CCTC Joint Conference: A Great Success

The Council of Chairs of Training Councils Joint Conference, on the theme of “Training the Next Generation: Key Issues for Professional Psychology,” was held February 10 - 13 in Orlando, Florida. The Conference was jointly sponsored by all of psychology’s major training councils and included both joint plenary programming for all councils as well as council-specific programming unique to that professional domain. Prior to the Conference, the APA Commission on Accreditation provided Site Visitor and Self-Study training. The APPIC Conference Committee consisted of Drs. Arnold Abels (Chair), Steve McCutcheon, Marla Eby, Karen Hoffman, Sharon Berry, Teri Simoneau, and Executive Director Ms. Connie Hercey. The Joint Conference overall Program Chair was Dr. Robert Hatcher. The Joint Conference was a great success. Despite blizzard conditions in the eastern half of the U.S. which curtailed travel, there were nearly 600 attendees. The unexpectedly chilly, cloudy, and drizzly conditions in Orlando, however, served to deter registrants from wavering in their educational purpose; most sessions were very well attended.

Power point presentations from the joint programming of the Conference can be found on the CCTC website at www.psychtrainingcouncils.org. Presentations from the APPIC individual council program can be accessed on the APPIC website.

NOTE: Watch for details about the projected 2012 Joint Conference!!!

Here are some vignettes from this year’s Conference. See more photos on pages 4 and 5.

CCTC 2010 Conference: Returning from the recent CCTC 2010 Conference in Orlando, I am reminded of lyrics by Bob Marley: “Let’s get together and feel all right!” What an accomplishment this conference represented – 14 training councils working together toward a greater end! This union reflected several years of consensus building amongst the councils and is a credit to their leadership – individuals who helped shift gears and work together toward common goals. You will see reports from the conference in other areas of the newsletter and I encourage you to review programs and power point presentations on both the APPIC and CCTC websites for further information. There were many opportunities during the conference to meet with and learn from members of other training councils who share a common interest and vision with APPIC. I personally felt my own psychological shift at times, away from suspicion and criticism of others, to actively remembering that we are all interested in similar outcomes for the education and training community, and I worked to move beyond those automatic stereotypes and negative thoughts to an openness that was a mission of this conference. I heard from many others about the same process of moving to neutral so that the common goals could be heard. The Chairs of Councils of Training Councils (CCTC) will continue to expand on the conference outcomes to identify the next steps for building bridges, and continue to share responsibility for important issues such CONTINUED ON PAGE 6
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Genesys Regional Medical Center

- **SETTING-RELATED ISSUES**  
Robert H. Goldstein, Ph.D.  
Rochester, NY
In the past decade, the pursuit of postdoctoral residency training has burgeoned. APA has recognized new specialties and has accredited postdoctoral programs in those areas. The Department of Veterans Affairs has spearheaded the movement by greatly expanding postdoctoral funding and requiring APA accreditation of its programs. Clinical neuropsychology, through training conferences, established a two-year duration of postdoctoral training and other standards for that specialty. APPCN provides a membership group and computer match for residencies. Paralleling this expansion of programs has been the “competency” movement, delineating skill expectations for trainees/psychologists at different career points. Lists of competencies have proliferated within practice areas and the recently published APA Benchmarks gives some promise of codification of competencies.

In my view, the assumptions underlying the parallel development of postdoctoral residency training and delineation of competencies are based on an underlying assumption of quantity. That is, with more years of training, the trainee/psychologist acquires (1) more skills and, within each competency or skill area, (2) greater skill or adeptness, and (3) stronger skills. Perusal of faculty recommendations for internship and postdoctoral programs drives home the pervasiveness of these underlying assumptions. Moreover, the APA Commission on Accreditation Guidelines and Principles, adopted in 1996, clearly reflect the quantitative assumption. This is particularly evident in nearly point-by-point translation and transposition of internship standards to the standards for postdoctoral residencies. There is a rigid symmetry and mere substitution of one set of numbers for another in these sets of standards.

What is missing from these schemata is consideration of the professional identity development of the growing/developing trainee/psychologist. These approaches fail to account for this evolving identity. In particular, they fail to recognize that psychology...
skills/competencies, specific behaviors, standards, and attitudes are configurally and hierarchically organized and, as such, cannot be considered a quantitative sum of training hours or Likert-scale measured competencies. There is no change in professional status more illustrative of this – and given shorter shrift! – than the postdoctoral resident and residency training.

Undertaking a postdoctoral residency ordinarily entails at least three elements which serve to internally develop and reorganize professional identity. First, the resident has a doctoral degree, having completed the terminal academic degree in the field. This feels different. Apart from statutory details such as licensure, you are now a real psychologist, not a student or trainee. Although I wouldn’t claim empirical validation for this, I consider this observation to be evidence based. Second, the resident has also committed to, and embarked upon, specialty training which is clearly identified, demarcated, and is a differentiation from more generic practice and other specialty practice areas. This also entails identification with supervisor/mentor role models in the specialty area, further recasting the resident’s professional identity. Third, the competencies which are being strengthened or developed become re-organized concomitantly into a professional identity. In my opinion, this is transformative, analogous to the Piagetian processes of assimilation and accommodation. Some competencies become cardinal or superordinate. Other competencies become subordinate, do not continue development, or perhaps erode. The psychologist becomes, for example, a neuropsychologist, not just someone who sees more neurological patients, gives more and different tests, knows more about the brain, or has greater amounts of particular competencies.

Accordingly, in my opinion, the Commission on Accreditation, in their policy sessions, should begin to consider ways of reconceptualizing postdoctoral residency training in a manner that takes into account the alterations in professional identity and re-organization of existing, developing, and inchoate competencies which accompany that status. The current conceptualization, now over 15 years old, is basically quantitative and nearly point-by-point symmetric with the internship. It needs to be abandoned. Other APA initiatives, such as the very recent revision of the Model Licensing Act, recognize the status of the doctoral-degreed psychologist as ready for imminent licensure as a fully functioning and responsible generic professional. The Commission on Accreditation should acknowledge this, cease infantilizing residents, and develop a set of guidelines and principles for the residency that respects and realistically reflects their status as psychologists in advanced training. The time is now. [The opinions expressed here are solely those of the Editor, not those of APPIC or any other organization with which the Editor is associated.]
Dr. Jeanette Hsu chairs a breakout session of the VA Psychology Training Council.

David Shern, healthcare executive, gives keynote address.

Your e-Editor makes a presentation.

Dr. Gene D’Angelo

Dr. Bob Hatcher
as the match imbalance. I am further reminded of Michael Jackson’s lyrics from “We Are the World.” Let us realize that a change will only come when we stand together as one.

Programming for APPIC was outstanding, and once again we had an outpouring of exceptional workshops, presentations, and posters. Many thanks to Dr. Arnie Abels, Program Chair, who provided incredible leadership once again, along with the planning committee including Connie Hercey, APPIC Executive Director (without whom so much less would be accomplished), Marla Eby, PhD, Teri Simoneau, PhD, Lisa Kearney, PhD, and Karen Hofmann, PhD.

**2010 Match** The APPIC Internship Match Statistics are summarized elsewhere in the newsletter and I encourage you to review them carefully with an eye toward what needs to happen next. This year’s results were very similar to the 2009 Match with approximately 23% of all applicants (or 846 individuals) unmatched, with 278 positions unfilled on Match Day. By the time you read this newsletter, most of these positions will have filled through the Clearinghouse, and many of the applicants will have made arrangements for next year – complete their dissertation, obtain additional clinical hours, or broaden their experiences before the next Match. APPIC is hopeful that we will soon see a shift in the Match imbalance based on the steps being taken across the education and training community, with action steps identified by CCTC. Specifically, colleagues from a number of training councils worked collaboratively to organize resources in a common site: The Internship Development Toolkit – which can be found on both the CCTC and APPIC websites and will be a work in progress. We are hopeful that this toolkit will help programs in a variety of agencies work toward the development of internships that will meet APPIC membership criteria, and then move toward APA accreditation. In addition, the graduate training councils have agreed to take action toward the expectation that 75% of their students each year will match with an internship (this is also the basic expectation for any accredited doctoral program), and either reduce the number of students in their program or build internship positions accordingly. Long term, this concerted effort should play a significant role in altering the Match imbalance.

**Clearinghouse:** The APPIC Board has been working to identify alternative solutions to the Clearinghouse process. As you likely recall, I asked for email feedback in January regarding a proposal under consideration for the 2010 Match – to delay the opening of the Clearinghouse by one week to slow things down, allow for careful consideration of options, and avoid overwhelming both training directors and applicants on Match Day. APPIC Members were so generous with their time and thoughtful recommendations, and we had an outpouring of feedback from internship faculty, graduate training directors, and students (with over 200 individuals responding). However, we also realized that the timing was off and it might not make sense to try to incorporate a change so close to Match Day. Instead, we have reviewed the feedback and are now headed in a new direction – elimination of the Clearinghouse as we know it (soon to be a term that shall not be used!) and development of a second Match (or Match 2). We will present this information throughout the year to our internship and doctoral program members, with emphasis on education and answers to frequently asked questions, with the goal of implementation in 2011. We are hopeful that this change will fine tune the process, reduce the chaos experienced by many through the current clearinghouse process, and address concerns about who is able to utilize the Match process. Watch for this educational information in coming months through the APPIC listserv and website.

