever disciplines they feel are most appropriate given their own unique system and situation.

We would clearly suggest that having psychology (and other non-physician healthcare disciplines, such as professional nursing and clinical pharmacy) written into the underlying authorization statute would be in the best interests of our nation’s children and their families, not to mention future generations of graduate students.

Federally Qualified Community Health Centers were a component of President Lyndon Johnson’s War on Poverty, providing a “health care home” through the delivery of comprehensive, culturally sensitive, quality primary health care that often includes access to pharmacy, mental health, substance abuse, and oral health services regardless of a patient’s ability to pay. These are our nation’s true “safety net” and are distinct from the community mental health center initiative associated with President Kennedy. HHS currently funds over 1,000 federally qualified centers that operate approximately 4,000 service delivery sites in every state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. More than half of the centers serve rural populations. The HHS Fiscal Year 2009 budget submission reported that in 2006, health centers served 15 million patients, providing over 59 million patient visits. Approximately 37% of patients are children; 7% are senior citizens; 40% are without health insurance; approximately two-thirds are minorities; and 59% are female. Health center patients are more likely to suffer from chronic diseases, such as hypertension and diabetes, and have demonstrated success in chronic disease management.

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In FY'2008, $2,065,022,000 was appropriated. A major initiative by the Bush Administration was to promote the integration of Health Information Technology (HIT) into health centers as part of an overall Health Resources and Services Administration (HRSA) strategy. Without question, community health centers possess the potential for providing exciting training experiences and are deemed “Health Professional Shortage Areas” for fulfilling federal loan requirements.

Since our Boston convention, Clark Campbell, Chair of the Committee on Rural Health, and Gil Newman, Chair of the Board of Educational Affairs, have convened a meeting of interested parties to explore systematically expanding psychology’s presence within the federally qualified community health center environment, especially focusing upon integrated healthcare opportunities. This evolution has long been enthusiastically supported by APA President James Bray and as envisioned, would provide the leadership of our State Associations with a unique opportunity to make a real difference in the lives of their own state’s citizens, while at the same time providing our next generation of non-physician healthcare providers with unsurpassed training opportunities. They would gain, for example, experience in utilizing telehealth and Health Information technology, as well as learning to appreciate the nuances of the clinical skills of other disciplines, rather than remaining isolated in their own traditional professional “silo.” These skills will be absolutely necessary as we enter the healthcare environment of the 21st century.

Both the Children’s Hospital GME program and the federally qualified Community Health Center program are administered by HRSA, which is also responsible for HHS’s other health professions student support initiatives (i.e., loans and scholarships). The challenge for APPIC is to develop a viable presence within the HRSA strategic planning process. The federal government has a long history of funding training and service delivery initiatives which support its underlying mission of ensuring that all Americans will have access to the quality health care they require, in a cost-effective manner. Study after study, for example, has unequivocally demonstrated that those who live in rural America have unique and truly pressing healthcare needs. The same can be said for our steadily aging population and various ethnic minority populations. The Institute of Medicine (IOM) has released a series of groundbreaking studies stressing the importance (and given the advances occurring in communications technology, the possibility) of our nation developing truly client-centered, gold standard quality of care measures which will allow clinicians, administrators, and individual patients to objectively explore what types of therapies are most effective (i.e., work) and under what conditions, for individuals and across population subsets.

Rather than functioning within psychology’s traditional academic silos, the critical questions are: Will the membership of APPIC take the necessary steps to help shape HRSA’s agenda for the Obama Administration? Does APPIC truly understand the unprecedented challenges of the 21st century healthcare environment – the importance of telehealth care, virtual realities; and probably more importantly, the critical need to develop interdisciplinary and even transdisciplinary research and clinical training experiences? Under the leadership of President James Bray and your colleague Cynthia Belar of the Education Directorate, APA is poised to take the next step. However, without your grassroots support and encouragement (including providing creative solutions to society’s most pressing needs at both the local and national level), the challenges of the 21st century will indeed be daunting. With your active support, it will become a very exciting journey. We should all appreciate that psychology has always been in control of

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**VA Psychology Training Council History**

By Wayne G. Siegel, Ph.D., ABPP

The Veterans Affairs Psychology Training Council (VAPTC) held its inaugural meeting on July 21, 2008. Although the VA has been and continues to be the single largest provider of psychology training at the predoctoral internship and postdoctoral levels, psychology training within the VA had not formally organized on a national basis, prior to the creation of VAPTC. Thus, we consider the formation of the VAPTC to be a significant historic event for VA psychology training. In years past, a series of Directors of Training and Chief psychologists, known as the VA Psychology Training Advisory Committee, had advised Central Office on psychology training issues; however, there was concern that the views of all VA Directors of Training weren’t well represented. When she assumed her role as Deputy Chief Consultant for Mental Health in VA Central Office, Dr. Antonette Zeiss set as a top priority the formation of the VAPTC, ensuring that VA psychology training was represented both inside and outside VA and giving VA training directors a unified voice.

The overarching mission of the current VAPTC is to represent VA training in psychology and shape the future of VA professional psychology training at all levels, from practicum to postdoctoral, by 1) facilitating the sharing of information and resources, 2) soliciting ideas for advancements in the evolution of psychology training programs, 3) promoting the development of procedures and programs that facilitate program accreditation, 4) facilitating the professional development and mentoring of training directors, 5) promotion of VA training programs among eligible psychology doctoral programs, and 6) promoting the views of VA psychology training to groups and organizations who impact training, and 7) consultation with VA Central Office’s Office of Mental Health Services and Office of Academic Affiliations.

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Representing VA Psychology Training: A Look Back

As noted above, the VA Psychology Training Advisory Committee was loosely organized with no specific mission or objectives. It had few members and, because it was not a formal training council, had no representation nationally as did established formal psychology training councils. Although ably represented by psychology leaders like Kathie Larsen from the Seattle VAMC and Phil Laughlin from the Knoxville, Iowa, VAMC, the role and function of the PTAC changed with each VA Deputy (or Acting Deputy) Chief Consultant for Mental Health. Regardless, the PTAC served some useful functions (e.g., allocation of training funds, expansion of the number of trainee slots, increases in training stipends) and was better than having no collective voice at all.

In addition, over the years, a variety of individual VA psychologists have been involved in APPIC, APA, VA, and other endeavors related to training. Several have been involved with the governance of APPIC, including its current Chair, Steve McCutcheon, Ph.D. While VA has never had a formal seat on APA’s Commission on Accreditation (CoA), several psychologists who are VA staff or have been VA staff in the past have been members (including most recently, Robert Gresen, Ph.D., Donna Horn, Ph.D., Edmund Nightingale, Ph.D., Brad Roper, Ph.D., and Wayne Siegel, Ph.D.), and some have been elected to the Board of Directors of APA.

Another organization that helped to represent VA Directors of Training was the Association of VA Psychologist Leaders (AVAPL). An organization not formally endorsed or supported by the VA, AVAPL formed a Training Special Interest Group. Although AVAPL could not represent the interests of VA, it could serve as a mechanism to represent the interests of VA’s Directors of Training to other organizations, including APA. More importantly, this Training Special Interest Group provided a forum for Directors of Training to discuss important issues and to share ideas and documents. The Training listserv was one of the most active listservs on the AVAPL website. The idea for the Training Special Interest group came from the President of AVAPL at the time, Peggy (Cantrell) Krieshok, Ph.D. This was not the first time Dr. Krieshok was instrumental in shaping the future of psychology training in VA.

From 1997 through 1999, Peggy (Cantrell) Krieshok, Ph.D., from the Kansas City VAMC, was Chair of APPIC and, in this role, joined the Council of Chairs of Training Councils (CCTC) and represented APPIC’s interests there. CCTC is an organization connected to (but not an official part of) APA’s Education Directorate. It is made up of representatives from a wide variety of training councils at the doctoral, internship, and postdoctoral level of psychology training. Dr. Krieshok noted, however, that VA was not represented on CCTC, and she petitioned the organization to extend a formal seat to VA. Dr. Jeffrey Burk, Chief Psychologist at the North Florida/South Georgia Veterans Health System and chair of the VA Psychology Training Advisory Committee, was selected to represent VA on CCTC and continued to do so until 2008.

Future Directions for the VAPTC

Given VA’s contribution to psychology training and its lack of formal representation within the larger psychology training community, it could easily be argued that the formation of the VAPTC is at least 25 years past due. The VAPTC and its newly elected officers are now charged with prioritizing what aspects of its mission and objectives it should focus on. Based on a survey of its membership and discussions among its officers, the inaugural year of the VAPTC will focus on developing an intranet based sharing of VA Psychology Training Program self-studies and other program resources, mentoring and training resources for training directors, the formation of a national Multicultural and Diversity Committee, and formally representing VA Psychology Training interests in the larger psychology training community. The focus of the VAPTC will likely change and evolve as factors that impact the profession of psychology and the Department of Veterans Affairs change. The fact that there is now a Council and processes to address these issues is a major step in the evolution of VA Psychology.

Given the scope of VA psychology training programs (437 internship positions in 90 programs, including 4 programs new this year and 201 postdoctoral residency positions in 54 programs), we believe that what benefits VA Psychology Training will also significantly impact the broader psychology training community.
The National Register criteria to determine equivalence.

require APA accredited or the equivalent and then use criteria into their regulations. Other board may state boards have adopted the National Register credentialing, and other types of employment. Many however, neither is universally required for licensure, required for graduates seeking employment in the VA.

I generally start by stating that an APA accredited and from applicants for the National Register HSPP credentialing, and from APA/CPA accredited sites. The majority of students familiar with APPIC internships and how they differ about APA/CPA accredited internships but may be less review mechanisms for internship training. They know those who provide internship training, those who select training sites for internship, and those who evaluate internship training.

Quality Assurance in Internship Training

Doctoral students need to be aware of the types of review mechanisms for internship training. They know about APA/CPA accredited internships but may be less familiar with APPIC internships and how they differ from APA/CPA accredited sites. The majority of students will know very little about CAPIC listed internships, and their characteristics.

Students are often concerned about the risks of not completing an APA/CPA accredited internship. The importance of having an APA accredited internship is one of the most frequent questions I get from students and from applicants for the National Register HSPP credential. I generally start by stating that an APA accredited internship and an APA accredited doctoral program are required for graduates seeking employment in the VA. However, neither is universally required for licensure, credentialing, and other types of employment. Many state boards have adopted the National Register internship criteria into their regulations. Other board may require APA accredited or the equivalent and then use the National Register criteria to determine equivalence.

What are the most common internship problems?

1. Supervisor is licensed as a psychologist, but not at the doctoral level.
2. Supervisor has a doctoral degree in psychology, but the degree is not from a regionally accredited institution.
3. Supervisor has a doctoral degree in psychology from a program that is neither APA/CPA accredited nor ASPPB/National Register Designated.
4. Fewer than two psychologists serve as supervisors.
5. Fewer than two interns are training at the site.

Origination of the Criteria for Evaluation of Internship Training

The current internship criteria developed by the National Register grew out of the reviewers’ experience in reviewing large number of applicants (12,000+) during the National Register’s grandparenting period (1974-1978). Al Wellner, Ph.D., founding Executive Officer of the National Register, was also chair of the APA Committee on Accreditation during 1974-1979. He and Carl Zimet, Ph.D., Chair of the National Register at that time, suggested to APIC (APPIC’s name at that time) that APIC adopt the same criteria to strengthen both organizations effort to identify proper internship training. These events help explain why the criteria adopted at that time by APA, APPIC and the National Register were so similar (Ron Kurz, personal communication, 9/21/93).

Although modified independently over the years and with greater detail by APA and APPIC, the three sets of criteria remain very similar. The main difference among the three is that the National Register allows for the internship to occur after the completion of the doctoral degree. For the National Register criteria, go to http://www.nationalregister.org/internship.pdf. (See recommended web pages at the end of this article for APPIC and APA criteria)

These criteria were adopted by licensure boards to determine standards for an acceptable internship. Over time small but significant differences in licensing requirements for internship evolved, just as they did for doctoral degrees. Having completed an APA approved internship usually clears all hurdles at the state and national level. However, if the internship is not APA accredited, licensing boards and credentialing organizations examine the characteristics of the internship. In that instance differential outcomes may highlight problems in implementation of the training experience. Some of the examples below may be typical outcomes of the evaluation by a state licensing board or national credentialing organization.

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The First Dear Applicant Letter:
After a careful review of your application, Internship Confirmation Form, Internship Guidelines Compliance Worksheet, and an additional written explanation received from Dr. X, it appears that the internship program you completed does not meet the Guidelines for Defining an Internship or Organized Health Service Training Program in Psychology.

Next are the several reasons that may be given. Let’s examine those pitfalls.

Pitfall 1: Supervisor is licensed as a psychologist but not on the basis of a doctoral degree in psychology.

