I am honored to be writing my first column as Chair of the APPIC Board, and want to start by highlighting the current and immediate past Board members who make significant contributions to the work of APPIC every day! Most importantly, I want to thank Steve McCutcheon who has served in this role for the past 4 years as one of the longest APPIC chairs ever, and who continues as my coach and mentor. Steve did a great job moving forward the vision of the APPIC Board, and has done so with an amazingly collaborative style, bringing together all constituents in the education and training community. In addition, I want to highlight the following individuals (current and former board members) who work tirelessly on behalf of APPIC for our internship and graduate programs, as well as the students for whom we advocate on a daily basis: Karen Taylor, Gene D’Angelo, Arnie Abels, Marla Eby, Jason Williams, Lisa Kearney, Joel Stocker, Mona Mitnick, Teri Simoneau, Jeff Baker, Jeanette Hsu, and Greg Keilin. I have learned tremendously from each of them and am grateful for their dedication and ability to see the forest for the trees! Last but not least, my thanks to our longstanding guide and Executive Director, Ms. Connie Hercey, who always has APPIC’s best interests at heart and I know she has my back!

I want to highlight the goals we are working toward and the major accomplishments of the past few years.

CONTINUED ON PAGE 4
ASSOCIATION OF PSYCHOLOGY POSTDOCTORAL AND INTERNSHIP CENTERS (APPIC)

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

CCTC/APPIC Conference
Let me urge you all to attend the 2010 Council of Chairs of Training Councils Joint Conference, scheduled this February 10-13, in Orlando, FL at Hilton Walt Disney World Resort. This conference will feature general and organization-specific offerings, via keynote and plenary sessions, paper/ presentation sessions, panel discussions, and council meetings. As new Chair-Elect of the VA Psychology Training Council, I had the privilege of attending the Council of Chairs of Training Councils semi-annual meeting and, for the first time, was able to observe first hand the collegial interaction of these organizations, as they work toward a coherent program and trajectory for professional education and training despite current obstacles such as funding. I urge you to attend this conference both for the content of knowledge to be gleaned and the opportunity to be energized and refreshed by your colleagues from different constellations and settings.

Submissions Still Solicited
We continue to seek suitable submissions to the e-Newsletter. In this era of long, labyrinthine, and low probability paths to publication, this venue still promises rapid editorial review and decision. For example, those of you contributing presentation proposals to the CCTC Joint Conference noted above should consider subsequently sending them to us. I know there are papers from last August’s poorly attended APA Convention that found few ears upon which to fall; give us a chance to more widely publicize your deserving contributions. Once again, submissions need not conform to APA style and should be sent to APPIC@aol.com, to my attention. Thanks very much in advance.

Associate Editors Wanted
Associate editorships are still solicited for Geropsychology, Forensic Psychology, and Consortia. These important areas are still underrepresented, and there is important news to be disseminated. E.g. the Council of Geropsychology Training Programs has been accepted as a member council of the CCTC, an important attainment recognizing the maturity of the field. The rest of us need to be updated on these events so, candidates, will you please come forward? You must be a supervisor of trainees in an APPIC Member program. Please e-mail your brief statement of interest with curriculum vitae attached to APPIC Central office, to my attention, at APPIC@aol.com.

Thanks to Dr. McCutcheon
I want to thank Dr. Steve McCutcheon, APPIC Past Chair, for his many years of column contributions to this newsletter. Along with Dr. Nadine Kaslow, I believe he shares the record for most Chair’s Columns published. Steve is ably succeeded by Dr. Sharon Berry, who in recent years has served triple duty as Health Psychology Associate Editor, and author or co-author of the “APPIC Members as Advocates”, and “Ask CoA” columns. Her first contribution as Chair graces our front page.

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

APPIC E-NEWSLETTER  November 2009 Volume II Number 2  PAGE 2

IN THIS ISSUE

APPIC Holds Annual Meeting at APA.........................Robert W. Goldberg.................1

SPECIAL ARTICLES

2009 APPIC Match Survey of Internship Applicants...............Greg Keilin .................5

Enhancing Neuropsychology Education and Training
Guidelines: Are We Ready?.........................................................Brad L. Roper...........12

Healthcare Reform – Teamwork Improves
Opportunities for All......................................................Jennifer Beard Smulson.........14

The “APPIC Match” Song..................................................... ‘Selection Vampire & Vampiress’.........16

ALSO IN THIS ISSUE

Remarks from the e-Editor
Remains from the e-Editor.........................................................Robert W. Goldberg.................3

Tips for Trainers: When Bad Things Happen
to Good Trainees.........................................................Maria Eby .................15

Ask CoA........................................Nancy Elman & Jeff Baker, & Joyce Weinberg-Kage.........17

News from the Education Directorate...............................Catherine Grus .............19

Associate Editors....................................................Philip Keesies, Ian Nicholson, ........20

Yoon K. Jung, James M. Stedman, and Robert H. Goldstein

APPIC E-NEWSLETTER  November 2009 Volume II Number 2  PAGE 3
This survey of applicants who were regis-
tering for the 2009 APPIC Match after being con-
ducted via the internet between February 25 and 20, 2009. All 3,825 applicants who registered for the APPIC Match sent were sent an e-mail message (along with two reminder e-mails) about the availability of the survey at a specific internet address. A total of 2,674 internship applicants (70%) completed some or all of the survey.

Results of the survey are presented below. Missing data and “Not Applicable” responses were eliminated, and percentages do not necessarily total 100% due to rounding. Some survey items requested opened-ended comments about the AAP, APPIC Directory Online, the Match, etc. that are not reported below; however, these anonymous comments were reviewed by the appropriate APPIC Board and/or committee members who are responsible for each area.

Some of the more interesting findings from the survey include:

1. COST: The average cost of participating in the selection process was essentially unchanged this year. This compares to a 11.0% increase from 2007 to 2008 and a 1.7% increase the previous year.

However, it should be noted that the average cost of submitting applications for the 2009 Match increased 17.9% from 2008 to 2009.

As seen in previous years, the cost of participation varied dramatically across applicants. While the average applicant spent $1,705 (SD= $1,496, median = $1,300), many applicants spent considerably less while an average of 14.7 internship applications (see question 20). Submitting applications submitted, the number of interviews received was unchanged from last year.