**Ongoing APPIC Resources:** In closing, I want to highlight ongoing APPIC resources available to you throughout the year!

- **EPP Journal** – we are very proud of the journal we share with APA and hope you continue to find this helpful in your daily work, and that you will consider contributing to this publication.
- **Informal Problem Consultation or IPC:** members of the APPIC Board continue to provide informal problem consultation to students, interns, postdoctoral fellows, graduate faculty, directors of graduate training, and internship or postdoctoral training directors. Our goals include protecting the integrity of the APPIC Match contract, maintaining quality control over the APPIC membership criteria, and general humanitarian assistance for students and training directors. Please contact me directly by email for IPC requests or find further information on the APPIC website (we are soon to implement a web-based form that we would like you to utilize when you request consultation).

- **APPIC Mentors:** mentors are available to you at any time, with veteran training directors willing to help you with various questions about internship development or other issues; contact Dr. Arnie Abels at abelsa@umkc.edu
- **AAPI Online:** the online application launched in 2009 earned rave reviews by all constituents, and valuable feedback from all will be incorporated in fine-tuning the application for 2010.
- **APPIC website:** we are updating the website so this will be user friendly and provide easier access to the numerous resources offered – check back often for updates and new material. In addition, you will now be able to pay APPIC dues online which might make it easier for many.
- **APA Convention in San Diego:** APPIC will host our annual Business Meeting (with breakfast provided) on Thursday, August 12, 2010! Please join us for this time together and watch for details on the website!
- **APPIC Conference:** Plan ahead for the next APPIC Conference in early 2012! As you read the newsletter and can see first hand the creativity of our members, please know how valuable your individual feedback is to the direction of APPIC. We rely on your investment in our annual surveys, and for your attendance at our bi-annual conferences, where we get a chance to meet you and learn what is most important to you. The education and training community is truly a partnership of individuals representing the entire spectrum of professional development, and innovations can only be identified when you speak up and help us to think outside the box. Stay in touch with the Board at any time and volunteer your time! I trust that you will find this involvement as gratifying as I have! You can reach me at any time at: Sharon.berry@childrensmn.org
We are pleased to report that 2,823 applicants were successfully matched to internship positions. A total of 46% of all applicants who obtained a position matched to their first choice internship program, more than two-thirds (68%) received one of their top two choices, and four-in-five (81%) received one of their top three choices.

A total of 846 applicants were not matched to an internship position, while 278 positions remained unfilled. The number of unmatched applicants this year was identical to the number seen in the 2009 Match.

Compared to the 2009 Match, the number of registered applicants increased by 65 (1.7%) to a record 3,890 applicants, while the number of internship positions increased by 50 (1.6%) to a record 3,101 positions. Furthermore, the number of accredited positions in the Match decreased by two, while the number of non-accredited positions increased by 52.

Here is a summary of the changes in numbers of applicants and positions as compared to the 2009 APPIC Match:

<table>
<thead>
<tr>
<th>Applicants:</th>
<th>Registered for the Match</th>
<th>+65</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Withdrew or did not submit ranks</td>
<td>-6</td>
</tr>
<tr>
<td></td>
<td>Matched</td>
<td>+71</td>
</tr>
<tr>
<td></td>
<td>Unmatched</td>
<td>No Chg</td>
</tr>
<tr>
<td>Positions:</td>
<td>Offered in the Match</td>
<td>+50</td>
</tr>
<tr>
<td></td>
<td>Filled</td>
<td>+29</td>
</tr>
<tr>
<td></td>
<td>Unfilled</td>
<td>-21</td>
</tr>
</tbody>
</table>

Following is an eight year comparison of the 2002 and 2010 Match statistics:

<table>
<thead>
<tr>
<th>2002</th>
<th>2010</th>
<th>8-YEAR CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Sites</td>
<td>610</td>
<td>674</td>
</tr>
<tr>
<td>Positions Offered</td>
<td>2,752</td>
<td>3,101</td>
</tr>
<tr>
<td>Positions Filled</td>
<td>2,410</td>
<td>2,823</td>
</tr>
<tr>
<td>Positions Unfilled</td>
<td>342</td>
<td>278</td>
</tr>
<tr>
<td>Registered Applicants</td>
<td>3,073</td>
<td>3,890</td>
</tr>
<tr>
<td>Withdrawn Applicants</td>
<td>231</td>
<td>221</td>
</tr>
<tr>
<td>Matched Applicants</td>
<td>2,410</td>
<td>2,823</td>
</tr>
<tr>
<td>Unmatched Applicants</td>
<td>432</td>
<td>846</td>
</tr>
</tbody>
</table>

INTERNSHIP PROGRAMS PARTICIPATION

| Training Sites Participating in the Match | 674 |
| Programs Participating in the Match | 1,176 |
| Positions Offered in the Match | 3,101 |

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

| Positions: | Filled in the Match | 2,823 (91%) |
| Remaining Unfilled | 278 (9%) |
| Programs: | Filled in the Match | 1,013 (86%) |
| With Unfilled Positions | 163 (14%) |

NOTE: 30 programs at 25 sites submitted fewer ranks than the number of positions available. As a result, no ranks were submitted for 58 positions, which remained unfilled.

APA or CPA Accredited Positions:

| Filled in the Match | 2,246 (97%) |
| Remaining Unfilled | 74 (3%) |
| Total | 2,320 |

Non-Accredited Positions

| Filled in the Match | 577 (70%) |
| Remaining Unfilled | 204 (30%) |
| Total | 781 |

Non-accredited positions represented 73.4% of all unfilled positions.

RANKINGS

Average Number of Applicants Ranked Per Position

| Programs Filling All Positions | 8.3 |
| Programs With Unfilled Positions | 2.8 |
| All Programs | 7.5 |

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

CONTINUED ON NEXT PAGE
**APPLICANTS PARTICIPATION**

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants Registered in the Match</td>
<td>3,890</td>
</tr>
<tr>
<td>Applicants Who Withdrew or Did Not Submit Ranks</td>
<td>221</td>
</tr>
<tr>
<td>Applicants Participating in the Match (includes 26 individuals who participated in the Match as 13 “couples”)</td>
<td>3,669</td>
</tr>
</tbody>
</table>

**MATCH RESULTS**

<table>
<thead>
<tr>
<th>Description</th>
<th>Number (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants Matched</td>
<td>2,823 (77%)</td>
</tr>
<tr>
<td>Participating Applicants Not Matched</td>
<td>846 (23%)</td>
</tr>
</tbody>
</table>

Match Results by Rank Number on Applicant’s List:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Number of Applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,295 (46%)</td>
</tr>
<tr>
<td>2</td>
<td>614 (22%)</td>
</tr>
<tr>
<td>3</td>
<td>373 (13%)</td>
</tr>
<tr>
<td>4</td>
<td>201 (7%)</td>
</tr>
<tr>
<td>5</td>
<td>135 (5%)</td>
</tr>
<tr>
<td>6</td>
<td>80 (3%)</td>
</tr>
<tr>
<td>7</td>
<td>52 (2%)</td>
</tr>
<tr>
<td>8</td>
<td>25 (1%)</td>
</tr>
<tr>
<td>9</td>
<td>14 (0%)</td>
</tr>
<tr>
<td>10 or higher</td>
<td>34 (1%)</td>
</tr>
<tr>
<td>Total</td>
<td>2,823 (100%)</td>
</tr>
</tbody>
</table>

**RANKINGS**

Average Number of Rankings Submitted Per Applicant:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matched Applicants</td>
<td>7.8</td>
</tr>
<tr>
<td>Unmatched Applicants</td>
<td>4.4</td>
</tr>
<tr>
<td>Overall</td>
<td>7.0</td>
</tr>
</tbody>
</table>

Each Position was Ranked by an Average of 8.3 Applicants

**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</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,034 (37%)</td>
</tr>
<tr>
<td>2</td>
<td>788 (28%)</td>
</tr>
<tr>
<td>3</td>
<td>486 (17%)</td>
</tr>
<tr>
<td>4</td>
<td>256 (9%)</td>
</tr>
<tr>
<td>5</td>
<td>127 (4%)</td>
</tr>
<tr>
<td>6</td>
<td>46 (2%)</td>
</tr>
<tr>
<td>7</td>
<td>33 (1%)</td>
</tr>
<tr>
<td>8</td>
<td>24 (1%)</td>
</tr>
<tr>
<td>9</td>
<td>12 (0%)</td>
</tr>
<tr>
<td>10 or higher</td>
<td>17 (1%)</td>
</tr>
<tr>
<td>Total</td>
<td>2,823 (100%)</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), 28% with “second choice” applicants, and so on.

Furthermore, 65% were filled with “first” or “second” choice applicants, while 82% 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.
2010 APPIC Match Statistics for Couples

This year, a total of 26 applicants participated as 13 “couples.” Eleven of these couples had both partners successfully matched to an internship program, while two couples had at least one partner who was not matched.