One criterion addresses the qualifications of the internship supervisors. Licensure is required for at least one of the two required supervisors. For the National Register and many licensing boards, it is insufficient if the supervisor’s license was based upon a master’s degree in psychology. For the two individuals who are face to face supervisors and who certify to the credentialing authority the satisfaction of the internship by the applicant, their degrees should be a doctoral degree in psychology. Many licensing boards also want face-to-face supervision provided by psychologists who meet the doctoral standard. Not having doctoral level supervisors may also pose a problem for psychologists seeking participation in health care plans and may be an issue for those seeking expedited mobility. This does not mean that those supervisors may not be competent in supervision; they could serve as adjunctive but not as primary supervisors.

Pitfall 2: Supervisor is licensed as a Psychologist on the basis of a doctoral degree but not from an institution that is regionally accredited or from a program that is approved by a credible quality assurance mechanism (APA/CPA Accredited Program or ASPPB/National Register Designated Program).

This is a variation of the first pitfall but in this instance the supervisor’s doctoral degree may cause the problem. It is not clear the degree to which accrediting bodies, APPIC, or CAPIC look beyond the supervisor’s license and actually examine the origin of the doctoral degrees. The criteria often do not address this issue, and state licensing and national credentialing requirements vary. For example, in CA licensure applicants from state approved schools will now be evaluated on a case-by-case basis to determine whether the degree meets the statutory educational requirement for admission to the CA licensing examination. These are programs which are housed in institutions which are not accredited by one of the regional accrediting bodies approved by the US Department of Education. Thus, knowing that a person is a licensed psychologist in CA does not tell us that the licensee has a doctoral degree which would meet standards for licensure in other jurisdictions or for credentialing by national organizations. If that licensed psychologist starts supervising doctoral students, he/she may unwittingly be creating a future licensing roadblock for the student.

Supervisors who completed a doctoral program in a program which is neither accredited nor designated, even though housed in a regionally accredited institution, do not qualify as acceptable supervisors for the National Register (A list of eligible programs is available at www.nationalregister.org/designate.html.)

A suggested approach to solving this problem is to request a CV from the supervisor and verify that degree from a recognized source such as the National Register, which has on file transcripts of more than 25,000 psychologists. The APA Membership Office or the state board may also be able to verify doctoral degree program, institution, and year of graduation.

All this goes to the issue that licensure is insufficient to qualify someone as a supervisor. It is important for interns to carefully qualify their supervisors in advance.

Pitfall 3: Remember the Twos: Two psychologists, two interns and two supervision hours face to face

The Second Dear Applicant letter
The internship criteria specify that there must be two or more psychologists on the staff as supervisors, at least one of whom was actively licensed as a psychologist by the State Board of Examiners in Psychology. According to your supervisor, he was the only psychologist on staff. There was a second psychologist on staff as a supervisor, but she was there for only two weeks of your training. The drug and alcohol licensed counselor who provided supervision does not fulfill the requirement of having two psychologist supervisors. Apparently there were no arrangements made by the internship to bring in a second acceptable supervising psychologist when the second psychologist left.

A Third Dear Applicant letter
The internship criteria specify that there must be a minimum of two interns at the site during the applicant’s training period. The requirement of two interns makes it appear that there is the potential for a training environment. From the information we received, it was confirmed that you were the only doctoral level psychology intern on site from 09/01/2005 to 08/31/2006. Although your supervisor indicated that you had meetings with doctoral externs and psychology associates periodically, that does not substantiate that an internship level training environment was maintained by the internship program. In addition, participating in professional training and in-service training with staff or professionals in training for other professions does not demonstrate that you interacted with and affected a collegial relationship with other individuals going through doctoral level training in psychology on a regularly scheduled basis.

Or another version of this situation can be described as follows:

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The internship criteria specify that there must be a minimum of two interns at the site during the applicant’s training period. The requirement of two interns makes it clear that there is the potential for a training environment. From the information we received, it was confirmed that you were the only doctoral level psychology intern on site from 09/01/2000 to 08/31/2001. Dr. X indicated that the program was unable to physically house and fund no more than one intern, and that although there were other training programs in the area, he said she could not arrange joint activities due to scheduling conflicts. Although Dr. X encouraged you to “seek creative ways of connecting with others” because she “valued and understood the loss of collegial contact” you would experience, it does not substantiate that a training environment was maintained by the internship program. In addition, participating in a conference where you met with other interns, and occasionally corresponding with local interns via email or phone does not demonstrate that you interacted with and affected a collegial relationship with other individuals going through doctoral level training on a regularly scheduled basis. There are several APPIC member and APA accredited psychology internship programs in that city which could have provided opportunities for meaningful interaction, support, and socialization with other interns. Accommodations should have been made in advance to ensure that the training needs of the intern took precedence over service requirements for the counseling center.

The solutions to these internship problems lie in the execution of the criteria. In the first instance, the internship director should have made immediate plans to bring in another qualified supervisor, signed a contract with that person, and notified the interns so that their internship would later qualify. This would be the basis for the letter that would accompany the internship confirmation form to the state board or the credentialing body of the special circumstances for that year. Similarly with the last two examples, it would appear that the experience was really more like that of an employee and that creating a training environment was really not the foremost consideration. Unfortunately, interns may not appreciate these necessities but they are the ones held accountable.

Pitfall 4: Good intentions: bad implementation

The National Register and most state licensure boards ask if the internship was APA approved at the time of the applicant’s training. If the answer is no, the next question is if the internship was APPIC listed at the time. Failing to be APPIC listed typically means that the internship must be individually examined to determine if the internship meets the 12 widely accepted criteria.

It is not infrequent that in response to a question about whether the internship meets APPIC standards, the internship supervisor states that “the program was designed to follow APPIC guidelines.” However, by examining the history of the internship in the APPIC Directory over the years, it was determined that the internship did not qualify until many years later for APPIC approval (and may not have even applied until many years later). As a result, at the time this individual was admitted, the internship may not have met criteria.

How is this assessed by the National Register and licensing boards? First, for any internship that is not accredited or APPIC listed, a copy of the internship brochure from that time period is generally requested. Invariably, the internship director sends a copy of the current brochure, if that even exists, stating that no copies of the brochure from 19XX exist. This has happened so frequently that at the National Register we now routinely ask that the internship director complete a form and describe in their own words how the internship met each of the 12 criteria at the time the applicant was in training. We have found that to be more helpful than simply relying on a brochure because the content and quality of the brochures vary tremendously.

Internships listed by CAPIC present a special challenge (www.capic.net). Most internships submitted as part of an application for the National Register credential are APA accredited or APPIC listed. Only a few are CAPIC listed. It is the latter group that is less well known especially outside of CA. In addition to the unfamiliarity, most of the CAPIC listed internships are half time and many do not fund interns, thus the intern may have difficulty getting licensed in states if unpaid internships are unacceptable. According to the survey results of students published in the APPIC Newsletter in November 2008, 19% of Ph.D. programs and 45% of Psy.D. programs would allow students to apply for an unfunded internship. Even so, lack of intern funding now makes internships ineligible to qualify for APPIC listing.

While half time internships pose no problem, it is important that the two half time internships be part of an organized sequence of training for the future psychologist. Often the search for qualified internships in today’s competitive environment drives the applicant to find any internship. Thus, for CAPIC internships or for internships that existed prior to APPIC approval, the completion of the internship form is an essential part of the quality assurance review by the National Register. For some individuals the half time internships are essential to their life style and education sequence. Secondly, with the competition for internship training it is important that internships have an opportunity to demonstrate whether they meet standards.

Thus, I was surprised to hear from a doctoral student at one of my recent presentations on credentialing and licensure that her doctoral program supervisor suggested that she should not pursue a CAPIC listed internship. I would not feel comfortable making that statement myself. I think it is a criterion based and empirical issue state by state and organization by organization. It is a different issue if the doctoral program requires an APA

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approved or APPIC listing internship.

Finally there is another category of internships which occasionally are presented for licensure or credentialing purposes: internships that are created to fill a need for a particular student. These are the most dangerous from the perspective of satisfying the professional goals of the student. Urgency may trump qualified training. Creating an internship out of a work setting is often unsuccessful. In the first place there is the requirement for two interns in training at the same time. That means recruiting another individual for training purposes. Secondly, converting an employee into an intern means that the need for the training environment supersedes service needs. This is not to say that service needs are not important but balance must be achieved. In this situation a contract is essential to protecting the student and making clear the characteristics of a training site. In most instances it will be necessary for the former employee to be assigned to a different location with new supervisors if the employment setting is serious about creating a training environment. It can be done. It just has to be carefully implemented.

International training sites

In the past five years or so I have seen increasing interest from doctoral students in obtaining experience working in foreign countries. Many of these students would like to complete an internship abroad. Even though internship training in some countries may not be as developed as our criterion-based system in the US and Canada, students should find out in advance if the experience would count for US licensure. One barrier is the qualifications of the supervisors. Is there governmental licensure in that country, and if so, is the license based upon a requirement of having a doctoral degree in psychology? Often the answer to both questions is no. If licensure exists it is typically at the master’s level in psychology. Finally, training in some European countries may be available only in psychotherapy training institutes as opposed to health service delivery systems. Unlike the US, some countries have two recognition systems or approaches to psychologists, one of which is as a psychotherapist. For these many other reasons related to structural barriers (work permits) and cultural barriers (language and culture) it is a challenge for US trained students. I am willing to try to advise these students if they are interested. Simply suggest that they email me at judy@nationalregister.org

What could be done by internship directors to solve some of these problems?

1. Certify Internship for all Interns at the time of Completion:

Internship directors should complete and sign the NR Internship Confirmation Form for each intern at the end of the year and then submit a copy to the National Register credentials bank. The National Register will serve as a bank for those forms until they are reviewed formally at the request of the applicant at the time of credentialing. At the same time supervisors should keep a copy and give a copy to the intern. Attach a copy of the brochure for that year to the form that you keep and be certain that the internship brochure is dated. Then at the time the intern applies for a license you will have in your files a contemporaneously completed form which attests to satisfactory completion of an internship. The internship form is available online at www.nationalregister.org/internship.pdf

2. Bank Official Descriptions of Internship:

Keep copies of dated internship brochures and descriptions, especially when the program is not APA accredited or APPIC /CAPIC listed for each year that the internship is in existence. Keep a list of the names in the internship class by year. This contemporaneous information is typically needed when former interns apply for licensure and the National Register HSPP credential. As both applications typically occur several years after the completion of the internship, each year’s description or contract with the student is critical to have on file and dated.

3. Determine that Supervisors at the Internship Site Meet Professional Standards:

At the time that the supervisor is chosen to be part of the internship staff, obtain accurate and verified information on education and training and licensure. Then keep dated copies of CVs on file. When former interns apply for NR, licensure, or other credential, the credentials of the supervisors may be questioned. Be certain that doctoral degree institution, program completed and date of degree are provided in response to questions about the credentials of the internship staff. As indicated previously, hiring supervisors who have completed a doctoral program from an institution that is regionally accredited but not APA Accredited or ASPPB/National Register Designated may not be sufficient to meet standards for the profession. The degree must be from a program that is accredited, designated or determined by a credible authority to be the equivalent. For instance, for credentialing by the National Register, state accreditation of an institution/program is insufficient to qualify a person as an acceptable supervisor, even if the supervisor is licensed as a psychologist. To do so would mean that a standard for supervisors is lower than what is expected for applicants for credentialing by the National Register.

Other Resources

http://www.appic.org/about/2_3_1_about_policies_and_procedures_internship.html

About the Author

Judy E. Hall, Ph.D., has been the Executive Officer of the National Register of Health Service Providers in Psychology since 1990. Before that she was the Executive Secretary for the New York State Board for Psychology for 12 years. She has served as President of the Association of State and Provincial Psychology Boards and Chairperson of the APA Board of Professional Affairs and APA Ethics Committee. Dr. Hall co-edited Global Promise: Quality Assurance and Accountability in Professional Psychology (Oxford, 2008). She is Fellow of APA.

For more information on the National Register, see www.nationalregister.org.
May, many internship directors have noted the progressively declining competency in psychological testing and test interpretation which has characterized recent applicants to our internships. About ten years ago, as an APPIC Board Member, I conducted the annual survey. One open-ended question asked was: What was the greatest training lack in applicants? About 75 out of 300 respondents spontaneously mentioned poor preparation in psychological testing. The situation has undoubtedly worsened in the last decade. Very few of my own program’s applicants this year had interpreted more than a small handful of MMPI-2’s. A faculty recommendation for one applicant claimed she was adept at Rorschach interpretation and was supervising students in his testing course. On her AAPI, that applicant declared a total of only three Rorschach administrations/interpretations!