In terms of a longer-term trend, the number of submit-
ted applications between 1999 and 2003, from 138 to 121, and has been steadily rising since 2003.

3. DEBT: Applicants reported their mean debt related to graduate level study in psychology was $75,235 (SD= $65,782, median-$70,000) at the time of the survey (see question 11). More than one-third (38%) reported a debt exceeding $100,000.

Please note that these figures do not include any addi-
tional debt that these applicants may accrue during the

remainder of their graduate training (e.g. during intern-
ship).
2. Degree Sought
Ph.D. 1254 50%
Psy.D. 328 12%
Ed.D. 263 9%
Other 8 0%

NOTE: Of the six who designated "other" reported that they were respecializing.

3. Is your doctoral program APA- or CPA-accredited?
Yes 2534 95%
No 127 5%

4. Location of your doctoral Program
United States 2526 95%
Canada 116 4%
Other, please specify 17 1%

5. Is your program housed within a religiously-affiliated institution?
Yes 409 15%
No 2243 85%

6. Please select the training model of your DOCTORAL program (as you specified on your AAPI):
Scientist-Practitioner 1255 47%
Practitioner-Science       97 4%
Research Practitioner       1030 39%
Local Clinical Scientist    56 2%
Practitioner-Scholar        1255 47%
Scholar-Practitioner        1030 39%
Scientist-Practitioner       1255 47%

7. Including the current (2008-2009) academic year, how many years have you been enrolled in your current doctoral program (excluding any time spent in other doctoral or masters programs):
This is my 2nd year 28 1%
This is my 3rd year 355 13%
This is my 4th year 1177 44%
This is my 5th year 724 27%
This is my 6th year 246 9%
This is my 7th year 91 3%
This is my 8th year 23 1%
This is my 9th year 8 0%
This is my 10th year 6 0%
This is my 11th year or later 0 0%

8. Please check the item that best describes your status PRIOR to entering your CURRENT doctoral program:
I had NO prior graduate-level training 1551 58%
I had a Master’s degree in psychology 610 23%
I had a Master’s degree in a mental health field other than psychology (e.g., counseling, social work, marriage and family) 226 8%
I had a Master’s degree 226 8% in an unrelated field
I had been enrolled 77 3% in a Master’s program in psychology but did not receive a degree
I had been enrolled 11 0% in a Master’s program in an unrelated field but did not receive a degree
Other, please specify 72 3%

9. Including yourself, how many students began your current doctoral program in the same academic year in which you were admitted? Please estimate if you don’t know the exact number.
Mean = 22.2 Median = 22.8 SD = 22.8 Mode = 8
1-10 1183 44%
11-20 543 20%
21-30 339 13%
31-40 167 6%
41-50 101 4%
51-60 104 4%
61-70 65 2%
71-80 42 2%
81-90 33 1%
91-100 53 2%
101 or more 25 1%

10. Including yourself, how many students from your current doctoral program applied for internship this year? Please include all students who initially applied, regardless of whether or not they stayed in the process or were successful in locating an internship position. Please estimate if you don’t know the exact number.
Mean = 18.8 Median = 13 SD = 20.6 Mode = 8
1-10 1315 50%
11-20 574 22%
21-30 263 11%
31-40 169 6%
41-50 95 4%
51-60 39 1%
61-70 43 2%
71-80 40 2%
81-90 43 2%
91-100 24 1%
101 or more 21 1%

11. Please estimate the total amount of DEBT that you have accrued to date as a consequence of attending GRADUATE SCHOOL in PSYCHOLOGY, including tuition, fees, living expenses, books, etc. Please include all forms of debt such as student loans, credit cards, personal loans, etc. Please DO NOT include undergraduate debt or debt that is unrelated to your graduate training.
Mean = $75,235 Median = $70,000 SD = $65,782 Mode = $0
$0 484 18%
$10,000 202 8%
$20,000 153 6%
$30,000 120 5%
$40,000 118 4%
$50,000 113 4%
$60,000 118 4%
$70,000 110 4%
$80,000 122 5%
$90,000 99 4%
$100,000-$140,000 381 22%
$150,000-$190,000 263 10%
$200,000-$240,000 130 5%
$250,000-$290,000 28 1%
$300,000-$400,000 4 0%
$400,000-$500,000 0 0%
$500,000-$600,000 0 0%
$600,000 or higher 0 0%

12. Which of the following internship programs would be considered acceptable to your doctoral program? Please check all that apply.
An accredited internship program 2613 98%
An APPIC-member internship program that is not accredited 1508 56%
An internship program that is NOT accredited and NOT and APPIC member 685 26%
An unpaid internship program 877 33%

13. Please check the item that applies to you (please respond even if you withdrew from the Match or did not submit a Rank Order List) If this is your FIRST time participating in the Match 2471 93%
If this is your SECOND time participating in the Match 178 7%
If this is my THIRD time participating in the Match 12 0%
If this is my FOURTH time 1 0%
Other 4 0%

14. Were you matched to an internship program by the APPIC Match? (i.e., did your official notification from National Matching Services (NMS) indicate that you were successfully matched to an internship program?)
Yes 2110 79%
No 491 18%
Withdrawn 10 0%
No ranking submitted 73 3%

NOTE: These results suggest that unmatched applicants and those who withdrew or didn’t submit Rank Order Lists may be underestimated in this survey.

15a. The materials and instructions provided by National Matching Services (NMS) were clear and comprehensive.
Strongly Agree 1607 60%
Agree 919 34%
Neutral 97 4%
Disagree 36 1%
Strongly Disagree 12 0%

15b. The registration process with NMS went smoothly.
Strongly Agree 1987 71%
Agree 670 23%
Neutral 60 2%
Disagree 27 1%
Strongly Disagree 14 1%

15c. The submission of my Rank Order List to NMS went smoothly.
Strongly Agree 993 77%
Agree 550 21%
Neutral 31 1%
Disagree 7 0%
Strongly Disagree 14 1%

15d. NMS was responsive to my questions and concerns (choose “N/A” if you never contacted NMS).
Strongly Agree 304 99%
Agree 142 47%
Neutral 45 9%
Disagree 12 2%
Strongly Disagree 14 5%
Not Applicable 1 0%

16. In general, my doctoral program faculty provided a high level of support for my internship application and interview experience.
Strongly Agree 933 35%
Agree 884 33%
Neutral 349 13%
Disagree 355 13%
Strongly Disagree 146 5%
Not Applicable 1 0%

17a. Which of the following statements is true about you?
Yes 83 3%
No 2545 96%
Unsure 15 1%

17b. I worked closely with other students in my program throughout the process (e.g., sharing information, giving and receiving support)
Strongly Agree 945 35%
Agree 888 33%
Neutral 345 13%
Disagree 330 12%
Strongly Disagree 149 6%
Not Applicable 10 0%

17c. I took the selection process very seriously (i.e., I worked hard on my application, invested much time and energy, etc.)
Strongly Agree 2224 85%
Agree 1294 48%
Neutral 591 21%
Disagree 5 0%
Strongly Disagree 6 0%
Not Applicable 2 0%
17d. I attended local or national workshops that focused on the internship selection process.