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

Following is a specific breakdown of the Match results for the 13 couples based on distance between matched programs:

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

INTERPRETATION NOTE: Most couples used the couples match in an attempt to be together during their internship year, and most tended to rank highly those program pairings that are located in the same geographic area. However, it should be noted that some couples had very highly-ranked program pairings that were hundreds or even thousands of miles apart, and some couples had very highly-ranked pairings where one partner chose to be unmatched. Thus, if a couple was matched to programs in distant cities or had one partner unmatched, we should NOT assume that this result was a lower-ranked pairing on their list.

Following are the Match results based on where a program pairing was ranked on couples’ Rank Order Lists:

<table>
<thead>
<tr>
<th>RANK</th>
<th># OF COUPLES</th>
<th>RANK</th>
<th># OF COUPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>11 to 15</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>16 to 20</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>21 and over</td>
<td>0</td>
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<tr>
<td>7</td>
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</tr>
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</table>

INTERPRETATION NOTES: 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. Three couples had Rank Order Lists that exceeded 100 pairs of programs, while one couple submitted more than 300 pairs of programs. One should not directly compare the results above with the results achieved by individual applicants (e.g., because 46% of individual applicants received their first choice, and 25% of couples received their first choice pairing, one should NOT conclude from this data that individual applicants “do better” than couples).

2010 APPIC Match Statistics for Applicants from Canadian Schools and Programs in Canada

The number of applicants from Canadian schools who participated in the APPIC Match this year increased by 4 (3%) to 134, while the number of positions in Canada decreased by 8 (6%) to 121. A total of 34 applicants from Canadian schools were not matched to an internship position, while 11 Canadian positions remain unfilled.

Here are the changes in numbers of applicants from Canadian schools and positions in Canada as compared to the 2009 APPIC Match:

Applicants:

| Registered for the Match | -2 (-1%) |
| Withdraw or did not submit ranks | -6 (-43%) |
| Matched                  | -12 (-11%) |
| Unmatched                | +16 (+89%) |

Positions:

| Positions Offered in the Match | -8 (-6%) |
| Filled                        | -2 (-2%) |
| Unfilled                      | -6 (-35%) |

APPLICANTS FROM CANADIAN SCHOOLS PARTICIPATION

| Applicants Registered in the Match | 142 |
| Applicants Who Withdrew or Did Not Submit Ranks | 8 |
| Applicants Participating in the Match (includes 0 individuals who participated in the Match as a “couple”) | 134 |

MATCH RESULTS

| Applicants Matched | 100 (75%) |
| To Canadian Programs | 90 (90%) |
| To U.S. Programs | 10 (10%) |
| Participating Applicants Not Matched | 34 (25%) |

RANKINGS

| Average Number of Rankings Submitted Per Applicant: |
| Matched Applicants | 6.4 |
| Unmatched Applicants | 3.8 |
| Overall | 5.7 |

INTERNSHIP PROGRAMS IN CANADA PARTICIPATION

| Training Sites Participating in the Match | 33 |
| Programs Participating in the Match | 55 |
| Positions Offered in the Match | 121 |

MATCH RESULTS

| Positions: |
| Filled in the Match | 110 (91%) |
| Remaining Unfilled | 11 (9%) |
| Programs: |
| Filled in the Match | 48 (87%) |
| With Unfilled Positions | 7 (13%) |

NOTE: 1 program at 1 site submitted fewer ranks than the number of positions available. As a result, no ranks were submitted for 4 positions, which remained unfilled.

POSITIONS FILLED

| Positions Filled by Applicants from Canadian Schools | 90 (82%) |
| Positions Filled by Applicants from non-Canadian Schools | 20 (18%) |
The Role of Direct Observation in Psychology Training

By David T. Smith, Lori E. Crosby, and Michelle M. Ernst
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Direct observation (DO) refers to a supervisor observing (i.e., in real-time or recorded) supervisee behaviors during the provision of clinical services for the purpose of evaluating supervisee’s clinical performance. The decision to critically examine DO as a supervision tool, which many might presume is a given standard in psychology training, was fueled by our psychology interns’ periodic reactions of surprise to being directly observed so often during the provision of clinical services at our Association of Psychology Postdoctoral and Internship Centers (APPIC)-member and American Psychological Association (APA)-accredited site. While interns understood fiscally-based requirements for DO (e.g., billing procedure necessitated supervisor’s presence), the frequent response has been that DO had not actually occurred for some time during previous training experiences, or was more appropriate for a first year graduate student. This was unexpected given research in the 1990’s that suggested that DO was one of the most utilized supervision modalities by clinical and counseling psychology programs (Romans, Boswell, Carlozzi & Ferguson, 1995).

While psychology training has moved toward a competency-based model for evaluating trainees (Kaslow et al., 2004; Hatcher and Lassiter, 2007), Kaslow and colleagues (2004) note that assessment of competencies should move away from a historical reliance on knowledge to a more comprehensive determination of whether an individual’s performance consistently meets the determined threshold for a competency. Consequently, contemporary evaluation strategies must not only document what a trainee knows but also what they actually do. Observing trainees’ work either directly via a one-way mirror or via audio or videotape review is a supervisory method that has received support in the literature with respect to helping trainees acquire skills and attend to the interpersonal process during assessment and therapy (Allen, 2007). However, the optimal amount of direct observation of a trainee’s clinic work needed by a supervisor, its role in evaluating the competency of psychology trainees, or its prevalence (Heckman-Stone, 2003) have not been clearly documented.

In an effort to better understand how, when and why DO is occurring during psychology graduate training, we asked our current and former interns and postdoctoral fellows to complete an informal survey. The survey asked them to indicate the amount of DO they received during their first four years of graduate school, internship year and postdoctoral fellowship year and reasons they did or did not receive DO. Twenty-three current/former interns and postdoctoral fellows completed the survey, the majority of whom were female (78.3%) and completed their internship at our large children’s hospital medical setting (78.3%). Responses indicated that all participants had some DO during their first year of graduate school. A decrease in the percentage of DO occurred from the first year of graduate school to fellowship with 20% indicating that they had no DO at all during their 4th year of graduate school, 10% indicating they had no DO during their internship year (most came from our training site) and 52% indicating they had none during their postdoctoral training. The most common purpose for DO was on-going assessment of skill level, although the purpose for DO varied across the sample (e.g., initial assessment of skill level, process-related feedback). Participants reported that the top 3 barriers to the use of DO were: supervisors’ perceptions that supervisee skills were too advanced, the supervisor seemed too busy, and equipment/space problems.

These data are rather consistent with the results of our informal survey with training directors conducted via the APPIC Listserv on the use of DO. Thirty-seven program directors (of which 22 programs trained practicum students and/or 31 programs trained interns) responded. Sixty-two percent of respondents reported that their trainees are directly observed conducting clinical work, with the most common response that it occurred 1-4 times per month per trainee. Results of both surveys highlight two important points: 1) DO is not always occurring (e.g. some trainees reported that they had not been directly observed during as early as their second year of graduate training) and 2) DO seemingly is often provided in the absence of a clearly defined rubric. In response, we examined some issues related to the use of DO in supervision and argue that the field would benefit from guidelines about the use of DO in psychology training and the further development of DO competency-based evaluation tools.

Barriers to the Use of Direct Observation

Current economic influences in training settings undoubtedly have played a considerable role in limiting the use of DO. The high cost of health care makes training an expensive endeavor that is rarely valued...
by third party payers of clinical services. DO is a non-reimbursable service and sometimes not permissible as a means to bill a professional fee when the service is provided by the supervisee. Supervisors may also need to take time outside of their own billable activities to watch trainees, and this may be discouraged or not feasible in a tight economic climate. Similarly, the cost of equipment may be a deterrent. For training settings with limited resources, it may not be feasible to purchase video taping equipment which would make it easier to conduct DO. In the same way, it may not be practical to build or redesign space to create treatment rooms which would allow supervisors to observe a trainee’s clinical work via an observation window. The inconvenience of setting up the equipment or arranging to be in the observation room may also be a deterrent. Furthermore, some supervisors may assume (accurately in some cases) that the trainee’s work has already been observed or is being observed by other supervisors.

Anticipated or perceived trainee anxiety likely remains another barrier; although there has been some evidence to suggest that when supervisors used a mirror and audio- or videotaping of the supervisee there were no significant differences in anxiety or performance by the counseling supervisee (Ellis, Krengel, & Beck, 2002). The reactivity factor (Kazdin, 1982) could also confound appraisals based upon DO because the supervisee might either perform better or worse than their true level of competence, simply because of their awareness of being observed. The potential effects of DO on the supervisor-supervisee relationship (Bernard & Goodyear, 2004) are worth considering in the larger perspective of effective training. It is likely that some supervisors may feel that requiring DO for their trainees will negatively impact the supervisory relationship by conveying a sense of distrust that the supervisee could do clinical work more autonomously. Undoubtedly, there are tensions between preserving the supervisory relationship, facilitating trainee growth, and maximizing patient care.