I recognize the expanding knowledge and technique base of the field and the corresponding difficulty in providing comprehensive experiential clinical training in four or five years of graduate study. However, psychological testing has been, and remains, the scientific and empirical bedrock of the field. Psychological tests represent the empirically validated assessment techniques which uniquely characterize our profession. Testing is a competency that sets us apart from the other mental health professions, which rely on qualitative interviews with little demonstrable validity or reliability. Psychological tests have been empirically validated and their uses empirically supported for nearly 100 years. APA has promulgated and published Standards for Educational and Psychological Testing for many decades. Psychological test applications involve standardized administration, objective rules for scoring, and empirically validated principles of interpretation embodied in hundreds of testing manuals and supported by tens of thousands of peer-reviewed studies. In my view, there has been far too much emphasis on requiring training in empirically validated interventions, when there exist only a few circumscribed treatment modalities supported by NIMH-manualized protocols carried out on limited numbers of carefully culled patients. Psychological testing, with its vast body of empirical findings and applications, dwarfs the corresponding intervention literature but has been underemphasized and neglected.

It is also important to realize that failure to provide training in the psychological testing competency will eventuate in the assumption of this function by other, inadequately trained disciplines. This process has already begun in my state of Ohio, where licensed counselors and social workers may now legally interpret psychological tests. Continuing education workshops trumpet that non-psychologists can learn to interpret the MMPI-2 in six hours, without prior background. Thus, for reasons of protection of the public as well as ‘guild’ issues, testing is professional turf which psychology cannot and must not abandon.

Accordingly, I would propose the following change in the Guidelines and Principles for Accreditation of Programs in Professional Psychology - for doctoral graduate programs - as follows:

G&P B3(c) (c). To achieve this end, the students shall be exposed to the current body of knowledge in at least the following areas: theories and methods of assessment, including psychological testing of personality and cognition; diagnosis; effective interventions...

The specification of psychological testing, beyond “theories and methods of assessment” is crucial. Far too many doctoral programs have failed to provide adequate training in testing by claiming that they have satisfied the more general “assessment” standard by other means. In my estimation, teaching students to do some mental status examinations and give a few Beck Depression Inventories does not constitute, or substitute for, training in the psychological testing competency. MSE’s and BDI’s do not go beyond what medical students are taught today on their Psychiatry rotations. Psychology should demand more and better of our trainees!

Your comments and reactions are welcome. Please recognize that this article reflects my personal viewpoint and does not represent APPIC policy or beliefs, officially or otherwise.
THE HEADLINES SCREAM THAT THESE ARE NOT ORDINARY TIMES! NOT EVEN CLOSE. INDEED, THE WORD “DEPRESSION” IS INCREASINGLY, ALTHOUGH CAUTIOUSLY, ENTERING STORIES ABOUT THE ECONOMY AND MAY BEGIN TO RIVAL ITS MORE WIDESPREAD USE IN THE MENTAL HEALTH LITERATURE.

AS WE APPROACHED THE END OF 2008, THERE WAS DAILY BLEAK ECONOMIC NEWS LITERALLY WORLDWIDE, WITH NO END IN SIGHT FOR THE DOWNTURN. SOME OF THE U.S. INDICATORS INCLUDE SLUMPING RETAIL, CAR, AND HOUSING SALES, AND AN EYE-POPPING LOSS OF 2.6 MILLION JOBS. THE MELTDOWN ON WALL STREET AND THROUGHOUT THE FINANCIAL SECTOR HAS BEEN SPECTACULAR, WITH THE DOW JONES AND NASDAQ RESPECTIVELY DOWN 35% AND 28% FOR THE YEAR. THE ECONOMIC CONDITIONS HAVE RESULTED IN DIRE STRAITS FOR BANKS SUCH AS CITIBANK AND WACHOVIA, MORTGAGE INSTITUTIONS, FANNIE MAE AND FREDDIE MAC, INVESTMENT FIRM IMPLOSIONS AT LEHMAN BROTHERS, BEAR STEARNS, AND CATASTROPHIC REVERSALS AT INSURANCE GIANTS, SUCH AS AIG. THIS PANDEMIC OF BAD ECONOMIC TIMES IS EVIDENT ACROSS ESSENTIALLY ALL ECONOMIC SECTORS WITH UNPRECEDEMTED VULNERABILITY AT ICONS SUCH AS THE BIG 3 AMERICAN CAR COMPANIES. BAILOUTS OF VARIOUS TYPES ARE BEING DEBATED BEYOND QUESTIONS OF WHETHER THEY ARE NEEDED TO HOW BEST TO DESIGN AND IMPLEMENT THEM.

EVEN PEOPLE WHO TYPICALLY REFRAIN FROM ATTENDING TO THE BUSINESS PAGES ARE ANXIOUSLY STARTING TO PEAK AT THEM MORE, EVEN AS THE STARK FINANCIAL CHALLENGES CONFRONTING THE NEWSPAPER AND MEDIA COMPANIES PLACE THOSE VENUES AT CRITICAL RISK. PEOPLE ACROSS ALL SOCIOECONOMIC STRATA ARE WONDERING ABOUT THEIR NEAR-TERM AND LONG-TERM FUTURE, AS AWARENESS RISES OF THEIR PERSONAL RISK FOR UNEMPLOYMENT AND AS THEY REEL FROM THE BODY BLOWS SUSTAINED BY THEIR SAVING ACCOUNTS (E.G., 401K) AND PROPERTY VALUES.

THE ECONOMIC FRAGILITY OF MANY ENTERPRISES HAS BEEN ZOOMING INTO FOCUS AS MANAGEMENT AND WORKERS BRACE TO DEAL WITH GREATER UNCERTAINTY. FOR EXAMPLE, UNIVERSITIES AND GOVERNMENTAL ENTITIES ARE ANNOUNCING HIRING FREEZES AND SEEKING OTHER WAYS TO REIGN IN EXPENDITURES. ADMINISTRATORS AND MANAGERS ARE LOOKING TO HOW THEY CAN STREAMLINE PROGRAMS AND PRIORITIZE IN AN ERA OF CUTTING EXPENSES AND SERVICES. CUTS IN PAY, HEALTH CARE, AND OTHER BENEFITS ARE BEING SCRUTINIZED, LIKELY AFFECTING ACCESS AND UTILIZATION OF HEALTHCARE SERVICES IN THE COMING MONTHS AND YEARS. HEALTHCARE AND SOCIAL SERVICE ENTITIES VARY IN THE STRENGTH OF THEIR FUNDING STREAMS AND FINANCIAL RESERVES.

IN THE CONTEXT OF SUCH PROFOUNDED ECONOMIC AND RESULTING SOCIETAL CHANGES, PSYCHOLOGY EDUCATORS AND TRAINERS ARE CHALLENGED TO NAVIGATE THEIR WAY THROUGH INSTITUTIONS THAT ARE BEING TRANSFORMED AROUND THEM. PSYCHOLOGY TRAINING PROGRAMS ARE NO MORE IMMUNE TO Demands FOR CUTS IN THEIR BUDGETS THAN ARE ANY OTHER PROGRAMS WITHIN THEIR SPONSORING INSTITUTIONS. MANY MAY BE EXPECTED TO BEAR SOME (FAIR OR EVEN DISPROPORTIONATE) BURDEN OF THE BITTER MEDICINE FOR THEIR INSTITUTIONS’ ECONOMIC PAIN. SOME TRAINING PROGRAMS FACED REDUCED LEVELS OF TRAINING, BECOMING INACTIVE, OR CLOSING.

IT SHOULD BE EMphasIZED THAT THE BULK OF CHANGES ASSOCIATED WITH SUCH POTENTIAL SCENARIOS WOULD OCCUR DUE TO NO FAULT OF THE TRAINING DIRECTORS, FACULTY, OR TRAINEES. THEY DO NOT REFLECT THE AFFECTED INDIVIDUALS’ COMPETENCE, COMMITMENT TO TRAINING OR NECESSARILY THE QUALITY OF TRAINING. THE ECONOMIC DECLINE HAS FOUND THEM: THEY HAVE NOT CREATED IT.

IN LIGHT OF THE CASCADE OF DEVELOPMENTS DESCRIBED ABOVE, IT WOULD BE USEFUL FOR THOSE INVOLVED IN ACCREDITATION REVIEWS (I.E., SITE VISITORS, MEMBERS OF THE APA COMMISSION ON ACCREDITATION, STAFF OF THE APA OFFICE OF PROGRAM CONSULTATION AND ACCREDITATION) TO GIVE SERIOUS CONSIDERATION TO HOW BEST TO REVIEW PROGRAMS THAT MIGHT BE FACING CHALLENGES STEMMING FROM THE BROADER ECONOMY RATHER THAN FROM THE PROGRAMS THEMSELVES. HOW DO THEY INTERPRET ACCREDITATION CRITERIA IN THIS EvOLVING ECONOMIC CONTEXT?

ACCREDITATION CRITERIA ADDRESS RESOURCES IN SEVERAL WAYS. DOMAIN C OF THE APA (2008) GUIDELINES AND PRINCIPLES FOR ACCREDITATION OF PROGRAMS IN PROFESSIONAL PSYCHOLOGY CALLS ON INTERNSHIP PROGRAMS TO DEMONSTRATE THAT THEY POSSESS “RESOURCES OF APPROPRIATE QUALITY AND SUFFICIENCY TO ACHIEVE” THEIR “TRAINING GOALS AND OBJECTIVES.” WHEN IT COMES TO POSTDOCTORAL PROGRAMS, IT FURTHER CALLS UPON THEM TO DEMONSTRATE ADEQUATE RESOURCES TO “ENSURE PROGRAM STABILITY AND SUSTAINABILITY.” IS THE LATTER EVEN POSSIBLE WHEN SO MUCH IS UNCERTAIN AND WHEN EVEN TITANS OF INDUSTRY ARE ON LIFE SUPPORT?

DOMAIN C ALSO STIPULATES THAT PROGRAMS HAVE “THE NECESSARY ADDITIONAL RESOURCES REQUIRED TO ACHIEVE...TRAINING GOALS AND OBJECTIVES. THE PROGRAM WORKS WITH THE ADMINISTRATION OF THE SPONSOR INSTITUTION TO DEVELOP A PLAN FOR THE ACQUISITION OF THOSE ADDITIONAL RESOURCES THAT MAY BE NECESSARY FOR PROGRAM DEVELOPMENT.” WHAT HAPPENS NOW WHEN STRATEGIC PLANS ARE GOING BACK TO THE DRAWING BOARD BECAUSE PREVIOUS PROJECTIONS DID NOT ANTICIPATE THE HISTORIC SHIFTS IN FORTUNE?

CONTINUED ON NEXT PAGE
The CoA Implementing Regulations further specify that internship training should be funded adequately, including providing adequate stipends and whenever possible basic support for health/medical insurance. Under usual circumstances, it seems obvious that these aspects of the accreditation and implementing regulations are relevant to training and to the quality of programs as well as to the humane and decent treatment of trainees and faculty. In no way am I arguing that they be changed. However, the dilemma in an exceptional era of scarcer financial resources, is how to reconcile emerging realities with these criteria that were developed during, and for, more financially robust times.

When there is evidence of shrinking financial support for programs that mirrors those of other real world enterprises (e.g., lower wages, contraction of healthcare benefits, personnel cuts, temporary suspensions of activities) how can the regulators of psychology training avoid de facto punishing training programs, and their champions (i.e., training directors) unnecessarily by weighing unrealistically heavily the Domain C components of the accreditation process?

Adverse accreditation decisions (i.e., revocation or denial of accreditation, probationary status, abbreviated site visit cycles) create additional stress for programs, sponsoring organizations and especially faculty. Such actions lead to demoralization, frustration, or other attitudinal or systemic barriers to training. When such actions are the result of concerns about financial stability, they not only add to the general stress, but also pile on to the financial demands on programs. Adverse accreditation outcomes risk worrying trainees, alienating faculty, and burdening administrators. Ultimately, they can detract from training and mentoring activities, as well as revenue-generating activities and research (which might improve their financial status), as key faculty and administrators need to focus on the bureaucratic and administrative aspects of dealing with accreditation challenges.

The intention of accreditation is to promote quality training by confirming adherence with accreditation standards. When necessary, adverse accreditation determinations are rendered to publicly recognize the limits of adherence and to push programs toward improvements in training such that better adherence to the guidelines ultimately can be achieved. The unintended effects of adverse accreditation determinations, on programs however, can be unfavorable, and can even be the “last straw” leading to their demise. By raising the demands for resources (e.g., fiscal, administrator time), adverse accreditation determinations may yield withdrawal of existing support from training programs. Such sanctions can lead administrators to perceive programs as flawed, thereby reducing their motivation to support them, or misattribute the outcome to program directors’ ineffectiveness, lessening their status within the institution. They cause administrators to wonder if otherwise well regarded programs are “non-essential”. If adverse accreditation determinations cause programs to be perceived as unworthy, embarrassing, or as drains on resources, administrators may further withdraw support so that they can divert resources toward more clearly successful ventures which garner more favorable publicity and fewer administrative headaches.