- Strongly Agree: 325 (12%)
- Agree: 457 (17%)
- Neutral: 146 (5%)
- Disagree: 513 (19%)
- Strongly Disagree: 899 (34%)
- Not Applicable: 323 (12%)

17e. I used reference materials e.g., the APA’s workbook, other books to educate myself about the internship selection process.

- Strongly Agree: 1068 (40%)
- Agree: 811 (30%)
- Neutral: 263 (10%)
- Disagree: 327 (10%)
- Strongly Disagree: 87 (3%)
- Not Applicable: 87 (3%)

18. To how many internship sites did you apply, i.e., how many separate internship applications did you submit?

- Mean = 14.7
- Median = 15
- SD = 5.4
- Mode = 15

For comparison purposes, the mean numbers of submitted applications in previous years were:

- 2008 Match: 13.9 applications
- 2007 Match: 13.4 applications
- 2006 Match: 12.9 applications
- 2005 Match: 12.4 applications
- 2004 Match: 12.1 applications
- 2003 Match: 12.1 applications
- 1999 Match: 13.8 applications

19. Considering ALL of the sites to which you applied, how many did NOT notify you of your interview status (e.g., received an interview, no longer under consideration) or before the “interview notification date” listed in their APPIC Directory information? For example, if all of your sites notified you in a timely manner, choose “0”.

- Mean = 4.2
- Median = 0
- SD = 2.4
- Mode = 0

**NOTE:** A total of 55.9% of applicants reported being properly notified of their interview status by all sites to which they applied.

20. How many interviews (telephone or on-site) were you offered?

<table>
<thead>
<tr>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.4</td>
<td>6</td>
<td>3.8</td>
<td>3</td>
</tr>
</tbody>
</table>

21. How many programs did you indicate on your final Rank Order List (i.e., how many program code numbers were listed)?

<table>
<thead>
<tr>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Mode</th>
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<tbody>
<tr>
<td>7.0</td>
<td>6</td>
<td>4.5</td>
<td>5</td>
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</table>

**NOTE:** Use caution when comparing these numbers with the results from questions 18-20, since some sites used multiple program code numbers.

22. Did you participate in the Match with another person as a “couple” (i.e., by using special matching procedures to submit pairs of rankings)?

- Yes: 39 (1%)
- No: 2622 (99%)

23. APPIC would like to know how much money you spent on various aspects of the application and selection process.

APPLICATION COSTS involve preparing and submitting applications to sites, and may include such items as obtaining official copies of transcripts, printing, copying, air and overnight mailing, etc. TRAVEL COSTS may include such items as air or train fare, care rental, taxi, gasoline, hotel, etc. OTHER COSTS may include such items as your Match registration fee ($110 or $140), clothing costs, phone calls, etc.

Please enter your BEST ESTIMATE of the dollar amount spent, digits only, in each of the following areas (e.g., one hundred dollars would be entered as simply 100):

**TOTAL COSTS**:

<table>
<thead>
<tr>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Mode</th>
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<tbody>
<tr>
<td>1,703</td>
<td>1,496</td>
<td>130</td>
<td>300</td>
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</table>

**APPLICATION COSTS**:

<table>
<thead>
<tr>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Mode</th>
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<tbody>
<tr>
<td>256</td>
<td>224</td>
<td>200</td>
<td>200</td>
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</table>

**TRAVEL COSTS**:

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<tr>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Mode</th>
</tr>
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<tbody>
<tr>
<td>1,276</td>
<td>1,314</td>
<td>900</td>
<td>2,000</td>
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</table>

**OTHER COSTS**:

<table>
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<tr>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Mode</th>
</tr>
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<tbody>
<tr>
<td>291</td>
<td>280</td>
<td>220</td>
<td>200</td>
</tr>
</tbody>
</table>

24. Location of the internship program to which your were matched:

- United States: 1979 (95%)
- Canada: 98 (5%)
- Other: 5 (0%)

**NOTE:** All five who designated “Other” reported being matched to an internship site.

25. Were you matched to a program that is CURRENTLY accredited by APA (American Psychological Association)?

- Yes: 1,721 (82%)
- No: 366 (18%)

26. Were you matched to a program that is CURRENTLY accredited by CPA (Canadian Psychological Association)?

- Yes: 179 (9%)
- No: 1,837 (91%)

27. Regardless of your new internship program’s accreditation status, is that internship program a CURRENT member of APPIC? (APPIC Members are listed in the APPIC Directory Online)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>2057</td>
<td>17</td>
</tr>
</tbody>
</table>

28. Is your new internship position:

- A one-year, full time internship experience: 2058 (99%)
- A two-year, half-time internship experience: 11 (1%)
- Other: 17 (1%)

29. Please enter the approximate amount of the annual stipend/salary for your position (e.g., if your stipend is $12,000 for the year, enter “12000”, if unfunded, enter “0”). Please estimate if you don’t know the exact amount.

<table>
<thead>
<tr>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Mode</th>
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<tbody>
<tr>
<td>23,36</td>
<td>23,000</td>
<td>5,990</td>
<td>24,000</td>
</tr>
</tbody>
</table>

The mean salary represents a 2.6% increase as compared to 2008.