**Formative Evaluations Support Direct Observation**

DO has long been a part of formative evaluations of psychology training. During the beginning period of the quest to establish the efficacy of psychotherapy, the role of the therapist was quickly identified as a potentially key variable. The psycho-dynamic and humanistic trainers in particular focused upon the therapist’s interactive skills, prompting a variety of analyses of those clinical skills as well as assessment approaches to help develop and analyze them. Truax and Carkhuff (1967) were among the leaders as they worked on the concepts of showing empathy, non possessive warmth, and genuineness. Their Likert scales showed a continuum of sophistication for each strategy, and were a way to provide formative evaluation of supervisees. Bernard (2005), when historically reviewing the major developments in clinical supervision, highlighted the family therapy Zeitgeist of the late 1970s and early 1980s as an impetus for change about the structure of supervision due to the core role of “work samples” (i.e., DO of behavior) in the live supervision approach used in family therapy models (Kivlghan, Angelone, & Swafford, 1991). The DO used in live supervision within the context of family therapy facilitates trainees receiving immediate, in-the-moment feedback of their performance for skill enhancement.

Three prominent supervision models, the Cognitive-Behavioral Model, Developmental Models, and Social Learning Theory Models support the use of DO as an essential tool in evaluating trainee performance. Cognitive-behavioral supervision involves interventions similar to those used in cognitive behavioral therapy (Bernard & Goodyear, 2005). Cognitive-behavioral interventions target both thought processes as well as behavior change and share critical features such as careful assessment of baseline behaviors (including “internal” behaviors such as thoughts), specificity of goal setting in collaboration with clients (i.e., specifying criteria), clearly specified interventions, on-going and systematic monitoring of behaviors to guide treatment and evaluate outcomes (i.e., formative evaluation), and specific feedback using reinforcement principles (e.g., praising correct behaviors). The supervisee “behaviors” should be amenable to the same principles as any other behavior. Paramount to this supervision, then, is on-going assessment of behaviors in order to provide appropriate reinforcement and documentation of goal-reaching. While self-monitoring of behaviors is acceptable for the cognitive-behavioral model, more objective data is generally considered to have higher validity, especially given the discrepancy between self-report of behavior and observed behavior. Supervision based on the cognitive-behavioral model has been shown to be efficacious in changing supervisee behaviors (Milne & James, 2000).

Observing a trainee’s work is also a necessary tool for supervisors utilizing a developmental approach to supervision. Stoltenberg and colleagues’ (Stoltenberg, McNeill, & Delworth, 1998) Integrated Developmental Model (IDM), focuses on trainee’s progression through 3 levels in the areas of self-other awareness, motivation and autonomy. The IDM levels apply across numerous domains of professional behavior (e.g., intervention, assessment) and when the trainee is consistently at Level 3 for all domains and able to integrate skills learned across domains, they have reached the highest Level 3i (Integrated). IDM suggests that supervision during early levels of development needs to be more structured in order to decrease anxiety and enhance understanding of intervention processes. When trainees reach higher levels, supervisors can provide less external structure while facilitating trainee ability for to take ownership of their own growth and self-assessment. It is relatively easy to see the role that DO would have in Level 1, with the specific feedback enhancing development of clinical skills and specifying trainee behaviors that are on-target, thereby facilitating trainee confidence and move toward autonomy. At higher levels, when self-assessment is valued, DO would still have an
important role to assist soon-to-be independent practitioners make accurate self-assessment.

Social role models of supervision explore the role that supervisors play within the supervision context, such as teacher, consultant, or counselor, and how these roles determine the nature of supervision (Bernard & Goodyear, 2004). Similar to developmental models, the roles those supervisors take changes across trainee years of experience, with the teacher role most prominent with novice clinicians and the consultant role typically seen with advanced students. The supervisor is asked to help the trainee develop intervention skills (e.g., reflections, reframes and paradox). It appears that some level of DO would be required to ensure that the trainee is using these skills. Personalization skills refer to the trainer’s use of their person (e.g. nonverbals) in the therapy session. DO would be essential to helping trainees build up these skills. Thus, DO may arguably be necessary even at highly-sophisticated levels of performance. This is concerning if our trainee survey data are reflective of the larger field. In our survey, trainees reported the anticipated trend of less DO as training moves to more advanced levels, yet about half of them reported no DO at the most advanced level of training prior to independent practice (postdoctoral fellowship) when the need for accurate self-critique is becoming most critical.

**Summative/Competency Evaluations Support Direct Observation**

Kaslow et al. (2004) identified several core foundational competencies for psychologists. Two of the 2002 Competencies Workgroups identified Relationship as an important sub-competency (Supervision and Individual and Cultural Diversity). To achieve mastery in the Relationship sub-competency the trainee has to: 1) effectively respond to a client’s multiple identities, 2) be open to issues of power and diversity in the counseling relationship, 3) appropriately respond to an individual’s level of mistrust, 4) be present during times of conflict, and 5) adapt one’s behaviors to match those of the client. It would be extremely difficult for a supervisor to evaluate whether a trainee is competent in this Relationship sub-domain without observing the trainee interacting with clients. A work sample (e.g., videotape) would provide data about the trainees’ nonverbal signals, level of empathic responding, and reactions to client behaviors and attitudes; all essential components of being competent in therapy.

Cognitive-behavioral interventions frequently involve use of a manual, which implies a need for some DO evaluation of final competence due to the specific and detailed therapeutic guidelines published in these manuals (Bernard & Goodyear, 2004). The empirical literature emphasizes the need for treatment fidelity during these types of intervention trials in order to enhance scientific internal validity, especially when two interventions are tested against each other. In fact, processes to provide adequate supervision to research therapists, which ensure that therapists are adhering to i.e., demonstrating competence in) the specific treatments, have been detailed at length (e.g., Borrelli et al., 2005) and usually includes DO. It would be inconsistent if supervisors of trainees involved in clinical care outside of the research arena did not hold their supervisees to the same criteria.

**Direct Observation and Ethical/Legal/Professional Issues**

Clinical supervisors naturally have an ethical obligation to assure valid appraisals of their trainees in order to protect the profession and clients. Psychologists, for example, are ethically mandated to evaluate trainees on the “basis of their actual performance on relevant and established program requirements” (APA, 2002), which broadly implies some amount of DO. However, there are no specific mandates in APPIC (Association of Psychology Postdoctoral and Internship Centers, 2006) or APA accreditation (APA Committee on Accreditation, 2005) guidelines.

While DO is certainly helpful for supervisors to evaluate trainee's clinical performance, in this competency-based training climate it is increasingly important for trainees to monitor their own skills and attainment of competencies to ensure they are progressing towards licensure. Self-assessment methods have been encouraged for students (life-long professionals included) to further their developmental growth of clinical skills, but some evidence would suggest that self-assessments are not completely reliable (Constantine & Ladany, 2000). For example, O’Donovan, Bain, and Dyck (2005) concluded that student therapist self-ratings were unreliable compared with observers of their skills. The inconsistency between what one perceives their level of clinical skill development to be and what it may be actually observed to be implies a need for DO of performance. Pointing out these discrepancies can give trainees important insight into where their self-critique may be biased and may facilitate development of strategies to enhance accurate self-assessment, setting the stage to establish a life-long habit of self-regulation leading to improved client satisfaction ratings (Hill & Kellems, 2002).

The need for assistance in accurate self-evaluation may be particularly true for trainees working with diverse clients. Worthington et al. (2000) found that for graduate student therapists there was not a significant relationship between self-reported multicultural competence and others’ ratings of skills (Constantine & Ladany, 2000; Worthington et al., 2000). It may be that self-report measures and observer-report measures assess different constructs of individual and cultural diversity. DO may reflect actual behavior while self-report reflects anticipated behavior. As a result, Kaslow et al. (2004) recommend that training faculty use both self-report and observational measures (e.g., pre and post-test; post-test only) to evaluate trainee mastery of basic, intermediate or advanced skills in individual and cultural diversity. Even new approaches to summative evaluation (Allen, 2007) of cultural diversity (e.g. portfolio) include work samples (e.g. videotapes of sessions), suggesting that DO is crucial to evaluating competence in individual and
cultural diversity.

Some structured DO tools have been developed to assist in the evaluation of trainee competency. Kligler et al. (2007) developed an observational tool to evaluate the competence of family medicine residents. The instrument took 10 competencies and broke them down into observable behaviors. Observers were asked to rate medical residents’ performance of each of the behaviors. Behaviors were rated as emerging, established and integrated or DNO (did not observe). All residents were given a debriefing session after the observation which the authors felt helped residents reflect and work towards integration. Of course psychology has developed some of these tools, yet many of them are site-specific and lack psychometric rigor (Heckman-Stone, 2003).

DO, while long discussed in the training literature as a helpful strategy, has not yet been established as a standard of clinical supervision for trainees. For example, there is currently no place on the APPIC Application for Psychology Internship (AAPI) (Association of Psychology Postdoctoral and Internship Centers, 2008) form for applicants to list the amount of DO they have received (although a binary question exists of whether the student’s clinical work has been audio or video taped and reviewed in supervision). Other professions (e.g., medicine, education) have developed standards for DO and have tied the observations to competence. Stern, Friedman, Nocini, Wojtczak, & Schwarz (2006) recommended medical professionals have a minimum number of intakes, assessments, and consultations observed before they can be considered competent. This specificity may be wise guidance for psychology programs in developing training experiences and to ensure that all psychologists obtaining a training milestone have had their work directly observed.