Can accreditors fulfill their quality assurance mission (i.e., serving as gatekeepers to accreditation), while supporting quality training programs within financially challenged institutions during these economically troubled times? I believe they can. To do this responsibly would require focusing on the other key aspects of programs and weighing less heavily some Domain C elements, at least temporarily. The truth is that institutions ultimately will decide if there is inadequate ability to continue to support programs: They will close the programs themselves if they cannot afford to fund them…regardless of whether accreditors believe that programs are adequately capitalized. Sponsoring institutions do not necessarily look to accreditors to make such determinations, especially since psychologists’ training in appraising the financial health and operations of organizations is generally relatively limited. Sponsoring institutions’ decisions about future resource allocation may be more charitable toward psychology programs if there is not the impression that insult (i.e., adverse accreditation determinations) has been added to the financial injuries with which they are already contending.

Promoting quality training during periods of economic turbulence may best be achieved by temporarily deemphasizing the financial support and stability of sponsoring institutions as an accreditation criterion within the gestalt of all of the accreditation criteria. Accreditation determinations should focus principally on the quality aspects of training, which is the area of greatest expertise of accreditors as well as the variables that are under the greatest control of training directors and faculty. In this way, those involved in accrediting training programs would be acting in the spirit of the guidelines and principles to promote quality training rather than cleaving rigidly to rules that may be somewhat maladaptive during these extraordinary times. Imposing further hardships on financially struggling internship and postdoctoral programs does not advance the interest of students, the public, or the profession.

My wish is that members of the Commission on Accreditation will be wise and sound in their judgments in weighing the costs and benefits of their actions. Their interpretation of the guidelines when evaluating programs at this historic juncture will reveal not only their capacity for critical thinking, but also their empathy for colleagues and students around the country, and the depth of their understanding that justice sometimes warrants balancing competing worthy principles.
For some years I’ve been intrigued by an exhibit just outside the Massachusetts Museum of Contemporary Art, where there are suspended several trees growing upside down. At first, it was fascinating to see that trees could grow that way, but more recently I’ve been struck by the fact that the trees, with their pot-bound roots and branches curling upwards, look somewhat unnatural (even a little bedraggled). In a similar way, I feel that psychology training, like many other things, has been turned upside down and is a bit pot-bound by the current economic picture. In this column, I’d like to think about how all this is affecting us, and what we might do to thrive as well as we can.

**Dilemmas for Interns and Postdoctoral Fellows**

Even in better times, we’ve been seeing a trend in which clinical and counseling psychology students have been accruing an increasing amount of debt. According to data collected by Greg Keilin (APPIC e-newsletter, November 2008), the median debt load for internship applicants was $70,000, with 38% carrying a debt of over $100,000. Moreover, yet another survey (published in TEPP by Fagan and colleagues) noted that 38% of interns felt that “the financial and time commitments outweigh the benefits of being a psychologist,” with another 21% saying that they were unsure. Even though 80% of this sample stated that “I would become a psychologist again,” these figures point to a clear financial discomfort within the field despite a commitment to its mission.

In this context, made worse by the current economic climate, psychology trainees face a number of difficult issues. Graduate students applying for internships face the expense of traveling to interviews, coupled with less certainty about a match than ever before (24% this year did not match), partly due to funding cuts at internship institutions. If they do secure internships, they may incur the expense of re-locating to another city, hardly offset by relatively modest internship stipends. A hidden contract behind many low-paying internships and postdoctoral fellowships in the past has been the potential for a job at the host institution. Not only are such jobs now fewer in number, but so are tenure-track academic posts, as well as research grants and the positions that are funded by them.

It is important for trainers to understand the special implications of these conditions for soon-to-be psychologists. The effect of this economic downturn is especially potent for this group, who may feel forced to “grow up” and relinquish dreams and experiments too soon. The realities of the situation need to be acknowledged, without despair, and ultimately with a task-oriented attitude. Frequent individual mentorship is now critical for our trainees, though this is made complicated by undercurrents of competition and distraction between established psychologists (who may have tenuous jobs in institutions where new opportunities are frozen) and rising psychologists (who may be seen as less expensive to hire but with fewer clear-cut prospects). Professional development information, often seen as an “extra” by many training programs, also acquires an added importance in the current professional market. Trainees need to learn about negotiating the licensing process quickly, about handling the financial aspects of professional psychology, about developing a diversified job portfolio that may include both adjunct academic positions and work in group practices, and about sailing these choppy seas in an ethical manner.

**Dilemmas for Training Directors and Supervisors**

Much training takes place in publicly funded health care institutions, which are particularly hard hit by the current crisis. Layoffs and cutbacks are a reality, for both training directors and our valued supervisors. As with our trainees, many of us have had an unspoken social contract with our institutions; we would work hard for the greater good, and the institutions would loyally take care of us. In many ways, we are powerless in these uncertain situations, and the well-documented loss of self-confidence that goes with the actual loss of a job can also visit the threatened employee. It’s tempting in this context to try to have more control. This can take the form of increased attention to productivity, resulting in undue pressure for trainee billable hours and less staff time for consultation with trainees. Similarly, supervisors might exert increased vigilance over trainees and their work (which can be good), but which can also be experienced by the trainees as critical over-control marked by an over-emphasis on the power differential (not so good). Alternatively, psychology staff may display a disengagement from the home institution, with a resultant palpable lowering of morale and presence.

Training directors are invested in mentoring trainees, and in their identities as training directors. The current climate threatens both, with the loss of funding for internships and fellowships. In the face of such losses, it’s natural to want to continue to offer excellent training, whether or not that training is funded, especially at a time where the mismatch disparity is growing. Offering unfunded positions, however, can paradoxically lead to an erosion of the training mission. Apart from its devaluing of psychology training, it can also lend an unfair advantage to trainees who are financially able to accept an unfunded.

**Tips for Trainers:**

**Reversals of Fortune**

*By Marla Eby, Ph.D | meby@challiance.org*

It is important for trainers to understand the special implications of these conditions for soon-to-be psychologists. The effect of this economic downturn is especially potent for this group, who may feel forced to “grow up” and relinquish dreams and experiments too soon. The realities of the situation need to be acknowledged, without despair, and ultimately with a task-oriented attitude. Frequent individual mentorship is now critical for our trainees, though this is made complicated by undercurrents of competition and distraction between established psychologists (who may have tenuous jobs in institutions where new opportunities are frozen) and rising psychologists (who may be seen as less expensive to hire but with fewer clear-cut prospects). Professional development information, often seen as an “extra” by many training programs, also acquires an added importance in the current professional market. Trainees need to learn about negotiating the licensing process quickly, about handling the financial aspects of professional psychology, about developing a diversified job portfolio that may include both adjunct academic positions and work in group practices, and about sailing these choppy seas in an ethical manner.

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**CONTINUED ON NEXT PAGE**
Since both APPIC membership criteria and APA accreditation standards expect funded training (with rare exceptions that are brief in duration), it is important to receive outside consultation with these bodies whenever one considers offering unfunded positions, either within or outside of the match. The alternative option of putting a program on hiatus for a year because of loss of funding is a difficult and painful decision to make, and again the training director benefits from consultation and outside support. Many of us have been there.

**Our Historic Moment**

In writing about the psychological effects of the Great Depression, Rogler makes two points that are particularly relevant to this discussion. First, he emphasizes that the largest effect of such a crisis visits young adults who are in critical transitions, from dependent roles to roles demanding adult responsibilities. I would argue that our interns and postdoctoral fellows are at such a juncture, and therefore need our help as their professional identities are formed. Apart from our mentorship and support, it’s a good time to be advocating for the funding of internships and psychology positions for underserved (and particularly stressed) populations, ideally with a loan forgiveness program attached for psychologists serving in these areas, such as offered through the National Health Service Corps. Perhaps this “psychology peace corps” could develop new perspectives on helping patients with a focus on issues of work, money and survival. Secondly, Rogler notes that the signature orientation of the generation coming of age in the Great Depression was social interdependence. We are not at this time in a Great Depression, but whatever we are in, we are in it together. Two principles spring to mind, both of which I suspect that I got from one of those movies from the forties. First, we might counter the ravages of this economy by leading with a modest and ethical sense of dignity, not only for our trainees, but also for ourselves. Mentoring our trainees through this storm, even when we’re tossed by it as well, helps ground us, and roots us to our identity and sense of professional self. And second, we might pay attention to still other uprooted trees. As psychologists, we might advocate for the view (articulated by Belle and others) that economic inequality has profound consequences for the psychological health of a society. The undercurrent of socioeconomic disparity is an important aspect of our mission to address diversity, and so deserves our attention.

**References**


**Federal Work Study**

**Funding for Internship**

*By Philinda Smith Hutchings, Ph.D., ABPP  Midwestern University*

Federal Work Study (FWS) is a program that provides funds to pay students to perform work during their education. Schools request FWS funding from the Department of Education, and then use that money to employ students in positions both on and off campus. Schools must use at least 7% of their allocation to employ students in community service positions, and it is preferred that these positions are related to their educational program or career goals. Schools may use FWS to employ students in internship positions in community service agencies. So, some doctoral programs are able to place their students in internship positions in community agencies, and the school pays the intern through FWS funds. It is permissible for students to earn academic credit as well as payment for these positions, and the guidelines specifically state that internships, practica and assistantships are appropriate (Operating a Federal Work Study Program, Chap. 2, www.ifap.ed.gov/sfahandbooks/attachments/0809V ol6Ch2.pdf, page 29). There are some restrictions on student, employment, and site eligibility.

You can find out more about FWS at http://www.ed.gov/programs/fws/index.html, http://studentaid.ed.gov/PORTALSWebApp/students/english/campusaid.jsp, or you may contact the financial aid office of a school or doctoral program. An internship program that has lost funding for intern stipends may contact schools to inquire whether FWS funds are available to support one or more of that school’s students in internship positions at the agency.
Commission Leadership
The 2009 Commission on Accreditation (CoA) is led by a Chair, an Associate Chair for Program Review, and an Associate Chair for Quality Assurance. The 2009 CoA Chairs are: Nancy Elman, Chair
Bob Knight, Associate Chair for Program Review
Roger Peterson, Associate Chair for Quality Assurance

CoA Policy Meeting
The CoA held its annual policy meeting on January 9 – 11, 2009. Most of the meeting was devoted to discussions on some of the thorny issues that have faced and continue to face CoA. These included issues regarding: distance education and academic residency; supervision requirements for practicum and internships; broad and professional training in doctoral and internship programs (as differentiated from broad and general education in scientific psychology); and sequence of training issues. Also, the CoA discussed fully affiliated internships and the nature of those internships in relationship to single site internships and consortia. The CoA will continue to discuss these issues and will provide additional information on those discussions later in 2009.

Distance Education
Question: Many internship training directors are skeptical of distance education for the professional practice of Psychology. Could you describe the CoA’s perspective on accreditation of these programs? Response: CoA cannot say more on this at this point as they are working toward a position clarification on Distance Education and will have this out for public comment as soon as it is ready.

Structure of CoA
In 2008, the CoA began implementing program review panels that were predominantly model-focused, consistent with the Snowbird Accreditation Summit. The CoA will continue to review the efficacy of these panels and the consistency of the decision making process as it implements more of these panels. The CoA is committed to fulfilling the “spirit” of the Snowbird agreement in using a thoughtful and evidence driven approach. In 2009, the CoA will continue its practice of having both Work and Policy Groups that meet during the CoA’s scheduled program review meetings. Every CoA member will continue to be assigned to one work group and one policy group. The work groups will continue as follows:
Accreditation Assembly
Training Issues
Research
Complaints

Ask CoA
By Nancy Elman, Ph.D., Chair, CoA; elman@pitt.edu and
Sharon Berry, Ph.D., Director of Training, Children’s Hospitals and Clinics of MN sharon.berry@childrensminn.org

Thanks to Dr Nancy Elman for her assistance with this article. APPIC and the CoA Chair have collaborated on providing this column for a number of years. It is believed this helps build a better bridge with the training community.

Accreditation Assembly
The second Accreditation Assembly was held on May 30-31, 2008 in Minneapolis, MN. The 2008 Assembly included site visitor training, open forum with CoA, and a number of break-out sessions. A total of 200 individuals attended the Assembly. The PowerPoint presentations and notes from that meeting have been placed on the Accreditation web pages. The 2009 Accreditation Assembly was held May 28-30 in San Diego, CA. The 2009 Assembly had a dual focus on the “big picture” of accreditation and quality assurance issues as well as the nuts and bolts of seeking APA accreditation.

Public Information
The Implementing Regulation C-20 requirements to report licensure rates for doctoral program graduates as well as a required table on attrition became effective January 1, 2008. As it reviews doctoral programs, the CoA is reviewing the accuracy of those data. This is a gentle reminder to DCTs to update the student outcome data on your website.

In requesting information updates from accredited programs, the CoA has begun requesting the URL for the C-20 information for all accredited doctoral programs. The intent is to eventually include the URL’s for education and training outcomes on our website with the listing of all accredited doctoral programs.

