The APPIC Board of Directors held the 2014 Annual Membership (‘Business’) Meeting on August 7, 2014, in conjunction with APA’s Annual Convention.

ORGANIZATIONAL STATUS AND PROJECTS

APPIC Chair Dr. Jason Williams reported that APPIC has developed a Competency Assessment Project, committing $50,000 to fund innovative and effective approaches to assessing competencies. A new Scientific Review Committee has been formed, co-chaired by Drs. Eugene D’Angelo and Elizabeth Klonoff, to pursue research on the vast data accumulated from the APPIC Match. Dr. Wayne Siegel will be Board liaison to the SRC.

Executive Director Dr. Jeff Baker gave the Central Office Report. He announced that Dr. Greg Keilin has been hired by the Board to serve as Match Coordinator. He summarized Central Office’s roles in membership services, business issues, fiscal matters, and relationships with APPIC’s constituencies.

Treasurer Dr. Marla Eby noted that monetary reserves have doubled in the past five years and that, despite costs incurred in developing APPIC’s technology initiatives, the organization is financially

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Glenside, PA

SETTING-RELATED ISSUES
Robert H. Goldstein, Ph.D.
Rochester, NY
Chair’s column  
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extremely concerned about the internship imbalance. Here is a quick update on some of the continued efforts to address the supply side of the equation. The first effort was to make a change in the match policy to only allow accredited doctoral programs’ students enter the match. While this will have a short term impact on the match, it does not solve the problem. The board is also very committed to having a process to help new graduate programs have a chance to send their students into the match and have created a new committee to review those programs to be sure they meet the APPIC Doctoral Program Associate (DPA) criteria. I would like to thank Pam Epps for her work on getting this group started. Look for more information on this process in the coming months.

Along with the DPA process we continue to work toward moving our membership toward accreditation, given that this is a minimal measure of quality. The Accreditation Readiness Project (ARP) continues to move forward with the on-going leadership of Allison Ponce. APPIC has partnered with the Western Interstate Commission on Higher Education (WICHE) to conduct the Accreditation Readiness Project. The goal is to support APPIC member internship programs that wish to become APA accredited. In the first phase on the project, which ended in July, WICHE designed and disseminated a survey to all APPIC member internships asking questions related to real and perceived barriers to accreditation. WICHE also designed a tool to assess the level of support and assistance programs might need to become accreditation-ready. In the second phase of the project, scheduled to begin this fall, WICHE will utilize the tool to help interested programs determine their next steps. Dozens of internship programs will receive individualized support and participate in shared learning communities as they move toward submitting self-studies to APA by December 2015. Details of the outcomes of Phase I are located on the APPIC website and please stay tuned for more information about the exciting opportunity to participate in Phase II of the Accreditation Readiness Project.

POST-DOCTORAL TRAINING:

Under the guidance of Wayne Siegel, the post-doctoral training work group has been hard at work coming up with the Postdoctoral Selection Guidelines (can be found here-http://www.appic.org/About-APPIC/Postdoctoral/APPIC-Postdoctoral-Selection-Guidelines). While these guidelines do require a tight timeline for recruitment for those of us with internship training programs, they are an important step in moving us toward some uniformity to selection, tighten the selection windows, while not alienating programs, and to bring about fairness to both students and programs. Along with the guidelines we are very pleased to announce the launch of the APPA (APPIC Psychology Postdoctoral Application). This is a flexible system that can be used by both member and non-member programs for this recruitment cycle. More details can be found (http://www.appic.org/AAPI-APPIC/APPAPostdoc-Application-Information) on the website. This flexible system will meet the needs of a wide range of programs - system significantly less structure that the AAPI (no hours). We hope that the AAPA will help bring some uniformity to postdoctoral selection and bring more programs into APPIC.

The Board continues to think about ways to move the movement toward competencies forward. At our August board meeting we approved the allocation of $50,000 to be used for small demonstration grants for programs using innovative ways of measuring competencies in their programs. The details are still being worked out, and we expect and request for funds to be announced later in the fall.

Another plug for our mentoring program is always needed. Please consider joining the program as it allows established training directors to serve as mentors or consultants to individuals who are developing new training programs. Dr. Pamela Epps coordinates this project: pepps@emory.edu.

As always, the entire Board of Directors welcomes your input, comments, ideas, and solutions. I also welcome dialog-please feel free to contact me directly at Jason.williams@childrenscolorado.org
Match Coordinator Dr. Greg Keilin presented data from this and previous years’ Matches, a summary of which was previously published in the May 2014 e-Newsletter. An extensive presentation of that data is available on the APPIC website.

Dr. Wayne Siegel described the new online APPIC Postdoctoral Psychology Application Centralized Application System (APPA CAS), which will collate and archive individual applicant information at negligible student cost and provide free program-specific access to applicant materials. Dr. Siegel also provided an update on the MyPsychTrack project, a system for tracking trainee hours being designed to integrate with ASPPB’s tracking system.

Reporting on other initiatives, Dr. Allison Ponce described the collaboration between APPIC and the Western Interstate Commission on Higher Education (WICHE) in assisting APPIC Member programs wishing to earn APA Accreditation and Dr. Jenny Cornish updated the audience on enhancements to the AAPI Online.

In addition, Dr. Elizabeth Klonoff reported on the status of the journal Training and Education in Professional Psychology, which is thriving with respect to number and quality of submissions. Dr. Sharon Berry, who provided an update on coordinated efforts by the APA Board of Educational Affairs, APAGS, and the Education and Practice Directorates to promote funded training opportunities. Dr. Pamela Epps was recognized for her accomplishments in the APPIC Mentor Program. Past Chair Dr. Arnie Abels and Treasurer Marla Eby were saluted as their terms of office expired.

AWARDS

Connie Hercey Award for Distinguished Contributions to APPIC. The award was presented to Dr. Susan Zlotlow for her incredible service to education and training in professional psychology. In her tenure as Director, she transformed the Office of Consultation and Accreditation from an evaluative unit (often perceived by programs as hypercritical and distant) to an approachable one offering truly collaborative consultation to facilitate program quality improvement.

Paul Nelson Award. Dr. Elizabeth Klonoff was the recipient of this award, presented by Dr. David Cimbora on behalf of the Council of Chairs of Training Councils. Dr. Klonoff was recognized not only for her significant accomplishments with education and training as Chair of the APA Commission on Accreditation but also for her deeply caring heart for the field and for students. Her excellence in bringing disparate points of view together in a respectful manner is reflected in the imminent revision of the Accreditation Guidelines and Principles into a competency-based set of Standards.

The e-Editor thanks Dr. Jeff Baker for contributions to this article. Content has also been abstracted from the APPIC Business Meeting Minutes of August 7, 2014, prepared by Dr. Jenny Cornish, available on the APPIC website.

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Dr. Liz Klonoff accepts the Paul Nelson Award from CTC’s Dr. David Cimbora.