Laws governing psychology licensure ostensibly support the use of DO in evaluation of trainees. For instance, many psychology state licensing laws require that the supervisor have “direct” knowledge of the supervisees’ clinical work if the training experience is to count towards licensure. As an example, Kentucky (Kentucky Legislature, 2005) emphasizes the need for regular supervision by requiring a certain amount of individual supervision meetings each week at the various levels of training and that supervisors “Have direct observation of the supervisee’s work at least once every two (2) months”. DO can be accomplished through audio taping, video camera, videotaping, a one way mirror, or as a co-therapist. However, even when minimum amounts and possible methods of observations are specified in state licensing laws, requirements on how long and how the observed behaviors should be handled are not (e.g., that DO needs to be conducted a certain percentage of client contact or to document competency).

Conclusions and Recommendations

The move toward competency-based training demonstrates the field’s strong value for producing clinicians who are verified as capable. If DO is not also valued as a critical component of formative and summative evaluations, we risk becoming a field of professionals who have a number of trainees taught by seminars/classes, the nebulous concept of experience, and supervision that mainly entails client conceptualizations, self appraisals, and indirect review of supervisee competence. We have briefly explored the role of DO in formative and summative evaluation; our conclusion is that there are strong theoretical, empirical, ethical, and legal supports for the use of DO in supervision. However, barriers to the use of DO such as the time involved, lack of reimbursement and lack of technological resources likely account for it not being collectively used in all levels of psychological training. We contend that the benefits of DO strongly outweigh any barriers as evidenced by research on clinical development, supervision and the prominent role of DO in the training of other professionals (e.g., physicians). Perhaps our field should work to ensure that all trainees receive some DO of their clinical work at all levels of training.

A first step to achieve this goal is to determine the prevalence of DO in training programs. Formal surveys are needed that assess how much DO is used at different levels of experience/training and in the different types of training programs. Studies examining the types of DO being used (e.g., audiotape, videotape, live supervision) and faculty and trainee preferences for DO would provide information about the benefits of DO. This research would give the foundation for more complex studies which could examine optimal levels of DO for specific levels of training (beginning, intermediate, and advanced). Research on the types of skills best evaluated via DO vs. self-report is also needed. It will also be important to determine if there are differences in clinical outcomes for clients seen by trainees who did or did not receive DO supervision.

Ultimately it would seem that there might be some minimum standards developed for duration and frequency of DO as well as the structure (e.g., utilization of clear criteria tied to clearly specified core competencies) for students at different levels of training. Should the rate and methods of DO be standardized, then trainees may react more positively when observed and be less concerned that one sample would skew their supervisors’ appraisals, and DO at all levels of training would likely decrease the initial discomfort often felt by trainees when observed. There is likely a minimum percentage of DO time needed to provide adequate training before licensure.

It may even now be beneficial if the number of DO hours applicants have previously had were recorded in application materials, rather than simply asking if they received taped DO. While the significance of this might be speculative (e.g., one could argue that some students with more hours of DO were weaker students who required close monitoring, rather than simply a reflection of good training), this information at least could help training sites prepare if a trainee had a small amount
of DO prior to coming to a site that uses a high amount. Having this information available might also help graduate programs determine if there is a relationship between the success of their matched applicants and the number of DO supervision hours received. In addition, if training sites are also required to report the amount of DO provided, this would likely help prospective applicants understand the type of supervision they will receive. Given the concerns related to the supervisor-supervisee rapport, we recommend even now that training sites voluntarily specify in their recruitment materials the amount of DO supervision provided by the site. DO may also be most effective if supervisors clarify the purpose of DO at the outset of training. This will decrease supervisee anxiety and focus DO as a feedback tool for enhancing the supervisee development as well as their final appraisals. The Veterans Administration training sites now have a requirement that a degree of proximity of supervision be specified for any trainee, which includes actually being in the room as the lowest or initial level (R. Goldberg, personal communication, October 26, 2009). Inter-rater comparisons within training sites and across supervisors can help with the identification of supervisee development or a need to resolve unreliable appraisals. When there is little observed evidence of gains, the supervisor is empowered to share DO evidence with the supervisee and discuss new options for behavior change or skill development. DO can assist supervisors to document trends over time, communicate problemat behaviors and determine trainee needs. The move toward competency-based training demonstrates strong value for producing psychological professionals who are clinically competent to implement that knowledge. If DO is not valued as an essential component of formative and summative evaluations, we risk becoming fields of clinicians trained largely by indirect methods of supervision and competency determinations based on knowledge rather than practice. We have argued here that DO would seem to be a mandatory component for assuring that competence has been obtained at all levels of training. Now more than ever, regular and intentional DO during training may be essential for the professional identity and integrity of psychological practitioners.

References


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APPIC’s Role in Specialty Education and Training: An Open Question

By Brad L. Roper, Ph.D., ABPP  Associate Editor for Neuropsychology | Email: Brad.Roper@va.gov

It was with pleasure and interest that I read an article by Nadine J. Kaslow, PhD, ABPP, past APPIC Chair (1999-2002) and current President of the American Board of Professional Psychology (ABPP), which appeared recently in The Specialist. (To access the article, go to www.abpp.org, click on “News” and select “The Specialist Winter 2010.”) In it, Dr. Kaslow articulated her firm commitment to both competency-based education and credentialing and underscored ABPP’s role in upholding standards of competency-based credentialing within the specialties. She also reviewed a strategic planning process on which she led the ABPP Board of Trustees (BOT) last December, envisioning the future of ABPP in the year 2020. She detailed agreement among BOT members that the vision for the decade should include a “culture shift within the profession,” such that ABPP board certification is expected for entry-level practice within psychology specialties.

Another part of ABPP’s vision is already widely accepted within clinical neuropsychology training, “...that students learn the value from their educators and trainers that board certification is the endpoint and they come to view board certification as accessible to them.” Several years ago, the most frequent goal stated by applicants to our neuropsychology emphasis internship position was to complete a two-year postdoc. Now, applicants also explicitly mention achieving board certification in clinical neuropsychology through ABPP. Why the change? In part it relates to the 2002 decision of the American Board of Clinical Neuropsychology (ABCN), our specialty board within ABPP, to endorse Houston Conference Guidelines. In so doing, they changed the eligibility criteria, such that those receiving a doctorate after January 1, 2005 would need to have training that conforms to Houston Conference Guidelines, including a two-year postdoctoral residency.

Linking specialty training guidelines to board certification is a necessary step in furthering board certification as the competency-based standard for specialty practice. But it doesn’t stop there. In no psychology specialty is board certification woven into the training curriculum like it is within the education of medical students and residents. Initial steps toward integration may be found, as the Association of Postdoctoral Programs in Clinical Neuropsychology (APPCN) has developed and periodically updates a written exam and oral fact-finding and ethics vignettes made available to APPCN member programs. These resources were designed to reflect the content of the ABPP exam in clinical neuropsychology. Furthermore, ABCN allows applicants to apply for board certification after completion of a two-year postdoctoral program. This potentially allows for an easy transition from formal training to board certification. However, typically graduates of clinical neuropsychology postdoctoral programs wait several years before seeking board certification, if they do at all.

Encouraging achievement of ABPP specialty credentials will require continued integration of competency-based training curricula with the process of board certification. Another aspect of the vision articulated by Dr. Kaslow is extremely important: that organizations hiring or employing psychologists expect specialty credentials and that such credentials will be tangibly reflected in terms of psychologists’ pay and reimbursement. Such measures would go a long way in expanding and encouraging specialty practice and credentialing.

At this point, I have some questions of the APPIC membership as well as leaders past and present. These are designed to encourage reflection and discussion about the future of professional psychology and APPIC’s role in it.

1. How has APPIC supported education and training in the specialties, especially at the postdoctoral level?

One obvious way that APPIC has supported specialties is via the designation of specialty-based columns, such as this one, in the APPIC eNewsletter. Some materials related to specialty accreditation have been posted on the APPIC website. APPIC has also maintained a liaison relationship with APPCN. Other reflections are informal: Members of APPIC’s leadership often have specialty credentials, and APPIC-member programs include many specialists. Furthermore, training that contributes to specialization is present within many APPIC internships and postdoctoral programs. But APPIC’s support of specialty training has been limited when weighed against its many other achievements and activities.

2. Should any reference to specialty education be included in APPIC’s mission? Although APPIC can claim much broader organizational representation of internships than it can postdocs, APPIC’s postdoctoral membership exceeds that of any other organization. Although much specialty training is done at the postdoc level, currently neither the APPIC mission or the twelve goals for its accomplishment make any mention of training within psychology specialties.

3. Should APPIC support achievement of specialty credentials and, if so, how? Part of the vision of ABPP articulated by Dr. Kaslow is “strong partnerships with all relevant professional organizations, including education, training, credentialing, employment, and psychology groups.” It is my hope that APPIC becomes an important part of such a partnership.