The CoA reviews data annually from all accredited programs regarding the status of the trainees (students, interns, postdocs) in the program and the faculty/staff engaged in education and training. The CoA reviews the data on programs submitted annually at its fall meeting to determine whether additional questions need to be addressed to any program prior to its reaffirmation of accreditation. The CoA has a set of outcome thresholds delineated in Implementing Regulation D 4-7 that are used to determine if there are issues that need to be addressed. Programs not meeting these accountability thresholds may be asked to provide the CoA with addi-

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tional information regarding time to degree, attrition, and internship attainment of students. The CoA voted to make some minor changes to the thresholds delineated in this Implementing Regulation (draft attached). In addition, consistent with the new Higher Education Opportunity Act (HEOA) the CoA will begin monitoring changes in student enrollment as related to faculty availability.

For review of all Implementing Regulations, go to: http://www.apa.org/ed/accreditation/implementregs200524.pdf

Site Visitor Update

Based upon feedback from site visitors, the CoA began in 2008 sending visitors a copy of the program’s response to their site visit report with a copy of the CoA’s decision letter. This is to provide the visitors with a copy of the materials that are available to the CoA in making its decision and to serve as a source of additional feedback to site visitors. All of the material is confidential and visitors will be asked to review the information and destroy it.

Question: Why are letters not sent to the site visitors for programs that are not accredited after the site visit? It would seem like this would be helpful information to the site visit team?

Response: CoA is reviewing its policies to determine whether or not to send all correspondence from CoA to a program that was reviewed to the site visit team AFTER the CoA has made a final decision. The CoA agrees that the information as a whole might be of use to site visitors; however, providing that information prior to completion of the review by CoA would place the visitors and the program in difficult positions.

Domain D: Diversity

Question: At this time in our country, why is there such emphasis on a “plan for diversity?” We all know that there are a limited number of minority students in the applicant pool. Why is the emphasis on racial diversity as opposed to other forms of diversity (e.g. age, religion, physically challenged, etc.)? What constitutes an acceptable plan to CoA? (see also the Implementing Regulation regarding Diversity: http://www.apa.org/ed/accreditation/implementregs200524.pdf)

Response: The CoA is concerned about actions that indicate respect for and understanding of cultural and individual differences and diversity and the Program’s effort or plans to recruit and retain diverse trainees and staff (Domain D). It is important to remember that the Guidelines and Principles further define diversity in regard to personal and demographic characteristics. These include, but are not limited to, age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation, and social economic status (See Domain A).
professionals, including psychologists in the NHSC Loan Repayment Program. Since then the demand for psychological services has significantly increased. Of the 1,058 mental and behavioral health professionals serving in the NHSC in 2008, 471 or 45% were psychologists. That being said most of the psychologists were not placed in Community Health Centers but in other FQHCs. There are currently 340 vacancies for psychologists through the NHSC.

**Expanding Efforts through Public Relations Campaign & Outreach**

The Education GRO staff also worked with the Bureau of Primary Health Care, which has oversight over the NHSC and FQHC programs, on a public relations campaign to promote integrated mental/behavioral health care services and describe what psychologists and other mental/behavioral health professionals do. APA also participated in the NHSC 25th anniversary conference as well as annual conferences for its Ambassadors Program. As a result, the FQHC Program began “depression collaboratives” and “chronic illness collaboratives,” which illustrated its increasing awareness of the need to address both mental and behavioral health issues in the populations served by CHCs.

Education GRO staff also reached out to the National Association of Community Health Centers (NACHC) to garner the support of its leadership to advance the use of integrated health care and the role of psychologists in CHCs. APA members were invited by NACHC to attend their annual conference and provide an article in their newsletter. Education GRO staff successfully advocated for $1 million in appropriations in FY 2000 sponsored by Congressman Bill Young (R-FL), then Chair of the House Appropriations Committee, for regional meetings of key local and state stake holders in health care to underserved populations for the development of a plan to confront financial and other obstacles that prevented them from collaborating in the provision of mental/behavioral health services. The initial funding provided for 25 states. However, the effort was so successful that all 50 states requested and received funding to also develop a plan for providing mental/behavioral health services to their underserved communities.

Seeking Support from Congress and Federal Agencies – During this period of time there was one opportunity to influence the law governing these federal programs. In 2000 Congress began considering the reauthorization of both the NHSC and the FQHC programs. In 2002, President Bush signed the legislation, known as the Safety Net bill, into law. Education GRO staff succeeded in gaining specific statutory language for the inclusion of mental/behavioral health professionals and services in both the NHSC and the FQHC titles. In addition, a technical amendment was accepted that changed the term “clinical psychologist” to “health service psychologist” to allow for the eligibility of doctoral level counseling and school psychologists.

In a simultaneous effort, Education GRO staff began advocating for a revision of the designation that determined a Mental Health Professional Shortage Area (MHPSA) to ensure that underserved communities have access to mental/behavioral health professionals, including psychologists. The timing was right since the Office of Shortage Designation already had plans to revise the medical and dental designations, and thus adding mental health made sense. The University of North Carolina Shep Center, which led the MHPSA project, completed the research for revising all three designations and the first, the medical definition, was published in the Federal Register for Comment. Unfortunately the final process of vetting the changes is arduous and time consuming; therefore, the mental health definition is still not public and most likely will not be for a number of years. Using the non-revised designation, according to the Office of Designation, there are currently over 2,700 Mental Health HPSAs nation wide. However, given that there are 5,865 Primary Care Medical HPSAs, there should be at least that same number of Mental Health HPSAs. Consequently, it is expected that the revision of the mental health designation criteria should more accurately depict the actual need and more closely resemble the primary care need.

**Exploring New CHC State-based Initiative**

In 2006, more than 10 years after the initiative began, it became clear there was significant progress with the NHSC but not enough with the Federally Qualified Health Center (FQHC). The FQHC program is a $2 billion effort with approximately 4,000 sites nation wide for the purpose of providing health care to our nations’ uninsured and underinsured persons. Thus, after consultation with the Bureau of Primary Health Care, Education GRO focused on the federally supported Primary Care Associations (PCAs) that represent the CHCs in each state. Then, Education GRO, in collaboration with the California Psychology Association (CPA) and the Practice Rural Health Committee, reached out to the California PCA. As a result of this effort, the California PCA expressed a serious interest in working with CPA and APA to get more psychologists hired by California CHCs, and to explore the possibility of creating psychology internships as well.

Ironically, the California PCA had been resistant in the past about utilizing an integrated approach to health care, but was now focused on including mental and behavioral health at their CHCs and on their own had been working with the California legislature to remove barriers and facilitate the flow of funds for mental/behavioral health services at California’s CHCs. The timing is right for this new and exciting initiative.
Internships and the Law

By Mona Koppel Mitnick, Esq.

This is my last Newsletter column as APPIC Board’s Public Member. I will resign, effective at the August 2009 Membership meeting in Toronto, and will be succeeded by Joel Stocker, a retired Health Lawyer. I have very much enjoyed my time with APPIC, both the people I’ve met and the issues facing APPIC over the years. I welcome Joel, and believe he will find his time on the Board as rewarding as I did.

In this column, I would like to highlight some of the major legal issues that have confronted APPIC and the Board during my nine-year tenure, often in the context of informal and formal ASARC complaints. It has been truly remarkable to me how many issues have arisen repeatedly over the years, causing concern anew each time they arise. Some examples (including the date of the relevant Newsletter article) follow:

• **Personal questions and information during interviews** (November 2000, July 2004, and November 2006). Interviewers have asked inherently discriminatory questions, and applicants have objected to their asking, for example, only female candidates (who have not raised the issue) about their family obligations; and only persons who appear to have a physical disability (who, similarly, have not raised the issue) whether they physically can perform the duties of the position. Interviewers also have asked inappropriate personal questions, which neither relate to bona fide qualifications or to the position itself, and were not raised by the applicant, for example, those relating to an applicant’s marital or family status, religion, and physical condition. Interviewers also have requested photographs as part of the interview process, which could raise the specter of discrimination. APPIC has advised that, if an interviewer has any doubts about asking a particular personal question or requesting personal information, don’t do so.

• **Legal Issues in Managing Problem Interns** (November 2001 and November 2002.) Training programs periodically encounter problem or substandard interns, whose performance and/or conduct require improvement if they are to continue in, or successfully complete, the training programs. To protect the interns, and to insulate training programs and personnel from legal liability, training programs should promulgate formal, written due process procedures, and apply those procedures to the problem interns, as appropriate. The basic requirement is that the procedures give the intern formal notice of his/her specific deficiencies, and a meaningful opportunity to improve—both in terms of the time to do so, and the necessary guidance and supervision.

• **Disability Issues** (March 2002). Training programs and personnel have certain legal obligations under the Rehabilitation and the Americans with Disabilities Acts, not to treat a qualified disabled person differently than a non-disabled person, and to provide reasonable accommodation to a qualified disabled person, unless to do so would create an undue hardship for the program.

• **Legal Rights of Interns Relative to Marital Status, Sexual Orientation, and Pregnancy** (July 2002 and July 2004). Discrimination based on pregnancy is a form of sex discrimination, prohibited by federal law, although sites are not legally required to treat pregnant women more favorably than other, non-pregnant, interns. The federal anti-discrimination statutes are not applicable to marital status, sexual orientation, or having or not having children, although most civilian federal employees are protected from prohibited personnel practices (which include discrimination based on marital status and conduct—including sexual orientation). APPIC has provided guidance to sites relative to pregnancy and family care issues.

• **Privacy and Confidentiality** (July 2003 and November 2003). Several federal statutes address the privacy and confidentiality of records, and many states have enacted statutes that are analogous to the federal statutes. Specifically, the Freedom of Information Act (FOIA) is primarily a disclosure statute, requiring federal agencies to disclose information in their records unless that information is protected by a FOIA exemption. The Privacy Act (PA) is the prototype non-disclosure statute, and the Health Insurance Portability and Accountability Act (HIPAA), and the Family Educational Rights and Privacy Act (FERPA) are based on the PA, respectively, relative to health and educational records. These statutes have raised significant questions about the appropriate disclosure or non-disclosure of interns’ records to graduate programs and training sites.

• **Legal Boundaries of APPIC’s Ability to Advocate** (November 2005). As an organization exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code, APPIC is prohibited by the statute from participating in any way in election-related activities in support or opposition to any candidate, party, or ballot initiative. This includes a prohibition against providing a mailing list. APPIC’s participation in partisan political activities could jeopardize its tax-exempt status. APPIC may, however, encourage its members to support or oppose specific legislation of interest to APPIC and the field of psychology, so long as the amount spent does not exceed 15% of APPIC’s total budget.

The above discussion does not represent the entire universe of legal issues confronting APPIC and psychology during my tenure, but only a sample of those recurring most often. As mentioned above, I will be available to APPIC until August 2009 and, thereafter unofficially, if anyone has questions or concerns.
From the first practicum and beyond, clinical supervisors serve an instrumental role in shaping and teaching future psychologists. Although there is variability in personality and supervisory styles, it behooves supervisors to develop an awareness of training features that facilitate the growth and development of trainees. From a pool of individuals, I inquired about their perceptions of former and current supervisor characteristics that have been most conducive to learning. In an effort to provide the supervisee’s perspective, I would like to highlight the main themes that emerged from their responses.

**Developmental Approach:** The majority of respondents reported that it was most helpful for supervisors to adjust the amount of guidance provided, depending on the developmental level of the supervisee. For the first practicum, a clinical supervisor may choose to focus on basic attending skills and writing SOAP notes but for the more advanced trainee, supervision may involve refining one’s theoretical conceptualization and applying advanced clinical techniques. A supervisor who follows this developmental approach “provides balance of clear support for the supervisee” and inserts “developmentally-appropriate levels of challenge” (Anonymous).

**Timely Feedback:** Respondents reported that it was most helpful when supervisors provided regular feedback on the supervisee’s performance. It is optimal when feedback is specific, constructive, and provided in a timely manner. If a supervisee is failing to meet specific objectives during a rotation, it is most helpful to him/her that this feedback is provided immediately so that there is sufficient time to improve on those skills. When negative feedback was provided, some respondents indicated that they were appreciative and less defensive when it was coupled with both positive and negative comments. One individual stated, “It is good to know what you’re doing right, too! Somehow, it increases my motivation to do even better.”

**Consistent Modeling:** Pairing supervisory style with therapeutic style may serve as an excellent teaching strategy. A respondent indicated that his former supervisor followed an empirically-supported conceptualization and treatment strategy. In supervision, all were expected to review the current treatment literature and to integrate knowledge into practice. Overall, consistent modeling heightened an understanding of the rationale used for this treatment modality.

**Respect of Supervision Time:** The majority of respondents indicated that it was best when supervisors were organized and thoughtful of the allotted supervision time.

It was also appreciated when supervisors directly inquired about the supervisee’s objectives for supervision and the needs at that time. Also, some cited that during supervision demonstrating good attending skills and being fully present with the supervisee were important qualities.