Dr. Susan Zlotlow
APPIC is a business, but it is a business with a heart. The APPIC Board is thoughtful in their discussion of possible changes to policies or new policies. The board works very hard to try and understand the consequences and possible unintended consequences whenever a new policy or revised policy is considered. There is usually only one reason a policy is needed. Something has happened and APPIC needs to make sure it does not happen again or happens in a more consistent manner. This action is designed to improve the quality of training programs but also to the students who are seeking an internship or postdoc. Students look to APPIC to protect the integrity of this system. The match system works great and the vast majority of students that are matched are matched to one of their top 3 rankings. However, where there are not enough slots then the system may continue to work but only if you are one of the ones that matched. This is in part a fault of APPIC. For decades it operated with a fair balance of students seeking internship positions. Over the past 10-15 years APPIC has allowed more and more programs to become members and that certainly helps with quality slots in the match but many of these programs have not yet decided to go for accreditation. APPIC needs to insure that all training programs are quality. Quality is measured with accreditation and that is quickly becoming the expected standard. No policies have been passed or even considered at this time regarding the requirement for accreditation as membership in APPIC but it has been mentioned. APPIC has 745 internship programs and 240 of them are not accredited. That is not to say they are not of good quality, the vast majority of them are likely very good internships and students gain a quality experience. However, the public needs some reassurance that these 240 programs are as good as the other 505 APPIC member programs. Accreditation is a standard this is applied in almost all health professions as a statement to the public that this program has been reviewed by a 3rd party and that 3rd party confirms that standards are being met. Why is it hard for a program to seek accreditation? Well, it takes time out of someone’s schedule, it takes administrative support, it takes financial commitment, it takes someone who can see the big picture and identify that expected outcomes of the program are being met. Those are all significant hurdles but not insurmountable. They can be done. It is time to seriously consider accreditation. APPIC offers a mentor system to assist with this goal. APA offers some grant funding to help programs move forward. APPIC will do what they can to assist programs to meet accreditation standards and encourage programs to seek accreditation. Why are programs not seeking accreditation? Well, as mentioned above it takes resources and professional commitment. Those programs that do not have these two components are at a disadvantage not only for accreditation but also for training interns. We owe it to future generations of psychologists to insure credibility to the public and to those who will be trained at these sites. Please give full consideration to seeking CPA or APA accreditation. It may be 10 or 20 years before this is required but it is coming. If your program is already accredited consider signing up as a mentor and offering your time to developing programs. If we can get 1000 more accredited training slots there will not be a major imbalance. If all 240 unaccredited APPIC member programs became accredited that would provide more than 750 accredited training slots. That would make a difference.
As some readers may recall, I have long personally advocated for a Postdoctoral Residency Uniform Notification Day to be required of APPIC Members, hopefully coupled with a computer match such as that conducted so successfully by the Association of Postdoctoral Programs in Clinical Neuropsychology (APPCN). There has been considerable debate about whether or not to establish such a requirement and, if established, what the actual ‘notification’ or ‘match’ date would be.

An additional sticking point has been the desire or preference of ‘research’-oriented programs to be exempt or excluded from a UND on the grounds that they are not practice programs and therefore are competing with a different population of programs (e.g., academic) to garner trainees. At the same time, many of these ‘research’ programs nonetheless provide for residents to engage in supervised clinical practice activities at least 25% of the time, those hours counting toward the practice requirements of state licensing boards.

While residencies are certainly free to label, describe, and characterize their programs as “research,” I consider this irrelevant for the purposes of a UND or Match. In my opinion, if a residency – however labeled! – is providing residents with supervised clinical hours toward licensure, then it is *ipso facto* a practice program and should be required to participate in any formally established APPIC postdoctoral UND/Match process.

**ASSOCIATE EDITOR FOR CLINICAL NEUROPSYCHOLOGY SOUGHT**

The e-Newsletter is still soliciting self-nominations to serve as Associate Editor for Clinical Neuropsychology, the position so ably filled by Dr. Brad Roper for many years. Any supervisor in an APPIC Member internship or postdoctoral program is eligible for consideration. With Clinical Neuropsychology so often at the forefront of training developments, we very much want to ensure that Members be informed about this area. Those interested are encouraged to submit a brief statement of interest, together with a curriculum vitae to my attention at editor@appic.org Thanks very much in advance!

Note: The e-Editor’s opinions are solely his own. They do not represent those of APPIC or of any other organizations with which he is, or has been, affiliated.
There are many areas of the country with limited resources for psychology training. In those areas, the psychologists who are involved in training are often operating in relative isolation. APPIC brings together psychologists on the national level, but it is equally important to build local and state training communities. In Arizona, one important contribution to this goal is achieved by bringing members of the training community together for an annual conference. It is attended by trainees and supervisors from throughout the state who come to learn, collaborate, and celebrate psychology training.

The Arizona Psychology Training Conference has grown out of a twelve-year collaboration between the Arizona Psychology Training Consortium and Arizona State University (ASU) Counseling Services. The Arizona Psychology Training Consortium is a subsidiary corporation of the Arizona Psychological Association (Hogg, 2003; Hogg & Olvey, 2007). The Consortium includes both APPIC-member internship and postdoctoral residency sites located throughout the state. The Consortium operates entirely through volunteers dedicating their time to train the next generation of psychologists. Since 2001, the Consortium has graduated over 400 interns and residents.

ASU Counseling Services provides an APA-accredited internship program and an APPIC-member postdoctoral residency program. There are also a few different types of practicum programs for advanced doctoral and master’s level trainees. In providing training for future psychologists for over thirty years, ASU Counseling Services has been one of the most stable and well regarded training programs in the state. The registration website for the conference is hosted by ASU Counseling Services, and continuing education credits are provided by ASU.

The Conference began as a joint training effort for Consortium and Counseling Services interns and residents, both to provide didactic training and as an opportunity to interact with other trainees in the state. The response from the trainees was so positive that in subsequent years the other APA-accredited and APPIC-member training programs in the state were invited to have their interns and postdoctoral residents participate.

From there, the Conference continued to expand to include training for current and potential supervisors in Clinical, Counseling, and School psychology settings. The most recent expansion was inviting academic Directors of Training and doctoral students who are applying for internships. Each change and expansion has been met with considerable enthusiasm from participants, as well as increasing numbers of participants. From our initial conference, which was attended by around twenty trainees, each of the last two Conferences brought together over 130 participants.

The Arizona Psychology Training Conference has several goals, reflecting the different roles of the attendees. First, interns and residents receive training in foundational areas of practice and issues relevant to their training. Topics include ethics, diversity, self-care, EPPP examination strategies, interviewing skills, and legislative advocacy. Second, supervisors receive training in supervision theory and enhancing their supervision skills. One example is a popular workshop on handling problematic trainees, which was modelled after the APPIC Informal Problem Consultation workshops at APPIC conferences (Williams, 2014). Third, doctoral students get to meet internship Directors of Training and learn more about local training sites. The doctoral students get practical advice about choosing the training opportunities that will best meet their personal and professional needs.