4. What should be APPIC’s role in education and training within psychology specialties?

From my admittedly limited perspective, there is great potential for APPIC to add to its many other important activities greater attention to specialty education and training. This could involve including specialty training in its mission and having that reflected in its organizational structure. It could also involve forging or enhancing relationships with organizations such as ABPP and the Council of Specialties in Professional Psychology as well as specialty-based training councils.

I recognize that opinions differ on issues related to specialization and APPIC’s role in it. I invite you to send your comments to me at the email address above, and I would also encourage further discussion on APPIC’s POSTDOC-NETWORK email list.
Tips for Trainers: Maturity and Dependency in Supervision

By Marla Eby, PhD

The experience of older supervisees in the training setting, particularly supervisees who have already obtained expertise in another profession, is often different from that of their younger counterparts. Such trainees are almost always seen as leaders in the hospital setting, but sometimes their leadership has a positive cast, and sometimes a negative one. Even more interestingly, this perceived leadership often is simultaneously viewed as both positive and negative, as in “This person has so much to offer, but...” and then there sometimes follows some complaint about the trainee talking either too much or too forcefully.

In a training setting, the goal of clinical supervision is to foster the development of the novice therapist or trainee so that this supervisee is ultimately capable of relatively independent practice. In other words, the supervisor hopes to enable the trainee to first become competent in a set of skills, and then confident in a sense of independence. The tasks then are both cognitive and interpersonal. It is hardly surprising then, that a host of theories about learning in supervision emphasize one or the other, and often both, of these traits (Worthington, 2006). On the cognitive side, some models emphasize the individual acquisition of skills. A variety of theories suggest alternatively, progressions from imitation to creative exploration, from basic listening skills to the application of therapeutic techniques, and from confusion to skills development and consolidation.

On the interpersonal side, models of supervisee development often emphasize the transition from a state of intense dependency to a state of relative independence. Such a “mothering” role for the supervisor can be highly appealing - one of the most valued objects in my office is a wooden box with an image of a mother duck followed by eight ducklings, given to me by eight psychology interns who clearly identified me with the mother duck. Theorists who discuss this dependency progression in supervision are numerous, and include models in which a preceptorship relationship is transformed into a mentorship and ultimately a peership. However, many models also posit a maturational progression: from an unsightful dependence to mastery and personal autonomy, from stagnation to a realistic sense of one’s abilities and limitations, and from a self-focus to a more reflective stance.

Models like these can feel helpful for clinical supervisors, particularly since many of us have had little in the way of theoretical or practical preparation for this daunting task. A hierarchy of skills to be taught, and expectations for the apprentice-like relationship, can be useful ground on which to stand. The recent emphasis on competencies in clinical training also appears consonant with such developmental models. Furthermore, it is important that there is a correspondence between the skills and competence of the trainee, and the level of independence in the risky business of treatment of sick patients, just like there would be if the trainee were flying a plane or conducting surgery.

However, that said, I find myself somewhat more troubled by the implications of the developmental line in trainees from dependency to autonomy than I am by the idea of a developmental line of skills. Part of my concern comes from the varieties of dependent behavior that supervisees already come pre-packaged with. Furthermore, the progression from dependence to autonomy is particularly value-laden in American culture, where the self-made man (and, even now the self-made woman) is accorded special respect. And maturity is too often linked with privilege. The house-owning supervisee seems more mature than the supervisee who is looking around for the cheapest apartment in town. The able-bodied supervisee can be more independent in practical matters than a supervisee who is partially sighted (and so can’t drive), or one who is confined to a wheelchair. Supervisees with certain characteristics that are traditionally related to dependency, such as high self-disclosure, emotional reactivity, and even gender, ethnicity, race, and relationship status may be perceived differently on this maturational spectrum, and their potential as a therapist may be linked to these judgments.

My arguments, then, with developmental models of supervision learning are as follows. First, these models are too often monolithic and simplistic, and fail to take into account the multiple contexts of learning. Second, these models fail to take adequate account of the many unique characteristics that each supervisee brings to both supervision and the work with patients. Third, in my view, developmental models are inherently judgmental and evaluative in a way that might actually hinder real growth. The very concept of developmental stages implies that everyone is on the same track, only in different (and therefore better or worse) positions.

So when we have an older trainee, do we have a disabled or flawed trainee who is “behind” according to age, or do we have a particularly spe-
cial and gifted trainee who can hop between two careers when most of us can only manage one? What is so interesting about the older trainee is not only what the trainee will develop into, but what this person – who has already in a sense grown up once, somewhere else – brings to the table. In coming to the new profession, the older trainee thus becomes the migrant trainee.

An image comes to my mind of the Galapagos. Imagine a bird, like one of Darwin’s finches, well-equipped for one island, journeying forth to a new land, with new requirements for adaptation. In a way, becoming a therapist is such a journey. As adult supervisees, we already have multiple adaptations to other places in our lives, and we bring all that – the baggage of all that, and the strength of all that – to supervision when we embark on the process of becoming a therapist. Furthermore, we never fully give all that up. We keep the characteristics of our old lives, and also develop new tools and ways of being for the new life. The model that I am thinking of, then, is less about developmental stages, and more about a migration and an adaptation.

What I have learned particularly from working with older trainees is that supervision should start with the assumption not that the supervisee is dependent, but that the supervisee is a dignified adult. The developmental model, with its emphasis on increasing autonomy and more mature behaviors, can lead to the idea that the unskilled therapist is somehow a less mature person. A worrisome corollary to this - and one that I have seen manifest all too often - is that the practice of doing psychotherapy is somehow seen as “better work” than other things a person might do. I think that these ideas are potentially dangerous. A modest advantage of the migration model is that the focus on adaptation is in parallel to the professional task of helping our patients, particularly our sickest patients. Beyond that, in this Galapagos-like model, the professional “island” of doing psychotherapy is just another island, to which the novice trainee must adapt with the help of the supervisor. We are not the “best island,” and we are not the “best people” for residing in that space. With such a metaphor, we are in a better place, I think, to help both our supervisees, and our patients, who need a therapist at their side, and not above them.


**Update from the Commission on Accreditation**

*By Richard J. Seime, Ph.D, ABPP*

**Chair, CoA**

I am writing this as the CoA is preparing for the first program review meeting of 2010 in April. We held our annual policy meeting in January, at which time the policy agenda was developed for 2010, orientation was provided to new members, and members were assigned to CoA policy and work groups. I have included a PDF of the Policy and Procedure Update-February 2010 that provides a summary of 2009 program reviews, the 2010 work and policy groups, and an update on implementation of recommendations from 2005 Accreditation Summit that called for conducting program reviews through specialized review panels.

I want to highlight progress made in matching program reviewer with programs especially with respect to internship and postdoctoral programs. The newly constituted postdoctoral program policy group has increased by 75%, and for internship programs the reviewer-program match has increased by about 30%.

The CoA devotes a good deal of time to policy issues. I want to highlight what the newly constituted postdoctoral policy group will be addressing this year. Postdoctoral program accreditation is the fastest growing sector for new programs seeking accreditation. It is also the “newest kid on the block” and there are issues at this level of training that are emerging as inter-
est in specialty training grows. Unlike internship programs, postdoctoral programs can be in traditional professional practice areas, specialty practice areas, or integrated as combinations of specialties and/or traditional practice areas (see Implementing Regulation (IR) - IR C-11). CoA is aware that there is need to further guidance concerning how currently accredited postdoctoral programs transition from a traditional program to one that may offer traditional and specialty training. Similarly, there is a need to clarify how emphasis tracks in traditional practice area postdoctoral programs integrate with overall program goals, objectives and competencies. We hope to have IR’s developed in 2010 to provide further definition and guidance for postdoc programs.

To again reiterate the role of IR’s, these are developed to provide clarification for the Guidelines and Principles for Accreditation of Programs in Professional Psychology. Before an IR that has implications for how programs are reviewed is adopted by CoA, there can be a period of public comment. The comments provided are considered in drafting the final language for any IR. These are posted at the Accreditation Public Comment website: http://apaoutside.apa.org/AccredSurvey/public/.

APPIC members are encouraged to comment upon two proposed IR’s currently out for public comment — Distance and Electronically Mediated Education in Doctoral Programs and another on Telesupervision. The period of public comment closes June 15, 2010.

I also want to remind you that after each CoA meeting, public minutes are drafted and these are posted on the APA accreditation website. We have also begun sending those newsletters directly to all training directors of accredited programs.

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**News from the Education Directorate at APA**

By Catherine Grus, Ph.D.
cgrus@apa.org

The joint training council meeting held by member organizations of the Council of Chairs of Training Councils (CCTC) in Orlando in February was an exciting event for all that attended and I am sure much will be written about it. The energy and ideas that resulted are likely to influence education and training in professional psychology for years to come. I am pleased to note APA’s involvement in supporting the meeting through its Bock Grant award program that is administered by the APA Board of Education Affairs (BEA). The organizers of this event applied for and received a grant of $8,000 to offset some of the costs associated with the meeting. Further, several APA staff and a member of the BEA were in attendance to participate in sessions and bring back some of the information and enthusiasm that was generated.