30. Please select the setting(s) that best describe the internship program to which you were matched (please check all that apply):

- Armed Forces: 811 (30%)
- Medical Center: 412 (14%)
- Child/Adolescent Psychiatric/Pediatrics: 334 (12%)
- Community Mental Health Center: 356 (14%)
- Corrections Facility: 385 (15%)
- Hospital: 356 (17%)
- Correctional Facility: 206 (8%)
- Private General Hospital: 135 (6%)
- Private Outpatient Clinic: 105 (4%)
- Psychiatric Hospital: 73 (3%)
- School: 52 (2%)
- Community Mental Health: 48 (2%)
- Other: 5 (0%)

31. What was the rank of the program to which you were matched? (please see the 2009 APPIC Match Statistics for the information)
44. IF YOU ANSWERED “YES” TO QUESTION 42: Which of the following best describes your geographic restriction?

A single city or town, or within a 100-mile radius of a city/town 421 (32%)
State/Province 170 (13%)
Region of the Country 583 (44%)
Other 160 (12%)

45. We would like to know the TOTAL NUMBER OF PRACTICUM HOURS that you reported on your AAPI. This includes all of your practicum hours, including doctoral hours and hours accrued in a terminal masters program.

In Section 2, Item 3, “Summary of Practicum Hours,” please look in the right-most column, TOTAL COMPLETED HOURS, and enter the hours listed for:

- Intervention and Assessment: Median =800 n=2208
- Supervision: Median =338 n=2193

NOTE: Intervention and Assessment hours increased by 1.7% from the 2008 Match, while Supervision hours decreased by 7.7%.

APRPC advises applicants to interpret these numbers cautiously.

Applicants should NOT assume that the numbers of practicum hours listed above are necessary to successfully obtain an internship, as many Training Directors have told us that they consider these numbers to be one of the less important aspects of an application.

46. For each of the following populations, what was the total number of supervised integrated psychological reports that you reported on your AAPI? This information can be found in Section 4 of the AAPI (“Test Administration”), Item 4.

- a. Adults: Median=7 n=2157
- b. Children/Adolescents: Median=5 n=2074

NOTE: Respondents who left the item blank were excluded from the calculation. Only medians were reported, as means and standard deviations were greatly affected by a few applicants who reported an extremely large number of integrated reports.

47. Please check ALL settings below in which you completed PROGRAM-SANCTIONED clinical experiences/pracica prior to November 1, 2008. Please exclude any clinical experiences that were not program sanctioned, such as work experience.

- Child Guidance Clinic 165 (7%)
- Community Mental Health Center 1267 (54%)
- Department Clinic (psychology clinic run by a department or school): 1252 (53%)
- Forensic / Justice Setting 481 (20%)
- Medical Clinic/Hospital 974 (41%)
- Inpatient Psychiatric Hospital 711 (30%)
- Outpatient Psychiatric Hospital 502 (21%)
- University Counseling Center/Student 807 (34%)
- Mental Health Center Schools 686 (29%)
- VA Medical Center 304 (13%)
- Other 996 (25%)

48. Please designate when you completed (or intend to complete) your doctoral comprehensive/qualifying/preliminary examinations:

- Not applicable 87 (4%)
- Prior to submitting internship applications 2166 (91%)
- Prior to attending internship interviews 39 (2%)
- Prior to the ranking deadline for the Match 15 (1%)
- Prior to the beginning of internship 66 (3%)
- During the internship year 6 (0%)
- After the completion of internship 7 (0%)

49. Please designate when your proposal for your dissertation or doctoral research project war or will be approved:

- Not applicable 17 (1%)
- Prior to submitting Internship applications 1766 (74%)
- Prior to attending internship interviews 116 (5%)
- Prior to the ranking deadline of the Match 65 (3%)
- Prior to the beginning of the internship 392 (16%)
- During the internship year 26 (1%)
- After the completion of internship 1 (0%)

50. Please designate when the final defense for your dissertation of doctoral research project occurred or will occur:

- Not applicable 65 (3%)
- Prior to submitting internship applications 84 (4%)
- Prior to attending internship interviews 22 (1%)
- Prior to the ranking deadline for the Match 6 (0%)
- Prior to the beginning of internship 1047 (44%)
- During the internship year 1060 (44%)
- After the completion of internship 101 (4%)

51. How many publications were listed on the Curriculum Vitae that you submitted to internship sites? (Please estimate if you don’t know the exact number).

- Mean =3.1 Median =1 SD =3.1 Mode =0
- None 1078 (46%)
- 1 1024 (44%)
- 2 1320 (56%)
- 3 to 9 1727 (72%)
- 10 to 14 58 (2%)
- 15 to 19 14 (1%)
- 20 or more 8 (0%)

52. How many of these publications are PEER REVIEWED JOURNAL ARTICLES and are either IN PRESS on IN PRINT? (Please estimate if you don’t know the exact number).

- Mean =1.3 Median =0 SD =2.2 Mode =0
- None 1268 (56%)
- 1 243 (11%)
- 2 287 (13%)
- 3 174 (8%)
- 4 87 (4%)
- 5 to 9 142 (6%)
- 10 to 14 16 (1%)
- 15 to 19 5 (0%)
- 20 or more 3 (0%)

53. How many presentations were listed on the Curriculum Vitae that you submitted to internship sites? (Please estimate if you don’t know the exact number).

- Mean =3.4 Median =3 SD =5.8 Mode =0
- None 490 (21%)
- 1 267 (11%)
- 2 231 (10%)
- 3 208 (9%)
- 4 130 (6%)
- 5 to 9 553 (23%)
- 10 to 14 287 (12%)
- 15 to 19 111 (5%)
- 20 or more 87 (4%)

### Coming Soon!

**Psychology Internship Development Toolkit!**

This resource was developed through a collaborative effort of individuals representing training council members of the Council of Chairs of Training Councils (CCTC). This effort is part of a comprehensive plan to address the match imbalance. The roll out will take place during the 2010 Combined CCTC Conference with the 14 training councils, and links will be available on the websites of all the councils plus CCTC!
the purpose of updating, expanding, an Interorganizational Summit on
In 2006 to discuss the need for
(NAN) met at the APA conven
is needed. Accordingly, representa
ues to develop, periodic evaluation
that training in the specialty is based
achievement was to clearly articulate
Another
ments of HC was reaching consensus
ment has served the specialty well for
2000 words, the HC policy statement
in clinical neuropsychology (Boake,
programs offering formal training
specified in the Houston Conference
G
ment:

As summarized by Kaslow (2004), interest in competency-based educa-
tion and training has greatly expanded
across the last two decades as profes-
sional organizations articulating competen-
ty based training models, a separate
section being devoted to competency
in the 2002 revision of the APA ethics
code, and with various training con-
ferrals yielding important develop-
ments related to modeling, defining,
and measuring competencies. Such
developments are mirrored in other
fields, including
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Empirically informed training in-
volving recognition that there is
a training sequence which begins
with basic or core knowledge, skills,
and attitudes, and proceeds through
increasing complexity and sophistica-
tion (Kaslow, 2004). An important
aspect of competency-based training
is determining which foundational competencies are needed prior to
the development of more advanced competencies. Importantly, the
HC policy statement indicates that training in clinical neuropsychology begins at the doctoral level and proceeds through
the residency. The residency proceeds in succession to the
developmental nature of training. For example, foundations in brain-behavior relationships are
said to begin at the doctoral level
and should be developed “to a con-
siderable degree.” The internship
is described as a period in which
the training toward the general practice of professional psychol-
ogy is completed, and where train-
ing in clinical neuropsychology is
extended based on the training needs of the intern. However, the policy statement notes that it is possible for
teaching at the doctoral level to
occur at different levels across
trainees, stressing that “the program-
networks to which individuals are
accomplished (pp. 348-349).
Similarly, as stated by Kaslow (2004;
p. 775), “Competence refers to an
individual’s capability and autono-
matic ability to understand and do
certain tasks in an appropriate and
effective manner consistent with
the expectations of the particular
profession or specialty. For example,
flexibility may not be required that
foundational competencies are in place for
the appropriate development of func-
tional competencies. At a practical
level, some foundational areas, such
as grounding in brain-behavior rela-
tionships, require intensive classroom instruction and are difficult to reme-
diate in settings in which training largely involves supervised delivery of
services. More generally, too much flexibility requires more guesswork
and accommodation from internship
and residency trainers regarding
what specialty-related knowledge,
skills, and attitudes to expect of
incoming trainees.
Finally, emphasizing the end pro-
tact over the process at each level of
training means that summative eva-
uation (e.g., residency exit cri-
tera) is emphasized over formative
evaluation (i.e., periodic evaluation
and feedback as part of the process
of training). Consistent with efforts
to define competency benchmarks
within professional psychology in
healthcare settings (Assessment of
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Continued on Next Page
Healthcare Reform – Teamwork Improves Opportunities for All

By Jennifer Beard Smulson, APA Government Relations Office

Healthcare reform continues to be the “talk of the town” in the nation’s capital – as well a topic of concern for practitioners, policy-makers, and communities all across the United States. It is nearly impossible to have opened a newspaper, watched the news, or listened to a friend’s conversation, without hearing the words “health care reform.”

In Washington, DC it is a dizzying swirl of interest groups, think tanks, lobbyists, policy makers and talkers, all vying for their own voice to be heard. Has APA made a difference on the advocacy front in this important national debate? How does an organization engage its grassroots and make a mark on a grand national debate of this magnitude?

APA has strongly lent its voice to this national debate. APA advocacy staff united in a grassroots -- and has made a substantial mark on a grand national debate of this magnitude.

AP A has also made inroads in the areas of workforce/ training and integrated health care. Uniting the guidance and leadership of the Education and the Public Interest Government Relations teams, AP A, has succeeded in securing language in both the House and Senate bills that provide new workforce education and training opportunities for doctoral level psychologists and psychology trainees.

These provisions, if included in any health care reform legislation, will help address the problems of insufficiency in areas mental and behavioral health care among other areas. Taking a proactive stance in the face of this critical shortage, specifically, the bill passed by the Senate Health Education, Labor and Pensions (HELP) Committee includes language promoting the development of a “first of its kind” training program. This program includes funding for fellows and postdoctoral training opportunities for psychologists.

These provisions, if included in any health care reform law, will help address the problems of insufficiency in areas mental and behavioral health care among other areas. Taking a proactive stance in the face of this critical shortage, specifically, the bill passed by the Senate Health Education, Labor and Pensions (HELP) Committee includes language promoting the development of a “first of its kind” training program. This program includes funding for fellows and postdoctoral training opportunities for psychologists.

We spend so much time trying to get our message in front of the public that we sometimes forget that the mental health landscape can feel overwhelming and frightening to the general public. Since the introduction of health care reform, there continues to be an extra-ordinary set of experiences, both directly and indirectly. Many of these events are on an unfamiliar spectrum of emotional and psychological trauma. Patients may attempt, or succumb in, suicide. Occasionally psychotic or autistic patients may exhibit frightening or even disturbing behavior that is both frightening and dangerous. Patients may need treatment and help for the trainee's ability to contain and cope with such experiences.

The answer is, with our eyes wide open. There are a number of ways in which we can anticipate and be attentive to such experiences. Here are a few guidelines that may be helpful:

1. Know your trainees.
2. Early on in their training, it is important that trainees are safe practice before setting off independently. Best practices regarding liability, including requirements for documentation, and skills in assessing dangerousness.
3. Ensure service-training communication. Events can happen quickly and without warning. It is important that every trainee is well-oriented to the service setting in which he or she works, and that he or she knows the best practices regarding safe practice before setting off independently. Such orientation requires good communication between the patients and the trainee.

4. When bad things happen, who are contacted by the trainee’s direction right away. An in-person meeting, as soon as possible, should be planned to discuss the event and plans. Be sure to contact the trainee’s supervisor and have an at-risk committee that convenes, and make an assessment of the trainee and the risk of harm. The trainee and supervisor are also important to rely on colleagues for support, so that trainees don't feel the brunt of the responsibility.

5. Be straightforward, but also turn to others for support. You may have your own concerns about work conditions, liability, and the trainee’s welfare. It is important to be straightforward, but also turn to others for support. You may have your own concerns about work conditions, liability, and the trainee’s welfare. It is important to be straightforward, but also turn to others for support.

6. Be thorough and forward, but also turn to others for support. You may have your own concerns about work conditions, liability, and the trainee’s welfare. It is important to be straightforward, but also turn to others for support. You may have your own concerns about work conditions, liability, and the trainee’s welfare. It is important to be straightforward, but also turn to others for support.

7. Take it seriously. When bad things happen, who are contacted by the trainee’s direction right away. An in-person meeting, as soon as possible, should be planned to discuss the event and plans. Be sure to contact the trainee’s supervisor and have an at-risk committee that convenes, and make an assessment of the trainee and the risk of harm. The trainee and supervisor are also important to rely on colleagues for support, so that trainees don’t feel the brunt of the responsibility.