Besides training that supports trainees and supervisors in their specific roles, plenary speakers have addressed a variety of current practice issues relevant for all participants. For example, the plenary speakers at the last conference spoke about the integration of psychology within primary medical care. The conference theme for 2014 will be the journey that psychologists experience throughout each stage of our professional careers.

The conference gives students, trainees, and supervisors the opportunity to meet psychologists working in different psychological specialties. For example, psychologists working in neuroscience get to interact with school psychologists working with children with cognitive impairments. Trainees and supervisors have many

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opportunities to network with each other in informal programs, providing the opportunity to discuss common concerns within the psychology community.

The format of the conference is similar to other professional conferences. Training programs, doctoral students, and former attendees are sent email invitations. The conference is structured to have two plenary sessions and six breakout sessions. There used to be separate tracks for interns, residents, and supervisors, but we found that allowing any attendee to pre-register for the breakout sessions of their choice was more enriching for everyone. One example of last year’s offerings was a breakout session for supervisors and trainees to meet with members of the Arizona Board of Psychologist Examiners about the supervision and training requirements for licensure. There was another breakout session on the national and state prescriptive authority initiative (Munsey, 2008). In recent years, current and recent trainees were included in the conference planning process, which helped to infuse the conference with progressive and relevant content for the new generation of psychologists. An example of a session suggested by a trainee was ethical uses of social media. Another was a panel discussing several specialty areas within psychology. The size of the conference is ideal for interactive dialogue on supervision and training issues within our profession.

One of the most distinctive qualities of the conference is that it has a “how to” emphasis. It is about applying theory and science to actual practice. For example, diversity concepts and developmental theories are framed as best practices in supervision. Supervisors learn how to be in full compliance with evolving national and state regulations and standards. Training programs share documentation and procedures with each other. Interns and residents acquire concrete skills that help them advance to the next phase of their careers. Attendees leave the conference with something that they can immediately put to use. That is probably what keeps supervisors coming back to the conference year after year.

A key challenge in the success of the conference has been balancing the need for a high quality of programming with managing registration costs to participants. The conference needs to be accessible to supervisors, who are often underpaid. The registration fees are kept to a minimum so that it is affordable to doctoral students, academicians, and supervisors. Training programs pay the registration fees for interns and residents. Speakers are not given honoraria, but are generally given small gifts as tokens of the organizer’s appreciation of their time. The conference relies heavily on the good will and dedication of members of the training community to contribute their time, efforts, and expertise.

One of the outcomes of the Arizona Psychology Training Conference is that it has encouraged and supported participants to create their own internship and residency training programs, and some of those programs have achieved APPIC-membership and APA accreditation. There is a vital need for the development of new internship and residency training sites (Keilin, 2014). Sharing training resources has helped “spin-off” programs get off the ground. The conference gets people excited about training.

Like many states, Arizona has a poorly funded public mental health system (SAMHSA, 2012). There are few medical and public health institutions that provide psychology training. That necessitates creativity, resourcefulness, and networking to provide collaborative training opportunities for students. The Arizona Psychology Training Conference is a model of collaboration in psychology training that can be replicated in other states. The authors would be glad to consult with other psychologists about establishing a training conference in their city or state.

Bringing people together who have shared needs and concerns creates community. Arizona is building a psychology training community.

REFERENCES


Williams, J. (2014). Chair’s column. APPIC e-Newsletter, VII (1) 4.
At the 2014 APPIC Membership meeting Dr. Carol Falender presented to attendees a set of guidelines proposed by the APA on supervision in health service psychology. This past August the APA Council of Representatives voted to approve those guidelines as APA policy. This is a significant event in that it speaks to the importance of supervision in the education and training of health service psychologists. While it is important to note that guidelines are not requirements, the supervision guidelines outline practices associated with the provision of quality supervision.

The supervision guidelines were developed by a task force convened by the APA Board of Educational Affairs (BEA) in March 2012. The task force was chaired by Dr. Carol Falender. Other members included Drs. Beth Doll, Michael Ellis, Rodney K. Goodyear, Nadine Kaslow (liaison from the APA Board of Directors), Stephen McCutcheon, Marie Miville and, Celiane Rey-Casserly (liaison from BEA). I participated as the staff liaison from the Education Directorate. The task force completed much of their work using technology and met for one face-to-face meeting in May of 2013. A draft of the guidelines was put forward for comment in the fall of 2013 and subsequently revised based on feedback received.

The goal in creating the supervision guidelines was to articulate optimal performance expectations for psychologists who supervise. This was based on the belief that supervisors strive to be competent as supervisors and use a competency-based and meta-theoretical (any theoretical or practice modality) approach in the provision of supervision. The guidelines are hoped to a) enhance the quality of supervision provided by psychologists, b) promote supervisee competency development, and c) assure regulators that high quality supervision is valued and provided.

The task force came to agreement about a number of assumptions that are foundational to the supervision guidelines. These assumptions are articulated in the document and include statements such as care of the client and protection of the public is primary and both supervisees and supervisors have responsibilities associated with the supervision process.

The supervision guidelines are organized around seven domains associated with supervision, these include: Supervisor Competence, Diversity, Supervisory Relationship, Professionalism, Assessment/Evaluation/Feedback, Problems of Professional Competence, and Ethical, Legal, and Regulatory Considerations. Each domain covered in the supervision guidelines begins with a general overview of the relevance of the domain to supervision and then the specific guidelines associated with the domain are articulated. Current, relevant literature is used to support each guideline. The guidelines will be published in an upcoming issue of the American Psychologist. They can also be found at: http://www.apa.org/about/policy/guidelines-supervision.pdf.
Tips for Trainers:
Talking About Diversity Now, Not When It’s Convenient

By Claytie Davis III, Ph.D.

This is my first Tips for Trainers and I am excited to begin my first year of service on the APPIC board. My hope is to provide readers with helpful resources related to issues that many of us face in our role as trainers of interns and/or postdocs. I want to thank Dr. Marla Eby for her service to APPIC and for her many Tips for Trainers over the last several years. I hope to continue her tradition of providing timely and relevant information to the membership. One change you will notice with the column is that I plan to have each edition end with a question or challenge for the reader to consider and act upon.

Before getting to the topic I want to remind the membership that this column started in the March 1998 edition and is a means of allowing the APPIC board to share “particularly interesting ways training directors were doing their job.” I want this column to be more than just lessons I have learned and/or heard. If you would like to share tips related to training or want to discuss how you have effectively managed a challenging situation please contact me.

For my first Tips for Trainers I thought I would address the issue of diversity - an issue that is always present and often not addressed unless it is part of the plan for the day (e.g., multicultural seminar) or we are given no choice but to address it (e.g., a competency issue has been identified). Diversity means different things to different folks and for many of us just the idea of engaging in a conversation about “diversity” raises anxiety. Depending on one’s identities, and previous experiences, these conversations may lead to thoughts of, “here we go again” or “am I going to be seen as the oppressor” to “I don’t want to have to teach these people about…” or “I don’t know how safe it feels to disclose what I know.” Ideally, this topic would elicit thoughts of “great, let’s get see what we can learn from one another.” For many reasons that has not been my experience.