What made this event so special? Certainly, the fact that it had been ten years since the last joint training council meeting should be mentioned. Also, worth noting is the number of training councils representing professional psychology has grown in this interval, including the (re-invigorated) VA Psychology Training Council and the newest member to CCTC, the Council of Professional Geropsychology Training Programs (CoPGTP). While these are certainly noteworthy in and of themselves, perhaps one of the most exciting things about this meeting was to observe how the relationships between professional psychology training councils have evolved with time.

In recent years, the leadership of these groups through CCTC has increasingly been engaged in conversations and initiatives addressing substantive topics including the competency benchmarks, the internship match imbalance, and better understanding quality and the role of practicum training to name a few. The meeting in Orlando continued this evolution and took it to a new level by engaging the membership of these groups in combined conversations. These conversations were largely focused on how we can collectively continue to promote quality education and training in professional psychology. While each of these groups maintains individual priorities and focus, there is increasing recognition, as attested to in the programming and discussions at the meeting, of how mutual dialogue benefits us all and enhances the profession.

As educators we can and do shape the future of professional psychology through our curriculums and the training experiences we provide for our students. Opportunities such as the CCTC joint training council meeting allow us venues to discuss questions and share opinions about such topics as, are we preparing our trainees for the populations and settings they are likely to be employed in and do they have the requisite level of competencies needed to safely and effectively provide services, and to have these conversations with individuals who represent areas of education and training that we may rarely or never interact with. I am excited to think about the yield of these conversations in terms of the directions it may take professional psychology education and training.
n past columns in this newsletter, the author has written about the need for education and training, at the internship level, on patient risk of suicide and patient risk of violence. Over the past 25-30 years, there have been a number of surveys documenting how inconsistent this training has been for psychologists. Thus, Berman (1983) reported that the average amount of formal didactic training for psychologists in the assessment and treatment of suicidal patients was 2 hours; while Bongar and Harmatz (1990) conducted national surveys and found that only 40% of graduate programs in clinical psychology offered some formal training in the study of the suicidal patient. Kleespies, Penk, and Forsyth (1993) reported that an estimated 55% of a sample of former graduate students in clinical psychology had some form of didactic instruction on suicide during their graduate school years. The instruction, when given, was quite limited (i.e., one or two lectures). Ellis and Dickey (1998) found that psychology programs seemed to lag behind psychiatry programs in suicide-related training in most formats (e.g., seminars, journal clubs, case conferences, etc.); and, more recently, Dexter-Mazza and Freeman (2003) found that 51% of a sample of psychology interns reported attending psychology graduate programs that offered formal training in the management of suicidal patients. There appears to be a similar picture in terms of psychology education and training on the assessment and management of patient violence. Thus Guy, Brown, and Poelstra (1990) noted that the psychologists in their national sample had a mean of one hour of clinical training on the management of patient violence during their pre-doctoral years. When they examined training received after the doctorate, the mean was still only 2.3 hours.

Of course, a question that might very legitimately be asked is whether or not such training, were it to be provided more consistently, would actually be effective in improving the management of such high risk patients. In this regard, there was a study recently published by McNiel and his colleagues in two separate reports (McNiel, Chamberlain, Weaver, et al., 2008; and McNiel, Fordwood, Weaver, et al., 2008) that has a bearing on this question. In the study, the investigators provided a 5-hour workshop on evidence-based assessment and management of risk of violence and risk of suicide to a group of psychiatry residents and psychology interns. A comparison group attended a 3-hour workshop on the application of evidence-based medicine to psychiatry that was not focused on risk assessment for violence or suicide. The participants completed a pre-test and a post-test questionnaire about their education, training, experience, and perceived competence in risk assessment. They were also presented with case vignettes both prior to the workshop and following the workshop and, in each instance, they were asked to write a progress note that included a summary of the assessment and plan regarding the patient’s risk of violence or suicide. Their progress notes were rated independently by two clinicians who were blind to whether the notes were written prior to or after participation in the workshop. The raters used a structured content analysis based on variables from the literature on standard care in risk assessment for violence or suicide.

The findings for progress notes on both violence risk and suicide risk indicated that, after the training, participants were able to identify in a more systematic way the evidence-based variables that pertain to violence risk and suicide risk. They were also able to be more explicit about the significance of risk and protective factors when they developed plans for intervention to reduce risk. In relation to the comparison group, the training group’s improvements were described as substantial. Further, the risk assessment training was associated with increased confidence in risk assessment skill.

As the authors point out, this study clearly has limitations. It does not answer the question of the duration of the observed improvements, and it was not done in vivo with real-life cases. Nonetheless, it does offer evidence supportive of the notion that training in suicide risk assessment and violence risk assessment can be effective in improving performance.

Of course, the author of this column has long maintained that didactic instruction in suicide and/or violence risk assessment is only one component of training in evaluating and managing such behavioral emergencies (Kleespies, 2009). Thus, there is a distinction between training and stress training. As Driskell and Johnston (1998) have pointed out, most training, which is focused on skill acquisition and retention, takes place under conditions designed to maximize learning (e.g., a quiet classroom, practice under predictable conditions, uniformity of presentation). Some tasks, however, must be performed under conditions that include time pressure, ambiguity, a heavy task load, and distractions. The evaluation and management of behavioral emergencies in a clinical setting can involve such circumstances, and it can be difficult to maintain effective performance and decision-making when there has been no training under such high stress conditions. The author sees that as a primary reason for maintaining that the field of clinical psychology needs improved training in behavioral emergencies at the practicum and internship levels. It is where our
trainees and interns encounter real cases involving suicide and violence risk and where they can best integrate didactic and experiential learning while evaluating and managing such cases with supervision and mentoring.

References


International Issues

By Ian Nicholson, Ph.D.

Former Canadian Prime Minister, Pierre Elliot Trudeau, in a speech to the National Press Club in Washington in March 1969, summed up the relationship between Canada and the United States as such: “Living next to you is in some ways like sleeping with an elephant. No matter how friendly and even-tempered is the beast, if I can call it that, one is affected by every twitch and grunt.” This quote has lived on in the Canadian consciousness for over 40 years as it has remained the Canadian experience of relating with the United States.

This is certainly true when it comes to the issue of internships as well. For many years, Canadian doctoral and internship programmes have been watching the internship imbalance in the United States. We were not experiencing the same imbalance in Canada.

Now, the issue needs to be put in perspective. Canada, this year, had 134 individuals participating in the match and 121 positions available. Two years ago, there were 111 individuals participating and 127 positions.

There are geographic disparities. Toronto, the largest city in Canada currently has four doctoral programmes with applicants in the match but has only 16 accredited internship positions in the city. However, if graduate students are willing (and able) to move for the year, there are a number of high quality internship programmes in other parts of the country.

Last year, there were 20 Canadian positions filled by applicants from US programs and only 10 Canadian applicants matched in the US. This is consistent with two years ago when only 8 went south of the border while 19 came north.

While generally porous, the border does have some problems. Since the 2001 terrorist attacks in the United States, visa and immigration rules have appeared to become more stringent, making it more difficult for Canadians to enter to US programs. Also, many programs at federal government agencies, such as VA hospitals, are only available to citizens of the US.

However, coming north, many are Canadian citizens who have gone to the US to obtain their training (for a variety of reasons) and have not problems with immigration issues.

The latest set of statistics erupted a long-simmering set of concerns amongst Canadian programmes. We have been very closely watching the “elephant” next door, waiting to see if the factors that were affecting the US would soon affect Canada.

We have had an increase in the number and size of Canadian doctoral programmes with a fifth major program in Toronto that will soon have applicants in the match and a potential sixth in the making. Internship programmes have continued to be affected over the years by reduced funding (when money is tight, a training budget is an easy target), irrespective of their prestige and heritage.

We have been aware of the problems in the US caused by the imbalance but have been relatively untouched. However, this is not the case this year.

The Canadian Council of Professional Psychology Programmes has targeted this as an issue for study in the upcoming year and will have it as a major topic for discussion at this year’s Annual General Meeting. The regulatory body in Ontario, the College of Psychologists of Ontario, has initiated a review of the issue within the province. The president of the Canadian Psychological Association has also indicated that the creation of new internship positions is a goal for his year as president.

Many of us have watched closely the “elephant” next to, have felt every “grunt and twitch”, and have been prepared to react should the situation begin to arise. Our hope is that it is not the situation described by American philosopher, W. Allen, in his 1979 speech to the graduates “More than at any other time in history, mankind faces a crossroads. One path leads to despair and utter hopelessness. The other, to total extinction. Let us pray we have the wisdom to choose correctly.”
I have the distinct pleasure of working at Counseling and Psychological Services (CAPS) at UC Davis where our campus has been rocked by recent overt acts of hate. This quarter multiple swastikas have been spray-painted and marked across our campus community and our Lesbian, Gay, Bisexual, Transgender Resource Center (LGBTRC) was vandalized with graffiti. These events at UC Davis occurred in the midst of the “Compton Cookout” and ensuing noose and KKK hood incidents at UC San Diego. It seemed more and more reports of explicit hate crimes were occurring here, there, and everywhere.

What do you do when this type of hate hits so close to home? What do you do as a center, as a training program, as a university, as a therapist, as supervisor/trainer, as a person…? What do you do with your own reactions when you are asked to respond, to lead, to counsel, to teach, when you too have been impacted? When the cultural trauma is so…present? These are the questions we have been asking ourselves, struggling with and are still working through at UC Davis.