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Tips fortrainees when bad things happen to good trainees

By Marlo Ely, PhD, et al.

H refore, it is important to have conversations about safety, especially with both trainees, it is important that the consultant not be in the usual evaluative role with the trainee.

Trainees should have a regular forum in which problems can be discussed with peers and with the supervisor. If the trainee wants to talk about an event that has happened to a member. While many trainees are afraid of the identified, ensure that the trainee cohort group knows that he or she is being well-supported.

9. Be thorough and forward, but also turn to others for support. You may have your own concerns about work conditions, liability, and the trainee’s welfare. It is important to be straightforward, but also turn to others for support. You may have your own concerns about work conditions, liability, and the trainee’s welfare. It is important to be straightforward, but also turn to others for support. You may have your own concerns about work conditions, liability, and the trainee’s welfare. It is important to be straightforward, but also turn to others for support. You may have your own concerns about work conditions, liability, and the trainee’s welfare. It is important to be straightforward, but also turn to others for support.
The Annual Meeting at APA Convention: Continued from Page 1

Over several years as APPIC Chair, including serving as Chair of the Council of Chairs of Training Councils, Ms. Mona Koppel Mitnick, Esq., was hailed for her nine years of service as Public Member. She is replaced by Joel Stocker, J.D., who has taken on this important task. Dr. Karen Taylor provided an update on the newly developed and installed AAPI Online. Among other speakers, Dr. Gene D’Angelo, Awards Committee Chair, was particularly articulate as he presented annual APPIC awards to Dr. Paul Robins (Excellence in Training), Dr. Lynette Sparkman-Barnes (Excellence in Diversity Training), and Ms. Tiffany O’Shaughnessy (Student Research). In addition, new Board Members Lisa Kearney, Ph.D. and Jason Williams, Psy.D. were introduced to the group. Pictured are some scenes and personalities attending the meeting.

Implications of the rapidly changing economy over the past year or so have impacted nearly every aspect of psychology training and practice. The economic downturn has increased the pressure for internship training programs, already challenged by the pressures of the “match imbalance,” and these challenges have in turn been exacerbated by the uncertain economy. From an accreditation perspective, the current challenges have led to questions about how the American Psychological Association Commission on Accreditation reviews Domain C of the Guidelines and Principles (G & P). We have, therefore, decided to briefly address these specific components of the G & P, in hopes of adding clarity and assistance to programs struggling or concerned with the question of resources and their intersection with accreditation.

Domain C of the G & P (http://www.apa.org/ed/accreditation/guiding-principles.pdf) states that an internship program will “…demonstrate that it possesses resources of appropriate quality and sufficiency to achieve its training goals and objectives” (p. 15). Areas further specified in Domain C are the formally designated intern training supervisors, the identifiable body of interns, and the additional resources necessary to achieve its goals and objectives. A standard for the nature of consortia programs is also specified.

Bill Robiner, in a column in the May 2009 APPIC E-Newsletter (pp. 16–17) called for “flexibility” in accreditation by the CoA as it relates to Domain C. He suggested that in the wake of the severe economic challenges of late 2008 and early 2009, “promoting quality training during periods of economic turbulence may best be achieved by temporarily deemphasizing the financial support and stability of sponsoring institutions as an accreditation criterion…” (p. 17). While it would likely be Pollyannaish to suggest that the economy is out of difficulty, the circumstances as we write this in October, 2009, appear to be slowly improving and it feels possible to be modestly optimistic that the worst has passed. That said, issues in health care and mental health care remain, and it is clear to us that the struggle for adequate resources in psychology training will be with us for a long time. There are a number of unknowns but what is known is that programs are likely to continue to struggle to provide adequate resources.

How then to continue to hold high standards for the training of interns in psychology, include the support and stability in sponsoring institutions, without seeming heartless or unrealistic in the face of such economic challenges? A number of things seem important to clarify. Accreditation is defined as the act of recognizing an institution of learning “as maintaining those standards requisite for its graduates to gain admission to other reputable institutions of higher learning or to achieve credentials for professional practice.” In psychology, accreditation is focused on competencies that programs aspire to for their trainees and the achievement of those outcomes. For that reason, each program is required to determine its needs and examine the outcomes for its trainees. The accreditation process is required to review all program aspects within this context. We ultimately believe that one of the worst things that psychology could do for itself as a profession is to lower its standards as a response to these challenges.

A question of particular interest to internships during these challenging times is how accreditors will interpret Domain C-3, the “necessary additional resources required to achieve its training goals and objectives,” and in particular, financial support for intern stipends, staff and training activities. Implementing regulation C-9 of the G & P for Domain C speaks directly to the question of unfunded internships and stipend equity. It makes an argument that internship training should be funded so as to (1) lend tangible value to the intern’s service contribution, (2) communicate a valid and dignified standing with the professional/training community; and (3) provide appropriate and realistic monetary resources to permit interns and their families to subsist during the training year. Much has been discussed at the national level about the dilemma of the huge debt load that many graduate students in professional training acquire in the attainment of a degree and that increase is found in psychology as well. That said IR C-9 also recognizes that in rare or unusual circumstances a program may have a compelling rationale for accepting an unfunded intern. A decision to provide an internship experience to an unfunded CoA intern should be made in consultation with the CoA and carefully reviewed by the program to assess the impact it may have on the achievement of its overall goals, objectives and competencies, as well as the morale of the other funded interns. We hope that the APPIC community understands that this standard does not reflect a lack of empathy on the part of the CoA for the frustration level experienced by both doctoral programs and internships...
I would like to start by expressing my appreciation to APPIC for allowing me this opportunity to provide you updates from the Education Directorate at APA. For those of you who attended the April APPIC membership meeting in Portland you heard about the many exciting developments in professional psychology related to models to define and methods to assess competence in trainees. The APA Education Directorate, in partnership with many groups such as the Council of Chairs of Training Councils (CCTC), and through the efforts of many individuals has developed several resources that are available to the education and training community. The Competency Benchmarks document, which presents a model that operationally defines competencies across the sequence of education and training, was revised in late 2008. A toolkit that provides a wealth of resources about different methods to assess competence has also been developed. Manuscripts detailing both these resources will appear in a special issue of the journal Training and Education in Professional Psychology later this year. You can go to http://www.apa.org/ed/graduate/competency.html to find our more. I am also pleased to note that there are efforts underway to develop additional resources for programs who are dealing with a student with problems of professional competence. To date, a sample remediation plan, based on the Benchmarks competencies, has been developed and work is underway on other resources for training programs related to having “difficult conversations.” Finally, it is very exciting to hear from programs that they are beginning to implement competency-based models to evaluate their students. If you have been doing this I would welcome hearing from you. We hope to soon be able to post promising practices from programs on the APA website. The internship match imbalance continues to be an issue of intense focus and one in which the ongoing dialogue between training councils through venues such as CCTC remains critical.
International Issues

By Ian Nicholson, Ph.D.