**Process-oriented:** As one respondent put it, an inductive learning environment involves the encouragement of exploring the self-as-therapist. Throughout the process of growth and development as a future psychologist, introspection and self-monitoring serve as vehicles for these positive changes. When supervisors model these behaviors and demonstrate the ability to normalize this process, it provides an opportunity for supervisees to extend this introspective process into a career-long practice, which compliments them in their roles as clinicians.

**Supervisory Relationship:** Notably, the supervisory relationships that were most memorable and important in the development of a future psychologist involved respect and validation, flexibility in teaching methods, collegiality, humor, and an openness to discussing mistakes and processing them.

The common thread in these responses is that clinical supervision is a place for supervisees to strengthen their competencies, receive guidance from those who are in a position of relative power, and to develop a sense of self as a psychologist. Many indicated that support and encouragement from supervisors have contributed to their self-efficacy. The collective voice of current and former supervisees may reflect values and experiences that you may have had in your former position as a trainee. I hope this article has helped bring attention to your important role in the professional development of future psychologists.

This is my last contribution to the APPIC e-newsletter as the APAGS Member at Large, Education Focus. On behalf of psychology graduate students, I would like to extend a warm “thank you” to the APPIC community for your continued support of quality education and training.
FROM THE ASSOCIATE EDITORS

Adult General Psychology
Everyday Chemicals and Diversity With Regard to Patients

By R. L. Stegman, Ph.D.

A n interaction with a coworker a couple months ago is an apt introduction to this column. We are located in a section of the hospital that consists of two long hallways connected by shorter hallways sort of like the rungs of a ladder.

Coworker: “You need to walk down the hallway!”
I: “What is going on?”
Coworker: “It stinks!”

My coworker went on to explain that an employee had arrived smelling quite strongly of the fragrance. She found to be quite offensive because it made her ill. She and I had a brief interaction about the incongruity of the situation: A health care facility that permits patients to make other parties ill- and especially our patients. She ended the interaction with an emphatic statement: “All hospitals should ban such things!”

As care providers we need to be aware of the potential for, and actual, negative impact everyday fragrances have on patients. Contrary to common belief, such fragrances are comprised of toxic chemicals and/or derived from toxic sources such as crude oil.

Years ago a dealer in what are now called green products stated to me: “Only corporate America could convince people that the smell of toxic chemicals means they are breathing clean, healthy air.” The state of California has a law that requires public facilities to post a warning when such chemicals are used in the building.

A woman in her forties is administered neuropsychological testing. The examiner burns incense in the room with the explanation that its purpose is to help her relax. The incense causes respiratory problems, gives her a headache, and interferes with her thinking. She is afraid to tell the examiner and literally suffers through the testing. The examiner obtains spuriously low results and he is totally unaware of it.

A therapist uses plug in room deodorants in her office. The aroma is vanilla with the rationale that the fragrance has a relaxing effect. What she does not know was that the aroma is not vanilla. It is a very toxic chemical that has an aroma similar to vanilla. When she stops using the room deodorants, the number of patients who complain of headaches drop significantly. It is relevant to note that the results of various surveys have been quite consistent regarding room deodorants: Between 35 to 40 percent of people have negative reactions to them. In addition, and in recognition of such, manufacturers print in the instructions that use of the product should be discontinued if one has such reactions.

A therapist in private practice simmers a potpourri when in her office. (Producers of such products use industrial grade solvents along with formaldehyde to maximize production while minimizing costs). The odor permeates the hallway and adjoining offices so residents in the adjoining offices and their patrons are forced to breathe the fumes. Also and something the therapist does not realize, patients self select. That is, only those who tolerate the chemicals see her in therapy. The others seek services with a different care provider and, therefore, she loses business.

An employee who works in an allergy clinic regularly wears very strong cologne.

Individuals with allergies are more likely than the general population to have a negative reaction to the chemicals that make up the cologne. In other words, patients have to be in a setting that elicits symptoms in order to receive treatment for symptoms.

The matter becomes more complicated when one understands that approximately 40 percent of fragrance products are counterfeit. Some petroleum distillate combined with some aromatic compounds (toxic chemicals) suspended with a phthalates (disrupt the endocrine system) and a counterfeiter has a very cheaply made “fragrance” for which the company makes an astronomical profit. Dog food, dry wall, and Infant formula are not the only toxic products produced in other countries. So a person who uses an “herbal” shampoo is likely sharing benzene with all in his/her general area.

The concept of individual differences is a good way to understand the need for diversity with regard to fragrances. There is considerable variety in fragrances for a reason.

People have different preferences as to what is or is not a pleasant aroma. More importantly, however, is that most people have intolerance to one or more fragrances.

A not infrequent interaction involves a person who states s/he loves a certain fragrance while stating how much s/he dislikes a certain fragrance because it elicits various negative physical reactions. All too frequently the person fails to recognize there are people who avoid his/her favorite fragrance for the very same reason.

The incorporation of negative reactions to everyday chemicals as part of diversity thinking has the benefit of providing an additional dimension to interventions. What is considered psychological may well be physical. A woman who is quite depressed due to various unexplained symptoms finds they all but disappear when she removes her scented candle collection from her home. A man who suffers daily from excruciating headaches discovers they are gone when he stops all use of colognes and fragranced personal deodorants as well as fragranced items around the home. A mother who spends considerable effort and expense to maintain a germ free environment for her child learns that it is the toxic disinfectants that elicit most of her child’s asthma attacks.

A man who is physically drained almost constantly (i.e., depressed) finds that his energy level is good when he shifts from the adulterated Western Diet to a primarily authentic diet.

A reasonable posture for a care provider who uses a fragrance is the assumption that it will elicit negative symptoms in a percentage of his/her patient population. Hence, it is better to use very subdued levels of a fragrance or no fragrance at all as well as to be sensitive to communications from patients about such matters since information provided by a patient may well impact substantively on the nature and course of interventions.
In my experience, when we speak of behavioral emergencies, it is an individual’s risk of suicidal behavior or a person’s risk of engaging in violent behavior that first come to mind. There is, however, a third major behavioral emergency, i.e., the risk of being victimized or re-victimized by interpersonal violence, that is of equal importance in clinical practice. There are not only high rates of criminal victimization among adults in the United States, but also high lifetime rates of intimate partner violence (see summaries in McCart, Fitzgerald, Acienro, Resnick, and Kilpatrick, 2009; and Riggs, Caulfield, and Fair, 2009); and one of the strongest predictors of future victimization is past victimization. There are, of course, various explanations for victimization and re-victimization (e.g., needing to live in a violence-prone neighborhood or attempting to improve a relationship with a potentially violent partner), and it is important not to engage in blaming the victim. Especially for psychologists-in-training who plan to work with couples or marital partners, it is critical to learn about the risk markers for violence perpetration and for victimization as well as about how best to assist the individual at acute risk of being victimized or re-victimized. As Riggs, et al., have pointed out, there are significant associations between verbal aggression in a relationship and physical violence. There are also other diagnoses more commonly associated with intimate partner violence; i.e., depression, combat-related PTSD, substance abuse, and borderline personality disorder. Being the victim of domestic violence as a child or witnessing violence between parents has also been found to be correlated with the perpetration of violence in adult relationships. Identification of risk factors associated with interpersonal victimization has not been pursued in research to the same degree as risk factors for perpetration. As a result, there is little consistent evidence in the literature to support specific risk markers (Riggs, et al., 2009). There are, however, a few evidence-based factors that are significantly correlated with particular incidents of domestic violence. Relationship conflict and arguments, of course, frequently precede a physical altercation, and incidents of violence when the male partner has been abusing alcohol have been found to be more likely to involve severe violence. Confrontation may not be the best strategy at a time when the partner is intoxicated. There is evidence to support the fact that women who leave a violent relationship are at increased risk of violence. In addition, there is some evidence that women who have experienced violence by a partner are better able to perceive an impending threat of violence. If a woman feels that her partner is close to becoming violent, it is important to give very serious consideration to her concerns. If a clinician has reason to believe that a patient or client is at acute risk of becoming a victim of partner violence, or of being re-victimized when violence has occurred, an immediate form of intervention involves support of the individual’s coping mechanisms (including good self-care) and safety planning (McCarr, et al., 2009). The clinician needs to work with the victim or potential victim to understand situations that may arise in which there will be a high risk of future victimization. Then strategies and plans can be developed to reduce risk and, if necessary, find safety from the perpetrator or likely perpetrator. Helping the patient think through the activities of the next few days can be of benefit in terms preparing for and planning changes that they may need to make in their routine. If the individual wants to remove herself from a volatile relationship, it may be necessary to assist in finding a safe house or shelter, or in making contact with a victim’s advocate from the district attorney’s office. If it is needed, safety planning should include strategies to prevent suicidal and retaliatory violence. Victims of violence often have negative thoughts about themselves that can lead to thoughts about self-harm or suicide. They may need to be made aware of hotlines or how to access emergency services. Likewise, if the victim feels like retaliating against the perpetrator, the clinician needs to work with the individual to find more appropriate ways to manage their anger. Oddly enough, the clinician can also find himself or herself in the position of needing to protect the perpetrator. Except in graduate and internship programs that have a specific focus on assessing and working with victims of intimate partner violence, there is little reason to believe that there is widespread education and training on the evaluation and management of these often complex and high intensity situations (Kleespies, Berman, Ellis, McKeon, McNeil, Nock, Resnick, et al., 2000). They are situations that can arise in the practice of any active clinician, particularly those who engage in couples/marital therapy, and the decisions made by the clinician can have far reaching emotional, ethical, and legal repercussions. It would seem important that our psychologists-in-training develop the knowledge base and clinical skills to manage them well and the internship year would seem like a prime time for doing so.

References
Diversity Issues
By Kathryn Castle, Ph.D.

Approximately 300 million people currently live in the United States, and 26% of the population is comprised of populations of color (Black/African American; Latino/a; Asian; American Indian/Alaska Native and Native Hawaiian/Pacific Islander). When the data is distilled, we find the following breakdown: Blacks, 13.4%; Latino/as, 14.8%; Asians, 4.4%; American Indians/Alaska Natives, 2.0%; and Native Hawaiian/Pacific Islanders, 1.4%. Even with these percentages, overall members of underrepresented groups remain larger than the percentage of racial and ethnic groups within the field of psychology. Currently, only about 5.9% of persons practicing psychology are persons of color. Data from a draft of “Practicing Clinical Psychologists’” survey convened by the APA in 2007 reports that less than 2% of persons of Asian descent and Blacks and only 3% of Latino/as practice as clinical psychologists when looking at the N of survey respondents.

Interestingly, in 1998, Dr. Henry Toman wrote (in the APA Monitor, Vol 29; 12) about racial and ethnic diversity in the field of psychology. In his column, he discussed the increase of women in the field but also talked about the small number of persons of color entering it and the need to be mindful of this in relation to the increase in diverse populations in the United States. He noted that in 1998, out of 83,000, only 6% of APA members reported being from populations of color, currently (2007) only 6.5% of APA members (Associate, Member, and Fellow) are held by persons of color. Why after 10 years are we basically in the same place? Why, more than a decade later, is the same discussion significantly relevant? In Psychology, we have spent a great deal of time discussing, in training and practice, the need to be culturally competent, having cultural humility and practicing from a multicultural perspective all to better serve our demographically changing country but it appears that we continue to struggle in the area of increasing diversity within our discipline.

Is it that persons of color are not as interested in pursuing psychology as a vocation or could it be that as a field we have not yet figured out how to reach out to young people early on in their education to engage them and interest them in psychology? We have established “pipelines” (most generally in research) into psychology but somehow these “pipelines” do not appear to bring students or trainees of color in large enough numbers that they match the percentages of their populations in larger society. There have been many guideline developed for the provision of psychological services to ethnic, racial and linguistically diverse populations, LGBTQ communities, older adults, etc., but there do not appear to be any standard methods that are utilized to increase diversity of professionals within our discipline. Granted there is variety in terms of type of training program, location of training program and all should be taken into consider-

ation but should we have a guideline for the recruitment and retention of persons of color or other underrepresented groups in psychology training programs?

We continue to struggle with little progress and honestly we are not keeping up with the demand of the consumer. It is understood that the race or ethnicity of the clinician is not the most important aspect of the therapeutic relationship, as has been demonstrated through research, but can it be significant in assisting consumers in accessing our training clinics, ambulatory services or private practices, I would say yes. Anecdotally, I receive many calls per week from people in the community, medical providers and social service agencies looking for an African-American psychologist and I turn many away because I don’t have the availability to meet the request for service and the resources in my community, in terms of psychologists or color, are inadequate as well. The reasons that referral sources have expressed range from racial identity issues, reactions to experiences of racial discrimination and feelings of comfort in being vulnerable with someone that is assumed to share similar values, beliefs and experiences. So it appears that we have an important question to answer, what are we as a discipline to do? It appears that during this era and climate of change we must make inroads into diversifying our field so that we can remain relevant. We have done a wonderful job of weaving culture and diversity into the fabric of psychology, now we have to better operationalize this in terms of student recruitment and retention. Will this be a difficult task, yes, but we will all be the better for it.