I urge you whether your campus is dealing with overt hate or your community is characterized by covert discrimination or your university is pleased with its level of multicultural inclusiveness -- to think long and hard and deeply about how you personally can be a part of the change that is needed in our world. How you might contribute toward creating understanding and healing and establishing an environment where every single person is valued and treated with dignity and respect.

I want to share with you a note I sent to my fellow staff members at CAPS during what felt like the height of chaos here. I am an African American woman and the Director of Training and I want to set the context in which the message was sent… I sent my email the same day I heard about the noose being found in the library at UC San Diego and reading a personal email account of the reaction of a Black male student on that campus to seeing the noose. I sent it the day UC Davis’ own LGBTRC was spray-painted, including the quote: “Gays Go 2 Hell.” I sent it within two weeks of a swastika being carved in a Jewish students dorm room and a week after I sent it three other swastikas were painted on our campus. In the message below you’ll hear “me” come through – my reactions, my suggestions about how to cope, as well as details about our response as a unit. What a growing and learning experience this has been.

To my colleagues and friends, To Our CAPS Family,

I wanted to send a personal note from me to you of encouragement. I want to encourage (in courage) ALL OF US during what feels like a difficult, intense, heavy, uncertain, and unsafe time on our own campus, within the UC system, and in the larger world.

The incidences of hatred on college campuses seem to be escalating (e.g., noose found hanging in UCSD’s library last week along with ongoing “Compton Cookout” issues; vandalism of our own LGBTRC this past weekend; swastika carved into a Jewish student’s dorm room door earlier in Feb.). I hope we can support one another, the students, and the larger community through these overt incidents meant to hurt and intimidate.

I acknowledge that I personally am impacted because of my identity as a Black woman. It has been painful to hear stories from other African and African-Americans who have been demoralized and traumatized by these incidents during Black History Month none-the-less. I assume other staff who are members of the groups who have been targeted may also be facing their own challenges/reactions. Regardless of whether or not you identify with the populations who have been the targets of these hate crimes, I know you are concerned as well.

I invite you to stand together in solidarity; to be allies and advocates for peace, justice, and equality; to speak with each other about these issues; to talk with students about what is happening. With every student I encourage you to open the door to a conversation about how they are feeling about the current climate on campus and what they may need to support them. AND please, please, please talk about this with students who you KNOW come from marginalized groups - because for some of them their sense of safety has been severely compromised. I know from facilitating a dialogue on campus last week (for about 50+ students, staff, faculty, and administrators), as well as speaking individually with students, that for some folks their feelings of despair, hurt, anger, hopelessness, and victimization are very high.

I know staff will be playing a role in the campus’ response to the vandalism at the LGBTRC on Monday evening (thanks). I am aware as well, that CAPS Cross-Cultural Committee will meet later this week and I’m sure we will be discussing these issues too. Although the agenda for the Diversity Dialogue scheduled for this Friday has a slightly different topic perhaps the discussion can be expanded.

I am hoping we can use these situations to talk even more openly here at CAPS. I know when Dr. Joe White presents we’ll have the chance to dialogue in small mixed groups (Trainees, CAN Staff, Senior Clinical Staff). I hope we will all be fully present for the CEU (physically, mentally and emotionally) and will take advantage of having the time and space to engage in the personal and professional discussion that will occur.

What good timing to be able to delve further into cultural competency and diversity issues as we are working within our current campus climate. On that note… thank you, for the role you have played and will continue to play in our growth and movement – as individuals, as a center and as a community. This is hard but important work!!!

In the spirit of community,
Kristee

This is a message of hope. A message of encouragement in spite it all. I share it with you with that same intention… may we all live IN COURAGE!

I welcome your comments, questions, and reactions. I can be reached at khaggin@ucdavis.edu
Setting-Related Issues:
Specialization for an Uncertain Future

By Robert H. Goldstein, Ph. D.

One of the issues currently being debated in the psychology education arena concerns the topic of how specialized our training programs should be. As we seek to define what competencies should form the basis of a graduate curriculum, the question arises of how early in the process should specialization be introduced. This matter was recently brought home to me in a particularly vivid manner when I attended a local psychology convention/meeting. Over dinner, I chatted with a number of former students and caught up on what it was that they were currently doing. This led to some further discussion about the careers of other former trainees with whom they had contact.

Now, I know that some training programs keep close tabs on the activities of trainees who have passed through that program’s training sequences. But it’s kind of easy to lose touch, particularly with those who chose to relocate and wander off into the hinterlands. So it was with much interest that I learned about what had happened to some of the students who had been the focus of so much training effort.

The surprising thing was how varied their careers turned out to be and how far a good number of them had diverged from their original goals.

One former post-doc, who had been a fine traditional clinical therapist in-the-making, ended up shifting into a research mode and had become a nationally visible leader in the field of clinical psychoneuroendocrinology. Another intern, who had excelled in the program despite a major sensory disability, had left the clinical psychology field entirely and had become a major entrepreneur in the development and sales of products for persons with a similar disability. Yet another post-doc, who had specialized in community psychology, was currently serving a vital role as a forensic evaluator for a particular type of offender. And another intern whose goal had seemed to be that of an adult clinician was now serving as an administrator in a residential and out-patient facility for acting out children.

So, what was going on here? Why were these folks not doing what we had been teaching them to do?

Well, perhaps it was really that they were doing what they had been taught. Psychology, I would argue, attracts some of our best and brightest young people, as well as some very bright people who may have been part way through another career before catching the psychology bug. And what they may have been learning as graduate students was how to apply their intelligence in a particular direction, to understand how to confront and analyze complex questions and how to think in creative ways. After all, every clinical encounter forces a trainee to grapple with the issue of how what they have learned can be applied to this unique individual. It is never the same. No matter how “manualized” some techniques may become, they really are not cookie-cutter situations. No two presenting situations or individuals come with the same history, context or perspective on the world.

Why should we, then, expect that these trainees would find their life paths to be leading exactly in the direction in which we or they may have originally been aiming? Add to this the fact that our contemporary society has changed dramatically from one in which an individual could expect to stay in one job or line of work for an entire career to one in which multiple employers and multiple career turnings have become the prevailing norm. And this is what we seem to be seeing in our field as well.

Obviously, I’m talking here about a modest size sample and undoubtedly someone somewhere (perhaps at the APA) has really looked at this matter more closely. But I’d be surprised if my impressionistic sense of this is entirely off base.

And finally, you might ask, what does all this have to do with the point with which I began? Well, does early or late specialization really make such a difference? Will the training focus we provide really determine what psychologists end up doing with their professional lives? That’s not so self-evident as we might think. It would be interesting for training directors to reflect on their own career paths. How many had anticipated during their graduate training, or certainly as an undergraduate, that at this point in your career you’d be responsible for overseeing the work of interns and post docs? I suspect relatively few had expected that this is what you’d be doing. And yet, whatever background you came from, here you are. This wasn’t something you specialized in.

I also suspect, with no real evidence to support that suspicion, (but why should that stop me) that most teachers and supervisors harbor a wish to reproduce themselves via their trainees, i.e. to bring along a new generation of psychologists who would be interested in the kind of professional activities that they themselves find meaningful and important. The fact probably is, however, that twenty years from now psychologists may be involved in entirely different things than is
the case today. Some of you may be sufficient long in the tooth to recall how hard and long you worked to learn how to administer, score and interpret the Wechsler-Bellevue IQ test, and then all the newer versions of it and then all the tests of cognitive functioning that came along afterwards. Will these still be around when your trainees are your age? It has been suggested that over the course of a generation, much of what is learned in graduate school turns out subsequently to be no longer relevant, useful or even true.

So, while we may eventually come to some consensus about the role of specialization in psychology training, the bigger question may be: does it really make a difference? More and more, psychologists are being urged to find a “niche” for themselves in some unique area of clinical actively, since what had been traditional practice skills may be on the way to extinction. The impact of managed care, the push to become part of an integrated clinical health team, the entry into many clinical service areas of lesser trained but cheaper mental health caregivers and the pressure of a changing economy may all come together to make psychological practices of the future very different from what we may be training people to do today. In the meantime, ensuring that young psychologists can learn to adapt to ever-shifting circumstances may be the most we can do to help them on their way.

NEW MEMBER INTERNSHIPS

California State University, Northridge, University Counseling Services
Northridge, CA

Santa Clara University Counseling and Psychological Services
Santa Clara, CA

DeKalb-Rockdale Georgia Network for Educational and Therapeutic Support
Lithonia, GA

Chicago School of Professional Psychology
Chicago, IL

BRAINS - Helen DeVos Children’s Hospital
Grand Rapids, MI

Minnesota Sex Offender Program
Moose Lake, MN

The Emily Program
St. Paul, MN

Western Carolina University Counseling and Psychological Services
Cullowhee, NC

East Carolina University, Brody School of Medicine
Greenville, NC

University of Texas at Arlington Psychology Consortium – Sante Center
Arlington, TX

University of Washington, Tacoma Student Counseling Center
Tacoma, WA