As I write this Tips for Trainers there still remains much anger and confusion regarding the death of Michael Brown, a young Black man shot and killed by a police officer in Ferguson, Missouri. Shortly after the incident there were protests across the country and the talking heads were in full force in the media. Here, in Berkeley, there were protests that led to police coming out in riot gear – I should add that this occurred during week one of Orientation. I wondered, “should” I talk about this case with my interns and post-doctoral fellows? How would my identity as a Black man impact any conversation that might ensue? How would the conversation be similar and/or different with my cohort of three doctoral interns of color compared to my postdoctoral cohort that includes international individuals, people of color, and a White man? Would it matter if any of them have family members who work in law enforcement? These were all questions that I was struck with and to be honest I didn’t really want to have this conversation, especially during the first few weeks of the training year. The last point serving as my easy out. I rationalized, “it’s too soon to engage them in a discussion about race and power…they don’t know each other well enough to feel safe and honest with one another…I can ask the co-leaders of the Multicultural seminar to lead this discussion in next month.” Then I recalled a survey my postdoctoral fellows completed last year that queried other APPIC member postdoctoral fellows about their training experience related to social justice. One of the themes that emerged was disappointment that supervisors, staff, and the leadership of the organization did not facilitate conversation about social justice; often it was the supervisee who initiated diversity discussions. This was a significant factor in my deciding to engage in this difficult dialogue and I am glad that we did. I found that the trainees had been thinking quite a bit about the shooting and were also curious why no one in the agency had brought the topic up. It was a nice reminder that diversity dialogues are often more impactful when discussed in the moment as opposed to the planned or more convenient occasions.

Tips for Trainers Challenge: What will you do to ensure your trainees experience a training environment where social justice issues and discussions about diversity are a consistent part of your organizational culture? Another way to think about this question is to fast forward to your end of the year evaluation and ask yourself, what can I do now that will have my trainees leave here saying, “that place does more than just talk about diversity!” I welcome hearing from any who decide to take the challenge. Note that this challenge does not require an ice bucket or a need for a change of clothes.

There are several resources out there to help facilitate discussions about diversity – many of which can be found on the APPIC website. In fact, in the March 2000 edition of the APPIC Newsletter, Rodolfa, in his Tips for Trainers, asks several questions related to diversity that are just as relevant today: “Have you reviewed the components of your diversity training? Does your training include a review of the Multicultural Guidelines...When your interns evaluate the diversity training what do they say? Do they report [increased] competency in training individuals from diverse groups? Do you discuss your diversity training with other training directors? When was the last time you changed elements of your diversity training?” (p. 16).

Below is a reference to a book that includes experiential exercises related to diversity. I have also included a link to an essay about white privilege followed by a link to a host of resources related to issues that many of us face in our role as trainers of interns and/or postdocs.


http://alittlemoresauce.wordpress.com/2014/08/20/what-my-bike-has-taught-me-about-white-privilege/
http://appic.org/Training-Resources/For-Training-Directors
In my previous two columns in this newsletter, I have discussed the stress exposure training (SET) model for acquiring skill in evaluating and managing behavioral emergencies (APPIC Newsletter, November, 2013) and the most appropriate decision-making models for dealing with behavioral emergency conditions (APPIC Newsletter, May, 2014). In the present column, I would like to discuss one component of the cognitive and behavioral skills training that is part of the SET model; i.e., mental practice or mental simulation.

A major goal of stress training is to reduce stress or to make it more manageable. One way to begin to accomplish this goal is to provide practice under conditions that begin to approximate those likely to be encountered in the real world. In high stakes, complex, clinical situations, however, such as when a patient or client may be at risk to self or others, intrapersonal and interpersonal conditions can change rapidly. There can be unexpected shifts, and the clinician’s ability to predict how things will unfold can become very difficult. It is therefore important to know if stress training under one set of circumstances can be generalized to novel task or stress conditions.

There are, at least, two related studies in which this question has been investigated. Driskell, Johnston, & Salas (1997) examined whether the benefits of stress training would generalize from one stressor to a novel stressor. Next, they investigated whether it would generalize from one task to another.

In the initial study, a sample of U.S. Navy technical school trainees were asked to participate in a three-phase protocol. In phase one, the participants were trained in either a spatial orientation task or a memory search task both of which were computer-based. They then performed each task under conditions of either auditory distraction or time pressure. In phase two, all participants received SET training consisting of (1) preparatory information, (2) skills training, and (3) application and practice. Preparatory information included information on the type of stressor they would encounter in performing the task and information on the reactions they were likely to feel under stress. Skills training consisted of an attentional intervention in which participants were informed about avoiding distractions and focusing selectively on task-relevant stimuli. Those who would experience auditory distraction were instructed on how noise can be distracting and how it is important to ignore noise; while those who would experience time pressure were instructed on how time pressure can be distracting and how it was important to ignore time pressure.

The participants then performed the respective tasks. In phase three, the participants applied their skills by performing the task under either noise stress or time pressure. On a third trial, they performed the task under the other stressor (i.e., time pressure if training had been with noise stress and vice versa). The findings indicated that the improvement in performance from trial 2 to trial 3 was sustained when participants performed under a novel stressor. In addition, a reduction in subjective stress was also sustained when participants performed under a novel stressor.

In the second study, a similar pattern of results was found when participants performed a novel task while the stressor remained constant. The investigators concluded that the overall pattern of results strongly supported their hypotheses that stress training would be maintained and generalized when participants performed under novel stress conditions and under novel task conditions.

Meichenbaum (2007), in the SIT (Stress Inoculation Training) model, has noted how exposing individuals to milder forms of stress can bolster their coping resources and preparedness for dealing with similar but more intensely stressful and complicated events. As one component of training for evaluating and managing behavioral emergencies, those early in their training can be offered a series of crisis and/or emergency case scenarios. These cases need not have a single correct answer, but should be intended to provoke thought about possible approaches to resolving the crisis or emergency nature of the situation. The cases also should not necessarily include what might be considered “complete” information about the individual or the circumstances involved. Rather, in an effort to present the trainee with more realistic crisis or emergency conditions, the information about each case should be less complete than the clinician might like. Decisions about management must be made based on what, in fact, is known. The trainee should approach each case as though he or she were the clinician involved, and formulate his or her thoughts about managing the case.

A sample case (changed so as to make the identity of the patients undetectable) might read as follows:

You have been seeing a young, married couple in therapy for the...
past several weeks. The woman works for a small company and has recently been advanced to a beginning level managerial position. Her husband is a construction worker who has a history of problems with anger and impulse control. He also drinks to intoxication episodically. The couple came to therapy because they have been having intense arguments that seem to be fueled by the husband’s feeling that he is being left behind by his wife’s success. Late one day, he calls you from a bar. He has been following his wife and he has seen her going to dinner with a man who is a higher level manager at her work. He believes they are having an affair and he plans to confront her about it when she comes home this evening. He states that, if there is evidence to support his suspicions, he has thoughts of killing his wife and then himself. Thus far, he has only had thoughts, and he denies that he has made any definite plans or preparations.