Diversity Issues
By Yoon Jung, Ph.D.

It seems hard to believe that another internship season has come and gone already, but indeed it has. During our most recent Diversity Committee meeting at the San Francisco VA Medical Center, we reviewed the process of interviewing our prospective interns, with particular emphasis on the Diversity Committee’s role in this process. This discussion not only serves as confirmation of the importance of asking about working with diverse populations during the interview process, but also engendered a wish to advocate asking about cultural and diversity issues as a part of standard clinical trainee interview procedures. The SFVA Diversity Committee plays an active role in the intern selection process, primarily through ensuring that applicants are given the opportunity to express their views on working with diverse populations. More specifically, the Diversity Committee provides a sub-committee of volunteers from which one representative is selected to ask each candidate to discuss their experiences in working with diverse populations. Then, among the numerous interviews an applicant is scheduled for during the day, one slot is set aside for him/her to meet with Diversity...
Committee representative to discuss working from a diversity standpoint. The question is as follows: “Tell me about one of the most challenging times when your own cultural identity impacted your clinical work. How did it impact you? What did you take away from the experience? Are there any ways that you might have handled it differently?”

As we discussed the Committee’s role in the interview process this year, one of the many observations made was that the quality of responses to the “diversity question” was often not markedly different from responses to any one of the number or type of questions asked in the more free-form interviews. That is, applicants who answered the diversity question with, e.g., complexity in thought, introspection, and awareness, often did similarly well in other interviews which were not necessarily focused on asking about working with diverse populations. I found myself confirming this observation in my own mind while reviewing my personal experiences in interviewing over the years. In fact, I remember when beginning to interview prospective trainees and being assigned the diversity question, having concerns about getting a good enough “feel for” a candidate. I remember wondering if my interview would feel complete enough when I would quite possibly not have time to ask specifics about his or her vita, theoretical orientation, or favorite flavor of ice cream? These concerns were put to rest almost immediately, as almost without exception, I have not come away from a diversity interview without feeling I have gotten a good enough sense of how an applicant works clinically, personally, and emotionally. Later on, I found myself reflecting even further on what in particular we gain from directly asking a question about working with diverse populations. In my experience, when asking someone to talk about working with someone culturally different, I have not only gathered information and insight into an applicant’s clinical acumen, perspective-taking abilities, maturity, etc., but oftentimes something more. The richness of information that come forth when asking about diversity issues is related to the implicit calling to look internally at oneself to understand someone else’s struggle, vulnerabilities, and search for meaning. And more than a few times when asking this question, I have observed interviewees stop, ponder, and reflect in the moment while in the midst of describing working with someone who was of a different ethnic background, age, gender, social class, educational background, etc. I have found this type of “in the moment” reflection often indicative of the “best”, or most telling interviews, where you get a glimpse of how someone reconstructs, re-evaluates, and accommodates his/her worldview through openness to experience, humility, and compassion. And I believe that openness, humility, and compassion are among those factors that make up the very essence of a good therapeutic relationship. Not that these “in the moment” moments don’t occur otherwise, but explicitly asking a question that challenges one to reflect upon and describe how their own identity has interacted with a different other’s, sets the stage quite beautifully for this process to unfold.

Health Psychology

By Sharon Berry, Ph.D. | sharon.berry@childrensmn.org

This will be my last column, as I will be handing off the column to another APPIC member Training Director! Please consider writing this column twice each year, as this is a valuable resource and a great forum to share information and ideas with other health psychologists!

National Statistics: The Centers for Medicare and Medicaid Services (CMS) issued a recent report that indicated growth in national health expenditures in the U.S. is expected to significantly outpace economic growth in 2008/2009 due to the recession (published online by the journal Health Affairs). At the same time, employment figures for February indicated that, overall, the US economy lost 651,000 jobs. Interestingly, the health care industry added 27,000 jobs. I am wishing that a majority of these added positions were in the education and training community and hope that we can maintain current funding levels for training, while finding unique opportunities for growth in the number of internship and postdoctoral positions available for our future psychologists. Be sure to share with us (and on the listserv) any ideas you have or solutions you have found!

National Health Insurance: I have recently learned about Physicians for a National Health Program (PNHP), a non-profit research and education organization of 16,000 physicians, medical students and health professionals who support single-payer national health insurance (http://www.pnhp.org/). Their mission is single-payer national health insurance. They describe a broken health care system where the U.S. spends twice as much as other industrialized nations yet the system performs poorly in comparison and leaves an additional 47 million Americans without health coverage whatsoever, and millions more with inadequate coverage. Their statistics indicate that the bureaucracy associated with private based insurance consumes one third of every health care dollar, but a single nonprofit payer could save more than $350 billion/year, sufficient to provide high quality coverage for all U.S. citizens.

Hope: Despite these overwhelming statistics and the current economy, many health-training programs are thriving and are valued by their organizations. We have a number of psychology divisions that provide a psychological home for each of us, and several organizations that work to promote consistency across training programs and/or advocacy for the profession. Divisions 38 (health) and 54 (pediatric psychology) provide a number of resources that could be invaluable to you. Other possible “homes” for you include the Society of Behavioral Medicine (SBM) or the Association of Psychologists in Academic Medical Centers (APAHC). At the same time, please consider your program joining the revi-
talized Council of Clinical Health Psychology Training Programs (CCHPTP); each of these groups has a website and can be easily accessed for additional information.

**APA’s Vision:** As part of APA’s first-ever strategic planning process, the Council of Representatives adopted the following vision statement for the association. The statement is intended to describe the type of organization APA aspires to be and the impact it hopes to make over the next 20 to 30 years:
The American Psychological Association aspires to excel as a valuable, effective and influential organization advancing psychology as a science, serving as:

A uniting force for the discipline;
The major catalyst for the stimulation, growth and dissemination of psychological science and practice;
The primary resource for all psychologists;
The premier innovator in the education, development, and training of psychological scientists, practitioners, and educators;
The leading advocate for psychological knowledge and practice informing policy makers and the public to improve public policy and daily living;

A principal leader and global partner promoting psychological knowledge and methods to facilitate the resolution of personal, societal and global challenges in diverse, multicultural and international contexts; and

An effective champion of the application of psychology to promote human rights, health, well-being and dignity.

APA has also identified the following as Health Care Reform Priorities, recommending that reform must go beyond covering the uninsured to include changes in the way health care is delivered in this country:

1. Integrate mental and behavioral health care into primary care and other health care services.
2. Ensure access to quality mental and behavioral health promotion, screening and referral, prevention, early intervention, and wellness services for persons across the lifespan, with particular attention to at-risk populations.
3. Develop and maintain a diverse psychology workforce competent to develop and apply evidence based behavioral and psychosocial assessments and interventions to address the current needs and changing demographics of our nation’s population.
4. Ensure that quality mental and behavioral health care and access to psychologist providers are included in benefit plans for persons across the lifespan.
5. Eliminate disparities in mental health status and mental health care through the use of psychological and behavioral research and services that are culturally and linguistically competent.
6. Increase federal funding for basic and translational psychological and behavioral research and training to develop and evaluate empirically based treatments to improve health care.
7. Include strong privacy and security records protection in the development of health information technology, with special attention to mental health records.
8. Enhance the involvement of psychologists and other health care professionals with consumers, families, and caregivers in planning, implementing, and evaluating health care initiatives.

**International issues**

**CCPPP Liaison Report | By Sandra Clark, Ph.D.**

The Executive of the CCPPP recently held their mid-winter meetings which, as usual, were full and productive with respect to training issues on the Canadian front. The focus for the CCPPP over this past year has been specifically on addressing a number of student issues as well as issues regarding competencies in training, and the shortage of internship placements, among others. With the changing demographics and needs of students, we have been grappling with the issues of part-time internships, the balance between training needs and personal time/self care, the increasing expense of interviewing for internship, and the ever present issue of student anxiety around AAPI hours. For example, we are finding that more and more students are coming into internship with family commitments that continue to create additional issue that many training centres (both academic and internship) are trying to provide more clarity around is the AAPI hours, specifically the number of face-to-face or direct client contact hours required for internship, which continue to create significant anxiety for students who compare their actual hours with those reported on the APPIC website.

To continue on our key themes this year, we will be hosting a workshop on “Professional Psychology Training Issues: Challenges, Conundrums, and Constructive Solutions” at our annual pre-convention workshop as part of the CPA’s annual convention in June. The workshop will begin with presentations on three key topics, 1) competency and benchmarks, 2) challenges faced by students and training...
programs and student evolving needs, and 3) supply / demand and mobility issues. Following the presentations, working groups will focus integrating these ideas and creating plans of action for the next year.

Other issues and priorities for the CCPPP include focus on the definition, development, and evaluation of training competencies, flow in training from the academic setting to practicum and internship settings, our ongoing efforts in addressing concerns/queries from our member organizations and other organizations, to foster communication for academic graduate training programs and internships, as well as our ongoing involvement with a number of liaison activities. We also continue to be actively involved in the planning for the Joint CCTC meetings in 2010.

The CCPPP is very pleased to have such a strong working relationship with APPIC and our shared focus on excellence in professional psychology training. We look forward to seeing everyone at the Joint CCTC meetings in February 2010.

**Literature Review**

*By James M. Stedman, Ph.D. | University of Texas Health Science Center at San Antonio*

It has been a busy year- 12 internship related papers, most in our joint venture journal, *Training and Education in Professional Psychology*. The most important are six articles addressing the ongoing and real crisis of supply and demand, presented in a special issue of this journal (*Training and Education in Professional Psychology*, 1 (4), Nov 2007, Special Issue – further references to these articles will give authors, title, and page numbers only). Other papers addressed a variety of topics of interest.

1. Rodolfa, Bell, Bieschke, Davis, and Peterson introduced the problem in an overview, entitled The Internship Match: Understanding the Problem-Seeking the Solution. They acknowledged the ongoing crisis and urged the profession to seek solutions. Related articles appear below. Pgs. 225-228.

2. Baker, McCutcheon, & Keilin co-authored The Internship Supply – Demand Imbalance: The APPIC Perspective. These three know the issue up close and personal. They point out that we do have a crisis on our hands. In the past 5 years, new internship positions have increased by 5% demand for those slots shot up by 20%. If these numbers had to do with sub-prime mortgages, no one would be confused. Their solutions: voluntary cutbacks in grad school admissions, curtailing new grad programs, having grad programs develop affiliated internships. Pgs. 287-293

3. In Using Workforce Analysis to Answer Questions Related to the Internship Imbalance and Career pipeline in Professional Psychology, Rozenksy, Grus, Belar, Nelson & Kohout describe plans to apply workforce analysis technology to obtain accurate data related to the entire educational and professional pipeline. They believe these data will greatly aid decision making in all phrases of training and professional work, including helping to solve the supply-demand crisis. Pgs 238-248

4. Hutchings, Mangione, & Wechler, in A Critical Analysis of Systemic Problems with Psychology Pre-Doctoral Internship Training: Contributing Factors and Collaborative Solutions argue that cutting back on grad admissions is not feasible due to enforcement problems and antitrust lawsuits. They advocate expansion of internship slots and cite efforts by the NCSPP to help expand sites. Pgs 276-286.

5. Madson, Hasan, Williams-Nicholson, Kettmann & Van Sickle presented the grad student perspective on the issue. They review the history and factors involved and point out, among other things, the ethical obligation of the profession to solve this problem. Pgs. 249-257.

6. In an article entitled, Counseling Psychology Perspectives on the Predoctoral Internship Supply-Demand Imbalance: Strategies’ for Problem Definition and Resolution, Miville, Adams, & Juntunen surveyed counseling center training directors who recommended a number of factors related to preparation of counseling students seeking internships; however, in the end, the directors recommended a cutback in admissions coupled with an expansion of sites as the solution. Pgs 258-266

7. Hogg & Olvey report on pre and post doctoral training programs developed by the Arizona Psychological Association to help with training opportunities in that state. To date 51 predoctoral interns have complete the program. They offer their model as an example for other states. State Psychological Association Creates a Postdoctoral Residency and Internship Training Program. *Professional Psychology: Research & Practice*, 38, 2007, 705-713.


9. Neimeyer, Rice, & Keilin studied the relationship between grad programs’ stated training model and match rates of clinical students. They found match rates “broadly consistent with the emphasis of their academic training programs.” Does the Model Matter? The Relationship between Science-Practice Emphasis in Clinical Psychology Programs and the Match. *Training & Education in Professional Psychology*, 1, 2007 153-162.

10. Riva & Cornish studied changes and similarities in group supervision conducted in predoctoral internships, based on similar surveys conducted 10 years apart. They found some similarities – the case conference is still the most common format and some differences- more supervisors have grad training in supervision. Group Supervision Practice at Predoctoral Internship Programs: 15Years later. *Training and Education in Professional Psychology*, 2, 18-25.