I first would like to take the opportunity to thank Dr. Sandra Clark for her many years of writing this column. It was a pleasure to receive her words of advice, her thought-provoking reflections in the field of professional psychology.

The focus of this newsletter is on the topic of training and multicultural diversity issues. The National Council of Professional Psychology Programs (NCPPP) has taken the lead in developing a comprehensive curriculum for the training of psychologists in multicultural diversity issues. This curriculum is designed to ensure that all psychologists receive the necessary training to provide culturally competent care to diverse populations.

Diversity

By Yoon K. Jung, Ph.D.

I didn’t think it would come to this, but I’d like to start this column off by talking about construct validity. Well, seriously, never mind that it brings back a bit of shred trauma. I was talking about my dissertation—construct validity relates quite a bit to what I’ve been working on as a member of the VA PTMC Committee (that’s a lot of capital letters; translation: VA Psychology Training Committee on Multicultural and Diveristy Committee). Part of our committee’s mission is “to develop best practices training guidelines and resources pertaining to multicultural and diversity issues and psychology training with the goal of making this information available to the wider VA community.” As a member of the subcommittee that is responsible for surveying what is and isn’t being done in diversity training across programs, one important question that comes up asks essentially what construct validity is. That is, how do we know we’re measuring what we think we’re measuring? Or, in other words, “How do we accurately survey how successfully programs are practicing diversity training?”

Here is a small data set (N=69) culled from the MDC survey committee’s first attempt at measuring diversity training. Eleven items were embedded in a larger VA PTMC survey asking questions such as:

• Do you have a Diversity Committee?
• What are the goals of your training program?
• What types of activities are provided for development of multicultural competence, awareness, and integration?
• Are these diversity training activities directed toward trainees, faculty, or both?
• What are your program’s MDC goals?

As you can see, the data is quite varied and the results are often not what one would expect. For example, Western Canada might be the first week of January, Central Canada in the second week, and Eastern Canada in the third week.

We are interested in feedback from US programs as to what they think of this option. Am I wrong in thinking this would be workable in the US as well? Feedback can be sent to me at iniicholson@loc wrestling

FROM THE ASSOCIATE EDITORS

Behavioral Emergencies

By Philip M. Kleespies, Ph.D., ABD

VA Boston Healthcare System

I

t the Spring, 2008, issue of this newsletter, I was shining the spotlight on the medical-legal dead-end of a psychologist, Dr. Kathryn Faughey, in her Upper East Side office in New York City. Dr. Faughey was a woman who suffered from a serious mental illness and who had a prior history of violence. As I reported, Dr. Faughey was apparently not the intended victim. The assailant later confessed that he had intended to harm his former psychotherapist with whom he had a therapy relationship.

Throughout his own career as a psychotherapist, Dr. Faughey provided care to a fellow psychologist, members of the professional organization, the American Psychological Association (APA), and ACCA, the Section’s Division 12’s Section on Clinical

At the time of the death of Dr. Faughey are (thankfully) rare, there can be many situations in which particular circumstances may be at risk of being assaulted by a patient at some point in their careers. Most of these assaults result in minor injury or no injury at all. It is the emotional distress that is more disturbing. In addition, surveys have shown that many psychologists worry that a patient of theirs may pose a threat to a third party, and a good number have had a patient who actually did assault others.

In grappling with these difficult questions, ACCA and APA Division 12’s Section on Clinical Emergencies and Crises (Section VII) in conjunction with the APA Division’s Board of Directors formed a committee to begin examining how it might be best to address these issues in the education and management of patient-clinician violence. In the first of its efforts, the joint committee has produced the content of a pamphlet of information on office safety and the management of patient-clinician violence. This pamphlet highlights some of the major factors to consider when evaluating the risk of violence as well as tips on developing a plan for management and some suggested do’s and don’ts when interacting with a patient at risk of violence. It contains who are in training and less confident of their clinical abilities and status. A mentor for model for learning under such conditions seems feasible. In this model, an experienced clinician and an intern are paired in settings such as an emergency department so that the intern can learn and subsequently in a supervisory setting.

Currently, the initial intern may not have thoroughly investigated the stress involved in these emergency situations occurs, and stress inoculation is very important to clear decision making in situations in which professional hazard for psychologists. As summarized by Kleespies and Ponce (2009), numerous surveys have indicated that the frequency of patient-clinician violence, how violence risk might be detectet and managed, and how it might be prevented.

Reference


FROM THE ASSOCIATE EDITORS
Literature Review

By James M. Stedman, PhD, ABPP

This year we find a slow down in internship related articles, at least those I can locate via Psych Info. My apologies to those authors I may not have found.

Himbrick, Pimentel, & Albano (2009) considered how internships provide the field tests for ethics classroom work in grad school. They discuss a variety of ethical issues arising during internship, including dual relationships, differences in staff/intern orientations, and balancing intern competency with patient needs. They illustrate points with clinical examples. Cognitive and Behavioral Practice, 16(1) 2009, 34-51.

Netmeyer, Rice, & Kollin (2009) used match data to investigate clinical and counseling student placement differences. They found similar rates of successful matching and rankings of those matches for both groups. Differences occurred at the intern (state level) level, with clinical students matching at medical sites and counseling students matching at counseling centers. Training and Education in Professional Psychology, 3, 47 - 52.

Mours did a dissertation on use of therapy outcome measures at internship sites. He found that 47% of respondents used therapy outcome measures but many more thought it was a good idea but did not do it. Dissertation Abstracts: Sciences and Engineering, 68 (9 –B), 2008, pp. 6324.