(Kleespies, 2009)

How might you attempt to work with this patient? What information might you attempt to obtain on the phone? What might be your plan for managing the situation? What if the patient refuses to comply with what you might want him to do? These and other questions might be posed to the clinician-in-training.

Since virtually all psychology interns will have patients or clients who are at risk to self or others during their training years (Kleespies, Penk, & Forsyth, 1993), it would seem to make sense to have some preparatory training. Discussions about such simulated cases can occur in a group or didactic setting in which there is a focus on suicide and violence risk assessment and management.

REFERENCES


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ver the past two years, Community Counseling Center of Mercer County, PA, has partnered with our local CYS office to provide services to client families who are utilizing parenting strategies that are abusive at worst, and ineffective at best. PCIT is an evidenced-based program that works with primary caregivers and children, ages two through seven, who struggle with emotional and behavioral challenges. Treatment is delivered by a therapist/coach observing and speaking to a parent through a microphone from behind a two-way mirror with the parent wearing an earpiece to receive direction on how to interact with his or her child. This therapy and is applied in two stages: the first phase of treatment is child-directed and serves to increase attachment, warmth and positive parenting verbalizations; the second phase of treatment is parent-directed, where the adult learns to implement consistent limits and child-management skills.

For most families who have successfully completed the program, we have observed that there have been no reoccurrences of CYS involvement, nor has there been a need for booster sessions initiated at the request of CYS. An unexpected benefit of this training program and partnership is the level of increased competency parents have demonstrated with their older children who may be involved in various outpatient services. Our clinicians have reported that more than a few parents who have completed PCIT have shown increased initiative in their older child’s treatment, and have directly requested resources and instruction in the transference-of-skills to accomplish treatment goals in the home and community settings. Clinicians have also noted that PCIT parents have a willingness to try novel, and at times demanding approaches to behavior management based upon their experience of past treatment success and generalized parenting competencies.

As an agency, we are looking at the implications for decreased CYS involvement post-PCIT, not only for the identified client, but for the family as a whole, over the next one to five years. From what we have observed thus far, it is likely that the outcomes associated with successful completion of the PCIT program may be more far-reaching than we had previously anticipated.
Clinical Health Psychology: Making Decisions about Clinical Health Psychology Training

By Don McGeary, Ph.D., ABPP

Over the past decade, there has been a steady increase in the availability of training in Clinical Health Psychology at multiple training levels (including pre-doctoral programs, internships, and postdoctoral fellowships) and with multiple depths (as a sub-component of a more general program or as the primary focus of training). Psychologists now have a significant presence in medical settings, prompting great interest in the contributions of mental health to medical care and the integration of behavioral medicine concepts into medical environments (e.g., Primary Care, specialty medical services). In fact, the *Journal of Consulting and Clinical Psychology* recently dedicated an entire issue to the emergence of behavioral medicine and Clinical Health Psychology over the past 40 years (see Christensen & Nezu, 2013) and the *Journal of Clinical Psychology in Medical Settings* recently celebrated its 20th anniversary (see Rozensky, Tovian, & Sweet, 2014). As future Psychologists begin to examine their training options, there are many who may want to incorporate Clinical Health Psychology (CHP) into their educational experience. In so doing, it is important that they consider how CHP fits into their career interests and how focused or broad they want their training in CHP to be. The purpose of this e-Newsletter entry is to provide a basic theoretical framework for CHP training and orient the reader to a few of the available resources that may inform training decisions.

In my career thus far, I have had the opportunity to experience Clinical Health Psychology training in a number of venues as a student and later teacher of doctoral-level CHP courses, as an Internship Training Director in a large medical center, as the Director of an APA-accredited Postdoctoral Fellowship in Clinical Health Psychology, and as a board-certified Clinical Health Psychologist through the American Board of Professional Psychology (ABPP). Through these experiences, I have been fortunate to work with a number of wonderful Clinical Health Psychologists and have been able to witness, first-hand, the variability in how CHP is theoretically defined and applied in training. Definitions of Clinical Health Psychology differ across sources, but perhaps the most comprehensive definition can be found on the website for the Council of Clinical Health Psychology Training Programs (CCHPTP) as follows: “The specialty of Clinical Health Psychology applies to scientific knowledge of the interrelations among behavioral, emotional, cognitive, social, and biological components in health and disease to the promotion and maintenance of health; the prevention, treatment, and rehabilitation of illness and disability; and the improvement of the health care system. The distinct focus of Clinical Health Psychology is on physical health problems.” (http://www.cchptp.org/, accessed August 20, 2014).

Expected competencies in Clinical Health Psychology training may be expressed broadly (see Masters, France, & Thorn, 2009) or within specialized medical contexts with unique patient populations and clinical needs (e.g., Primary Care; see Nash, Khatri, Cubic, & Baird, 2013). Thus, CHP training programs (at all training levels) vary in how they incorporate CHP into their curriculum. Some may provide a more general CHP experience, imparting a broad array of behavioral medicine skills with exposure (either academically or clinically) to a wide variety of clinical populations. Others, however, may offer a more specific focus on a population of interest (e.g., chronic pain, HIV, cancer, insomnia). Those hoping to incorporate CHP into their clinical training should consider their own interests in CHP and seek experiences that are congruent with their goals. To help them in doing so, the following resources may be useful:

- Council of Clinical Health Psychology Training Programs (CCHPTP; http://www.cchptp.org/) – The CCHPTP website offers a slate of helpful resources regarding CHP training including recent publications describing CHP training and education and a growing list of predoctoral, internship, and postdoctoral programs emphasizing CHP in their training.
- American Board of Professional Psychology (ABPP; http://www.abpp.org) – ABPP not only provides useful information about how to become a board certified Clinical Health Psychologist, the organization’s website also includes a comprehensive list of all board certified Clinical Health Psychologists as well as brief biosketches of CHP practitioners practicing in different environments.
- APA Division 38 (http://www.health-psych.org/) – Division 38 represents Health Psychology in the American Psychological Association. The Division 38 website offers a number of links to CHP training competency lists, training programs (at various levels of education), and a section for frequently asked questions about CHP.

Although the above resources offer excellent information about CHP training, there are many other opportunities that may not be included on these sites. Thus, individuals interested in CHP training are encouraged to ask questions of the faculty and directors of training at programs of interest that

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can help them clarify how CHP is manifest in their curriculum. Relevant questions may cover how CHP is applied within training (e.g., broadly across various courses or site, specific to individual training experiences), competencies expected of CHP trainees (including core knowledge and applied skills), and placement of CHP trainees who complete the CHP curriculum. As Clinical Health Psychology continues to burgeon, opportunities for CHP are likely to increase. I hope that the resources in this Newsletter entry offer some guidance as future Clinical Health Psychologists seek the next step in their training. It is an exciting time for CHP!