CONTINUED ON NEXT PAGE
Neuropsychology

By Brad L. Roper, Ph.D., ABPP | Brad.Roper@va.gov

The Meeting of the International Neuropsychological Society in February is a primary venue for formal and informal interactions related to training in the specialty of neuropsychology. The meeting serves as an excellent opportunity for students to present research posters and presentations. Postdoctoral programs often do their primary or preliminary interviews at the meeting, and various groups and committees meet to discuss issues of relevance regarding training. Here are some training highlights from the 2009 meeting and elsewhere.

Within several venues, the issue of Medicare reimbursement rulings and their impact on training programs was discussed. It is very clear that some programs that offer internship and/or postdoctoral training have been adversely affected by the ruling that programs cannot bill Medicare, and perhaps by extension private third-party payers, for work done by anyone in a training role, even if the trainee is a licensed postdoctoral resident.

However, the extent of the impact on training programs is unclear. The issue is especially relevant within neuropsychology, as a two-year fellowship is a required part of training, and elderly patients constitutes a large portion of neuropsychology practice in many settings. The Association of Postdoctoral Programs in Clinical Neuropsychology (APPCN) has pursued the Medicare reimbursement issue during the year, communicating with APA regarding its position paper regarding Medicare funding (see http://www.aapnet.org/pdf/practice_gme08_hosp.pdf). Members of the Division 40 Education Advisory Committee, chaired by Cynthia Cimino, Ph.D., resolved to contact other divisions and training organizations that may be impacted by Medicare reimbursement rulings. If you have any information to offer on this issue, please email me at the above address.

It was discussed that the only long-term solution is legislative action that would enable psychology to gain access to Graduate Medical Education funds, similar to how the training of physicians, dentists, and podiatrists is supported. I believe that access to GME funds is not just an important training issue; it also has important implications for the future practice of professional psychology. Accordingly, the APA Practice Directorate should invest resources in seeking such legislation.

Some programs may have access to allied health funds via the Center for Medicare Services (CMS). The process of obtaining such funding at the postdoctoral level has been detailed in an article by Kirk Stucky, James Buterakos, Thomas Crystal, and Robin Hanks in Training and Education in Professional Psychology, 2008, pp. 165-175.

However, in order to be eligible for such funds, programs must not only be APA-accredited; they must be administratively housed within a hospital, which disqualifies many programs. Postdoctoral programs that are based in hospitals are encouraged to review the article to determine eligibility of such funding.

The Association for Internship Training in Clinical Neuropsychology (AITCN) is considering various ways to provide more resources for students and those offering training at the internship level. They plan to add various resources to the AITCN website (http://www.utmem.edu/aitcn) in the coming months. AITCN is also investigating ways to expand membership to better represent programs that offer training experiences in clinical neuropsychology at the internship level.

APPCN sponsors a computer matching program for two-year clinical neuropsychology residency positions. This year, there were 94 applicants in the Match and 75 positions offered across 55 training sites. The match rate for applicants was 67%, and the match rate for positions was 84%, consistent with previous years. Fifty-three applicants withdrew or did not submit ranks. This year, there was an increase in the number of applicants withdrawing from the match for Personal/Family/Health reasons. Withdrawals due to acceptance of clinical residencies outside of the match were stable from last year, but these remain a concern. Of particular concern are short-window or “exploding” offers extended by non-match programs, which reduce the ability of applicants to consider multiple programs. In the coming year, APPCN will be reviewing the effectiveness of the match, and considering options regarding enhancing the selection process to the benefit of both applicants and participating programs.

At the INS conference, representatives from several organizations led a symposium for students involved in training entitled, Becoming a Clinical Neuropsychologist: From Graduate School to Board Certification. Such presentations occur in different forms at the APA Convention as well as the INS meeting in February and the National Academy of Neuropsychology convention in the fall.

Finally, Celiane Rey-Casserly, Ph.D., ABPP was elected President Elect of Division 40. Celiane is a former Chair of the APA Committee on Accreditation, directs a postdoctoral program, and has much experience in training issues in other capacities.
T his essay will begin with two facts, one historical and one contemporary, regarding events in the Rochester NY area, the setting in which I have taught and practiced psychology for some fifty years. (Now if that doesn’t qualify as a major outbreak of serious geezerhood, I’m not sure what would. But, be patient and, before you know it, a point will show up a few paragraphs further along.) What’s more, these two facts will eventually turn out to be related to one another in a significant way and will, I hope, illustrate the point I wish to make.

Fact #1: In the 1946-47 academic year, a promising young psychiatrist, John Romano, M.D., well trained in both neurology and psychoanalysis, was appointed as founding Chairman of the newly established Department of Psychiatry at the University of Rochester School of Medicine.

Fact #2: Two psychologists from the Rochester area, Susan McDaniel, Ph. D. and M. David Driscoll, Psy.D., have separately, within the last few years, received awards from the APA for the work they have been doing. Both of them had, in their own ways, established close working relationships with the local medical community, thereby substantially improving the quality of care patients have received.

McDaniel, who has been a prolific author and teacher in the area of family practice, has written well-received books on primary practice psychology and has demonstrated how that concept can be put into operation in close coordination with family physicians and other MD’s. Driscoll has creatively arranged to move his clinical practice directly into the offices of a pediatric group practice so that he could be immediately available for instant referral and consultation.

Both of these psychologists were warmly welcomed into direct collaborative interaction with the medical community in Rochester, and this has happened in a way that might not have occurred, in other geographic areas. This kind of mutually respectful collaboration has occurred, in great measure, as a longer term consequence of Fact #1.

So, to return to fact #1, Romano quickly realized that in order to create a viable and productive department that served the three basic academic medical center functions of teaching, clinical service and research, it would be necessary to include in his department a critical mass of psychologists capable of contributing in each of those areas. In fact, the medical school in Rochester had already established a precedent regarding faculty psychologists by appointing, some years before, the first woman psychologist to a medical school faculty in the country. She was a sweet, grandmotherly looking little lady named Frances Parsons, whose appearance belied the steel-trap-like mind she repeatedly demonstrated while serving in the Department of Pediatrics.

Over the next twenty-five years, as Romano’s department developed, there eventually came to be some 33 full-time faculty psychologists at the medical school, mostly within psychiatry, but also in such departments as pediatrics, oncology, anatomy, radiation biology, student health etc. And, of course, a substantial number of part-time and adjunct clinical faculty, from the community as well as a continuously growing number of psychology interns and specialty post-doctoral fellows added to the size of the psychology presence there.

What this has meant is that over many years medical students and residents in a variety of specialties were constantly exposed to psychologists who were their teachers, supervisors and, in many ways, their role models. In the Psychiatry Department, a psychologist served for many years as associate chair and director of all clinical services. Many of the specialty services within the department, e.g., child and adolescent, family and marriage, student health etc. were also directed by psychologists. Yours truly served for many years as clinical director of three different inpatient units, ranging in size from 22 to 33 beds, and was responsible for overseeing all clinical and teaching activities on these floors. Since all medical students rotated through psychiatry at least twice during their clinical assignments, and an active medical-psychiatric liaison program provided for some psychiatric rotation for most medical residents, the concept of psychologists playing an active role in most clinical service areas was, for almost every graduate of the medical school and most medical specialty residents, simply a fact of life.

Now, I believe that there is some pretty persuasive evidence that early life experiences do tend to play some role in an individual’s subsequent world views and attitudes. And the early professional education of Rochester-trained physicians was heavily influenced by their association with their psychologist teachers as well as by their interactions with the many psychology trainees alongside of whom they had worked and learned. Added to this was the powerful influence of the bio-psycho-social model of human development and behavior that was promulgated and taught by George Engel, MD a long-time member of the faculty.

So, in later years, as many of these physicians remained in Rochester (attracted by the many desirable features of this community- and no nasty cracks about the weather)
it was quite natural for them to eagerly engage with psychologists whose work and contributions they had come to value during their education. Hence, the programs developed by McDaniel and Driscoll noted above were able to flourish in this community because, among other things, there was already a long-standing climate of comfortable working relationships between medical practitioners and psychologists.

OK, now finally comes the point of all this! I would argue that psychology trainees should have an opportunity to work closely with physicians and, in particular, with physicians-in-training, during their psychology graduate experience. In some settings, this is inherent in the nature of the institution. Internship or post-doc programs in medical schools, hospitals, VA services and, obviously, in health psychology programs, already provide an environment in which such relationships are naturally developed. But in many internship settings, it would require some effort and creativity to ensure that these kinds of mutually beneficial interactions are provided.

And that is exactly what I am urging: that we do seek out opportunities for our trainees to engage with medical students and residents if there are any in your area. If not, seek out connections with young physicians as an alternative. You might be surprised to find how receptive an internist might be to a call suggesting that an intern or post-doc spend an afternoon or two each week in their office observing how an MD practices. Of course, at the same time, this could give the internist a chance to learn what a well-trained psychologist could contribute to his/her own practice and how the services of a psychologist could benefit their patients. That sort of interaction could, I would suggest, pay great dividends for both psychology and medicine in the future.

Now, I understand that there are some who will find this idea objectionable. There are some who hold the view that psychology should divorce itself from medicine and pursue an entirely different path as “personality doctors” or life coaches. They would even argue that psychology’s decision to seek coverage under national health programs was a fundamental error. Perhaps, but we are where we are in history. Predicting, especially the future, is always risky, but it would appear that our society is heading towards some kind of universal health care. If psychology wants to be a part of that future, then it may well be time for us to stop fighting with organized medicine and, instead, see to it that medical professionals know about and appreciate the contributions that psychologists can make.

It’s true that there have been many areas of conflict between psychologists and psychiatrists, and much of this conflict has been connected to bread and butter economic issues. There is a significant body of opinion that sees psychiatry as a medical specialty that is facing major decline. Psychiatry, as a profession, has, by and large, long since given up on psychotherapy and ceded that activity to “non-medical” practitioners such as psychologists, social workers and a wide variety of other assorted therapists. One of their other major skill areas, i.e. diagnosis, has been reduced to a check-list type of process based on a rigidly defined DSM set of symptoms. It’s no wonder, then, that they have ferociously, but only partly successfully, contested psychology’s efforts to move into their last remaining unique area of competence: prescribing of medication. Even in this respect, they are already losing out to primary care physicians and other MD’s who by now write much of the nation’s prescriptions for psychotropics. But in this battle, it does not appear that it is the entire medical establishment that has been contesting psychology’s move into that area. Indeed, in those states in which psychology has won that contest, it has generally done so with the support of a major component of the medical communities in those localities.

So, there is every reason to believe that we can get along quite well with our MD colleagues, and the more they know about what psychologists do, the better those relationships can be. Similarly, it is equally important for psychologists to understand the way in which physicians typically conduct their practices. That kind of mutual familiarity and respect can, perhaps, only develop when there have been close working relationships between the two professions. And starting while they and we are still in our training years may be the best way to see to it that effective working relationships do develop. If you don’t believe me, ask McDaniel and Driscoll!
New APPIC Members

**Doctoral Internship Programs**

- Alaska VA Healthcare System  
  Anchorage, AK
- Arrowhead Psychological Clinic  
  Duluth, MN
- Baylor Institute for Rehabilitation  
  Dallas, TX
- Center for Psychological Development  
  Sherman, TX
- Central Louisiana State Hospital  
  Pineville, LA
- Charles George VA Medical Center  
  Asheville, NC
- Denton Independent School District  
  Denton, TX
- Fuller Psychological & Family Services  
  Pasadena, CA
- Hamilton Health Services  
  Hamilton, ON, Canada
- Hugh S. Smith, Ph.D. & Associates, PC  
  Lancaster, PA
- Indian Health Service  
  Fort Yates, ND
- The Jewish Family Services Collaborative  
  Richmond, VA
- McGuire VA Medical Center  
  Richmond, VA
- Mid-Ohio Psychological Services, Inc.  
  Columbus, OH
- Nova Southeastern University Center for Assessment and Intervention  
  North Miami Beach, FL
- Riverview Psychiatric Center  
  Augusta, ME
- Kaiser Permanente West Bay Consortium  
  San Francisco, CA
- Larned State Hospital  
  Larned, KS
- Long Island Jewish Medical Center – Zucker Hillside Hospital  
  Glen Oaks, NY
- Mailman Center for Child Development  
  University of Miami Miller School of Medicine  
  Miami, FL
- Minnesota Consortium for Advanced Rural Psychology Training  
  Detroit Lakes, MN
- Rocky Mountain Blood and Marrow Transplant Program  
  Denver, CO
- University of Arkansas for Medical Sciences Dept. of Pediatrics  
  Little Rock, AR
- University of California, Davis, Health System  
  Sacramento, CA

**Postdoctoral Residency Programs**

- Barrow Neurological Institute  
  Phoenix, AZ
- Central Arkansas Veterans Healthcare System  
  North Little Rock, AR