Daniel did her dissertation on supervisory alliance and countertransfer- ence. She found that solid alliance leads to more disclosure, with no differences across gender, ethnicity, or theoretical orientation. Dissertation Abstracts: Science and Engineering, 69 (9 –B), 2009, pp. 5772.

By the time this appears, the US Congress may or may not have passed a bill about changing the way health care is provided and/or financed in this country. Regardless of what may or may not happen, it will still be important for trainees to understand some basic ideas about how our health care system works, or perhaps, doesn’t work. And it is at this late stage in their careers, during their internships or post-docs, that there is a critical period, so to speak, during which they can learn a few basic lessons about health care economics. And who better to help them with this than their trainers and supervisors? So, I offer a little challenge: I’m going to mention two words or phrases which, I would argue, are fundamental to understanding the way things are being done now, and which is that you ask to see if you can help your trainees grasp the way in which these concepts will affect how they function in the future as professionals. My point is, of course, that these ideas have to do with two aspects of the current system, and changes will come only if this and the next generation of psychologists really comprehend how they and their patients are being discriminated against.

OK—I here they are:コストシフティング, LOSS RATIO; BEHAVIORAL HEALTH, and PROVIDED CARE. These are to be benign, but each concerns a basic and harmful set of ideas and practices that serve to distort what psychologists can do, how they are compensated for what they do and how this affects what happens to their patients.

Let’s start with COST-SHIFTING. This is the method that health insur- ers use to essentially short-change a one area so that the money not spent there can be used in some other way. The classic example of this is the current system for paying for health services under the Medicare plan. Basically, health care professionals and hospitals are paid at a somewhat below market rate by Medicare with the assumption that this would be made up for by higher fees charged to non-Medicare patients. Similarly, when patient co-pays are increased, the cost of care is shifted from the insurance company onto the patient. In the mental health field, a major cost-shifting process has taken place for years via higher co-pays, reduced or limited coverage, restrictions on the number of sessions and other methods by which finance new, or what finance away from mental health care to other areas. The effect of this has been, as we all know, less available care for our patients and a gradual but persistent drop in the income levels of psychologists.

Some change in this nefarious system of discrimination has finally come about via recent federal legisla- tion (which supplements some exist- ing state laws) requiring that there be “parity” between mental health and other health care payment arrange- ments. This improvement is limited, however, by a number of loopholes that still exist and it is not yet clear just how this step forward will be implemented. There remain many exceptions to the new requirements and much effort will be needed to undo the unfair cost-shifting that has prevailed for so long. The term LOSS-RATIO is, in one brief phrase, a reflection of the basic flaw in our private health insurance system. That term is the one used by the health insurance industry to describe the amount of money they spend in paying for actual health care (I’m not making this up). That is, any money spent for that purpose is considered by them to be a LOSS! Of course, in a for-profit company, any expense incurred reduces the level of profit generated. And the health insurance industry is in business to make a profit, not to provide health care! The difference between the loss-ratio and their income from premiums and other sources goes to cover overhead, administration and profit. That’s a simple business principle.

But the difference between the loss-ratio in a non-profit (e.g. govern- ment) system such as Medicare (around 97%) and, as in the for- profit insurance business world (around 70 to75%) represents the amount of money being skimmed off the top that doesn’t go to paying for health care.

And here’s where the two con- cepts come together: cost-shifting by the private insurance industry leads to a lower loss-ratio, and as should be obvious, higher profit levels.

Now, the term BEHAVIORAL- HEALTH has a nice neutral sound to it and some think it is an even more positive term for describing what we deal with. But, think about this for a minute. The phrase clearly impares the folks we work with are not ill, or disturbed, or distressed, or sui- cidal or any of those unpleasant real life experiences which need attention and treatment. No, they just need some adjustment of their BEHAVIOR to be healthy.

This is, again, the term preferred by the insurance industry and which allows them to minimize the real world impact of the human distress on which they would rather not

CONTINUED ON NEXT PAGE
spend money. Of course, I’m not suggesting that there is anything wrong with our profession’s research and application of behavioral techniques of treatment. But the insurance industries’ eager adoption of this terminology hardly reflects a defensible empirical orientation. It’s one more way in which they use words to achieve their financial goals by recasting the issue in a much more benign manner. If it’s just a matter of helping with some behavior, then why should they not cost-shift to some other really serious human problems? And so, the discrimination that’s been perpetuated over the years may, to the insurers, seem justified.

Now, finally, the term of art, PROVIDER. They love to call us PROVIDERS, again a nice neutral-sounding term. But what is a provider? Certainly not a professional who’s spent an average of seven years working towards and completing a doctorate, including thousands of hours of clinical experience. No, a provider could also be a master’s level person, or a mental health counselor or anyone else the insurers could get to work for them at a cheaper price. The term reduces everyone to a common level, and blurs differences in training and experience. So, they can advertise that they have a long list of providers available, even when some or many may be of limited professional competence. In my book, a provider is someone who shows up at the castle backdoor with a side of beef.

Well, after reading all the above, if you’ve had the patience to continue through my screed, those of you who and decreases the company’s loss-ratio. Psychologists and patients get screwed and the company’s profit goes up! OK, I guess you get my point. Psychologists in training have to know what they will be up against when they move out into whatever area of practice they choose. And the sooner you help them get the picture of what these “buzz words” mean for them, the better they’ll be able, we hope, to work for the changes that they and our society need to have happen.

All of this, you understand, my own opinion and does not reflect any official position of APPIC, but I sure hope that our organization does begin to weigh in on these issues. Our mission as teachers and trainers commits us to helping prepare the next generation of psychologists for what lies ahead of them. But don’t we also have an obligation to help, in whatever way we can, to ensure that their road ahead leads to an environment in which they can successfully practice what we’ve taught them? Our profession’s future depends on it!

New APPIC Members

Doctoral Internships
Greater Southwest Consortium in Professional Psychology
Dallas, TX
Iowa City VA Medical Center
Coralville, IA
Neurobehavioral Institute of Miami
Coral Gables, FL
North Texas Internship in Juvenile Clinical and Forensic Psychology
Granbury, TX
Western Psychological and Counseling Services
Portland, OR

Postdoctoral Residencies
Indian Health Board of Minneapolis
Minneapolis, MN
Norwich University Counseling and Psychological Services
Northfield, VT
West Coast Children’s Clinic
Oakland, CA
West Los Angeles VA Healthcare Center
Los Angeles, CA