**Consortia:**

**Mentoring emerging consortia: Mentor’s and mentee’s perspectives**

By Brenda J. Huber, Ph.D., ABPP

The Directory On-Line currently boasts a total of 86 consortia, 39 of which are also APA accredited. Each year, I have the opportunity to mentor training directors of new and emerging programs. As one might expect, many questions raised by the training directors are relatively individualized to the particular program; however, I have also found that there are several questions which I often ask and which seem to be particularly helpful.

1. **Describe the shared philosophy, values, or mission that holds your partners together as one organization?**

Often, I am approached by university faculty who want to develop programs that are a good fit for their students. They desire to “do their part” to contribute to a balance in the supply and demand of interns. Typically, though, the entities who are being invited to become part of a consortium do not have training as their top priority. Initially, partners may be united in the desire to access low-cost service delivery or to do the university a favor. It may take some time as a group begins to coalesce to define the common denominator that will become the consortium’s professional identity. When I begin to hear things such as, “We want to improve the overall system of service delivery in our community by recruiting and retaining trainees who are knowledgeable of various evidence-based practices; training keeps us engaged in life-long learning” or “We all believe that we have expertise in this special population (e.g. rural, seniors, refugees, etc.), and we want to join together to train the next generation of psychologists to serve this group well,” or “Our organizations serve many of the same clients and collaborating to train psychologists is one way that we have truly become inter-disciplinary and we want to continue to engage in inter-disciplinary training,” I know that the organization is beginning to take shape as an entity that collectively prioritizes internship training.

2. **What are the areas of competence that your consortium will be known for? How will you know that interns across all the different settings have met these goals? What is the “training package” that all interns receive every year that translates into those applied skills?**

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In the beginning, programs tend to make broad statements indicating that they essentially want their program completers to be “competent psychologists.” In response, I often challenge the training director to begin thinking about how the twelve months will be different from on-the-job training; presumably simply having the opportunity to practice one’s skills over time would lead to at least some increased competence. Sometimes it is also necessary to ask how it will be different from an expanded or elongated practicum experience. The program’s goals are really the organization’s definition of a “competent psychologist.” Once the program figures out what they want interns to learn, they must determine how they are going to teach it. One of the strengths of a consortium is the diversity of supervisors and applied experiences; the challenge is to have a cohesive curriculum that all interns are guaranteed regardless of the combination of settings, supervisors, and rotations they may experience. The curriculum will have a series of didactic seminars, case presentations, and required exercises or assignments in addition to the individual scaffolding within supervision. All aspects of the sequential, cumulative, and increasingly complex curriculum are aligned with these goals, and the program has an evaluation process (ie. schedule, forms, evaluation strategies) that charts the trainee’s progress on a course from post-practicum to post-doctoral on these identified competencies.

3. What do you think is important for applicants to know about the program? What will you include in your training manual for incoming interns?

There are basically two sets of documents programs need to prepare whether they are consortia or not, and the answers to the previous two questions will certainly appear in one or both of these. One set is usually referred to as the program’s “brochure,” but operationally, this tends to be the information that is accessible to interested applicants upon the organization’s website. It is important that the description provides the applicant both with information about how to apply, but also the structure of the consortium. Here are some prompts:

Will interns spend all of their time in one setting?
How will they be able to secure various rotations?
Will applicants be able to rank order different experiences as separate tracks?
What kinds of travel are expected? How will the cohort be developed?
What kinds of intern compensation/benefits available and who provides it?
What will a typical week be like?

Typically the “training manual” or “intern handbook” is much more comprehensive and contains evaluation tools and due process and grievance procedures. Consortium-wide expectations are spelled out including numbers of hours in direct service and the quality and quantity of assessments and treatment cases. In addition, the structure of the consortium is clearly explained including who is responsible for the training seminars and who is responsible for the quality of the experience as well as compliance with all APPIC/APA criteria. The expectations for supervisors and the various partners are typically articulated, just as they are on the consortium-wide agreement that is signed by all partners.

Recently, I went through a six-month process with one training director who was willing to share these observations about the benefits of engaging with a mentor.

1. Working with a mentor helped with the organizational flow of the material.

Working with a mentor made it possible for me to focus on one aspect of the application at a time. Similar to therapy when the therapist holds the container for the client, working with a mentor meant I did not have to hold everything at once. This process allowed for full exploration of one topic at a time.

Sometimes key information about an internship program needed to be in one or more places in the application. Working with a mentor, or someone who knew this, made it easier to get the information in the right place. For me this meant that putting the documents together (beginning, middle and end) was easier as my mentor also had a vision of the overall plan and how our documents needed to flow for this plan to materialize.

2. Working with a mentor meant help with details.

Many times working with a mentor saved me time. There were times when I could not find an answer to a question in the posted APPIC documents. Having a mentor point me in the right direction saved time and helped me work more efficiently.

3. Working with a mentor provided support.

It was helpful to have someone to talk with about ideas that were specific to the consortium site I am working to develop. Asking site-specific questions allowed me to discard ideas that were not working. This meant I could put my time and energy into ideas that are fruitful for our situation.

4. Working with a mentor meant I learned things I might not have known.

As my mentor has walked through the APPIC application process and worked with interns in a consortium she could anticipate problems for me. This meant I could write from a more informed perspective as my mentor provided me with the ‘inside scoop’.

It was helpful to have the perspective of a mentor in terms of what items were vital in the program and in the application. I could use the information from the mentor to discuss site needs and ideas with others who are key players in our consortium and put together an application/training manual that more accurately reflected our site.
Greetings from San Diego! At the time of the deadline for this article, the Association of Counseling Center Training Agencies (ACCTA) was holding its 37th Annual Conference. This year we gathered at the Rancho Bernardo Inn outside sunny San Diego from September 13-16 for four days of professional development, personal rejuvenation, and socializing with other counseling center training directors. It’s a little bit like a big family reunion, only with CE credits available.

For those who may not be familiar with ACCTA, I’ll say a few words about the organization before discussing the conference. ACCTA is a lively and diverse group of 178 training directors and coordinators at university and college counseling centers across the U.S. and Canada. We’ve grown significantly in recent years and continue to add new member programs every year. Our President of the last two years going into the conference was Dr. Mary Ann Covey (Texas A&M University). Taking over the reins at the end of the conference was our new President, Dr. Matt Zimmerman (University of Virginia). The primary purposes of ACCTA are to promote the development of university- and college-based counseling center internships and to value diversity and the enrichment it brings to our organization and the training profession. Another purpose of the organization is to develop relationships with colleagues by working together, sharing ideas and resources, and having some fun! These purposes are met via several ACCTA standing committees, ad hoc committees, special projects, and working groups. These goals are also accomplished via our multifaceted website, an active and supportive member listserv, and our Annual Conference.

The theme of this year’s conference was “The Role of Counseling Center Training Directors in Leadership and Advocacy.” Our keynote speaker was Dr. Louise Douce, who addressed “Changing the World, One Intern at a Time.” Dr. Douce and Dr. Karen Taylor (both of The Ohio State University) teamed up to present on “Conscience Clause Dilemmas in Training Programs: Skill Building for Trainers and Supervisors.” Each year ACCTA invites two aspiring training directors to attend the conference as Diversity Scholars; we were pleased this year to have Dr. Chun-Chung Choi (University of Florida) and Dr. Ellen Greenwald (University of Texas at Dallas) present to us in this capacity. We were also pleased to be joined by invited liaisons from national organizations with whom ACCTA has strong working relationships: The Association of Psychology Postdoctoral and Internship Centers (APPIC); APA’s Office of Program Consultation and Accreditation; APA’s Commission on Accreditation (CoA); the Council of Counseling Psychology Training Programs (CCPTP); the Association of University and College Counseling Center Directors (AUCCCD); Association for Coordination of Counseling Center Clinical Services (ACCCCS); the Association of Psychology Training Clinics (APTC); and the National Council of Schools and Programs of Professional Psychology (NCSPP).

ACCTA’s highest award is the Helen Roehlke Award for Excellence in Counseling Center Training. This year’s award went to Dr. Greg Keilin. Most of you are familiar with Greg for his outstanding service and exceptional contributions to training in psychology over the course of his career. Otherwise, the 2014 conference was notable for 18 CE credit-bearing presentations, Affinity Groups, Culture Sharing, business meetings, area sightseeing, lots of good food, and renewed friendships.

We hope you’ll feel free to check out ACCTA online: https://www.accta.net/. And to our counseling center colleagues who are not yet part of ACCTA: Please join us! ACCTA is a wonderful resource for those developing new internships and seeking APPIC Member-status and APA-accreditation for college or university counseling center-based training programs.
My best friend and her husband recently had a baby girl who is absolutely beautiful, healthy, and deaf. She is three months old and is in the process of being fitted with her first hearing aids. On a recent phone call with my friend, we veered from discussing many of the big decisions that she and her husband are contemplating in the context of their daughter’s deafness (e.g., medical care, family communication, and school placement), to considering a “differently important” choice: The aesthetics of her daughter’s bilateral over-the-ear aids. Different from years ago, when a (very) few shades of “skin-color” were the only available selections for these little devices, my friend’s daughter now has the option to sport aids that are bright pink, purple, or neon green. She can accessorize (once she gets a bit older) much like many people do with their eyeglasses.

When I was a child, needing eyeglasses was a dreaded prescription and wearing them engendered the special kind of shame that comes with standing out in an undesirable way. The glasses of (somewhat) long ago, like the hearing aids of the recent past, were constricted in their styling; basic, clunky, and almost exclusively utilitarian.

What a difference between then and now: The ubiquity of imperfect vision and therefore of eyeglasses has rendered wearing them benign, commonplace, and even desirable (depending on one’s styling preferences). Spectacled children are no longer the conspicuous outliers amongst their peers but rather a typical, substantial segment of the kaleidoscope of difference that characterizes any given classroom. Eyeglasses themselves have developed into an accessory; their varied shapes, sizes, and colors can now reflect the wonderful individuality of the noses and ears that hold them secure.

While imagining what life will look like for my friend’s daughter, I was struck by thoughts of how the dynamics of hearing loss and deafness have changed over the past few decades. There seems to be less pressure to “blend in” and too much societal acquaintance with hearing loss to “stand out” dramatically.

Congenital and progressive hearing losses are relatively familiar human conditions. Baby Boomers are reaching the level of maturity that often brings age-related hearing decline and medical advances have ensured that premature babies are surviving and thriving at greater rates than ever – not uncommonly with sequelae including hearing loss. Across the developmental spectrum, a greater percentage of people are wearing these little devices which vary in size from tiny to very small and can be worn inside or outside (i.e., “over”) the ear.

Awareness of and respect for physical differences have been developing over the past few decades – especially since the passing of the Americans with Disabilities Act in 1990. Might the augmented offering of over-the-ear hearing device colors indicate a paradigm shift related to “imperfect” hearing? Could the stigma that for so long has accompanied hearing loss and deafness be fading, and may organic acceptance be developing in its stead?

I’m realistic and I don’t anticipate that the complicated feelings that tend to surface in the context of hearing loss and deafness will extinguish any time soon. Nor do I believe that hearing “accessories” will match the popularity of eyeglasses anytime soon. There do seem to be (neon green) signs that we are heading in that direction, though.
I have pondered this bible verse incessantly since the recent news of a close family member’s cancer diagnosis. Having completed Psychology fellowship studies on an oncology unit, I had been quite familiar on a professional level with the emotions-roller coaster that can be activated by a “Big C” diagnosis. Mildly stated, the psyche is catapulted through an array of unpleasant sensibilities that include pain, shock, anger, confusion and, surely, sadness.

Ultimately, just how does one cope in this situation – when cancer becomes intimate? I posed this question to my father, a retired physician (and Baptist church deacon) whose career has seen both the burden of “unfair” medical illness and the joy of seemingly miraculous recovery. His reply was the above quote from Hebrews 11:1.

Religion has always been engrained and invaluable in my life. A wellspring for comfort in strife and a resource for peace during anguish, my faith has been key to transcending adversity. However, I sense that that faith has never been truly tested until now. Thus, I am moved to scan the Christian literature and reflect upon some of the ways in which religion, as a potential resource for emotional peace and spiritual hope, might be therapeutically palliative.

Two themes emerged from the articles reviewed. First, outcomes suggest a benefit to interpersonal, spiritual-connecting as a means of coping during distress. And second, studies indicate that faith-based efforts that motivate toward health awareness and self-care, also enhance post-illness health monitoring and wellness. (Aldwin, Park, Jeong, Nath, 2014; Koenig, Larson, Larson, 2001; Powell, Shahabi, Thoresen, 2003)

THEME 1, RELIGION & COPING:
Social support – such as that fostered by participating in prayer groups, witnessing the faithfulness of others, and positively interchanging with fellow church members – can reduce feelings of helplessness, confusion, loneliness and isolation. A strong social network can ameliorate depressive states and foster a positive inner spirituality that may be conducive to illness healing.

Solidifying one’s relationship with God may advance a transcendent understanding of one’s purpose in life; it can thereby reconcile feelings of unfairness and even make sense of, or confer acceptability upon, suffering. (Aldwin et.al, 2014; Koenig et.al, 2001; Powell et.al, 2003)

THEME 2, RELIGION & HEALTH PROMOTION:
Religious practice has been linked to improved self-care. Many church communities foster cultures that inspirit physical and mental wellness. Participants therein are less likely to engage in personally harmful practices (e.g., cigarette smoking, excessive alcohol consumption, and drug abuse) and are more prone to practice preventative healthcare measures (e.g., doctors’ visits, physical exercise, nutritionally healthy eating, and psychological counseling). Therefore, it may be anticipated that religion participants facing life threatening illnesses might be likely to continue practicing self-care techniques that could potentially buffer their disease progression. (Aldwin et.al, 2014; Koenig et.al, 2001; Powell et.al, 2003)

In conclusion, periodically, I reflect upon my therapy patients (and now also, my own family member) and wonder, “What prevents some persons from ‘breaking down’ - particularly when it seems like so many odds are stacked against them?” My father’s allusion to faith (ambiguously defined in biblical verse) as one explanation, is bolstered by literature themes that link personal religion to both successful coping and health promotion. Evidently, religion and faith play an important role in health resiliency. In sum, I end with yet another bible verse, Proverbs 3:5 – one that my mother and many quote when life’s challenges become difficult to accept or comprehend: “Trust in the Lord with all your heart and lean not on your own understanding.” (Nelson, 1982)

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Diversity Issues: Faith
By Tonisha Joonis, Ph.D.
The University of Missouri-Kansas City (UMKC) is known as an “urban campus” and is located in the heart of Kansas City, MO, also known as the “urban core.” As such, we are blessed with a wonderfully diverse student body, as well as staff and faculty. UMKC is the academic home to students who represent every US state and approximately 73 countries around the world. We are proud to be a campus family that is comprised of members that embody the spectrum of multiculturalism. As such, when we saw the need to surround, support, encourage, and assist our family and community, that is exactly what we did for our students from the Ferguson, MO area.

To recount the precipitating event, on August 9, 2014, eighteen year old Michael Brown was fatally shot by a police officer in Ferguson, MO. Ferguson, a suburb of St. Louis, is a majority African American community that is governed and policed by a majority white force. Regardless of one’s political views or other affiliations, we cannot argue the fact that it is a tragedy when a young person is killed, it is a tragedy when yet another young, African American male is dead, and it is a tragedy and travesty when another young Black or Brown male, unarmed and with no criminal record, has died at the hands of law enforcement. Although this is not an article about who is right and who is wrong, this is a wake-up call to remind us that we cannot shy away from a bold discussion about race on our campuses across the nation.

I am proud to say that the University of Missouri-Kansas City boldly entered this discussion and continues to stay in this uncomfortable yet necessary place in order to better support its students and the community at large.

Heeding the call to action as they followed the situation in Ferguson while simultaneously preparing to welcome a large class of new and returning students to campus for fall semester, UMKC Administrators took swift action. With the help of Directors and other Managers, UMKC reached out to each and every incoming student from the Ferguson area with a phone call and/or e-mail. They even offered to send vans to Ferguson to help these students move to campus and begin their college careers.

The Chancellor sent a clear message to the entire UMKC Community that the University is here to support anyone affected by the Michael Brown shooting and subsequent events. And, in preparation of the incoming students and families from the Ferguson/St. Louis area and any other student affected by the events, the Office of Residential Life enlisted the assistance of our Counseling Center to be present during move-in days and offer an opportunity for the students and their families to process their reactions and concerns.

Efforts continued as the NAACP Student Chapter (with the guidance of backing of the Office of Multicultural Student Affairs) organized and held a successful event that entailed a rally, march, candlelight prayer vigil, and processing time for students, faculty, staff, and the Kansas City community at large. The Counseling Center was again enlisted to come and provide support and participate by helping groups and individuals continue to process their feelings and concerns about these stressful events.

All of the formal events held so far have been very well attended and quite successful. The students have voiced feelings that have ranged from anger to fear and from discouragement to a sense of activism. The subject of race is an ever-present part of many discussions in the office, in the classroom, and in general gathering spaces. Moreover, those of us from the Counseling Center have been more present on campus, in the Student Union, and at general student activities in order to continue to be that supportive, empathic and comforting presence that is much needed at this time. This has been a joy and a challenge for our Counseling Center as we have been confronted with our ideas and biases around race and class. We have taken time to do our own processing about our feelings and reactions about what has occurred in the past several weeks and the impact it has had on us personally and professionally. We, too, have experienced a broad range of emotion and are still working to make sense of something that has deeply affected our entire community. I am proud to be a member of such a proactive Counseling Center and University, and I am proud to call UMKC home.

By Lynette Sparkman-Barnes, Psy.D.
Forensic Psychology: Keeping Staff Safe

By Pamela Morris, Ph.D.

Psychologists are trained to make sure that their patients are safe from harming themselves or others. However, within a correctional environment, the safety of all staff and offenders is a responsibility as well. Training psychology interns within a correctional setting to be aware of security issues presented not only by their patients, but by others within the prison, is a part of sound correctional management. Interns should learn to recognize potential danger, and know the proper means to respond in order to be sure everybody is safe. This education also provides insight regarding the minds of offenders, who, contrary to what our training has implied, may not always have their own or other peoples’ best interests in mind.

Psychology interns should be alerted that some offenders may not really want therapeutic treatment and should be prepared to look for warning signs. Some of the signs of lack of motivation for treatment should be reviewed. For example, if the offender presents a problem with no distress associated with it, the intern should determine how and if the offender really has an issue. If the offender does not seem invested in speaking about their issues, the intern should learn ways to figure out if this is due to discomfort, lack of insight, or lack of real distress or motivation. If the offender refuses to practice the therapeutic techniques that are prescribed, or complete self-help homework that is recommended, the lack of investment in their self-improvement should be explored, to determine if it is due to a lack of motivation to receive help or other inhibiting factors.

Referrals that want to spend time finding out personal information about the intern need to be stopped right away. Moreover, boundaries between the intern and the patient should always have their own or other peoples’ best interests in mind.

Offenders know that when they inform a staff member of potential danger, this danger needs to be reported by their clinician. Interns need to be warned that offenders will “test” them to see if they report things that they are supposed to report. An offender who begins an intern not to report something needs to be reminded of safety and security requirements and the fact that all staff need to pay attention to them. Interns should be reminded of potential dangers of not reporting security information. Although an intern may be torn between not wanting to break a patient’s trust and informing appropriate personnel of certain issues, the intern needs to learn that the offender was aware of security boundaries prior to disclosing information, and therefore is putting their job and the safety of others in jeopardy by reporting something potentially dangerous and asking them to not disclose it to others. They should be trained on clinically appropriate ways to handle reporting information that was disclosed in therapy.

Interns should be reminded that if an offender is in potential danger, they must not be allowed to return to the open population until their safety is assured. For example, if an offender reports that they have been threatened by another, or that they have been victimized either physically or sexually, the intern needs to keep the offender within their sight until the concern is appropriately investigated, and everybody’s safety and security is assured.

Moreover, interns should be warned of offenders who want to know them personally or have an unprofessional relationship. Offenders are on the winning end of compromising a staff member as such situations can lead to early release, a transfer, or another desire of the offender. Interns need to be reminded that if they have more personal feelings towards an offender, they should discuss it with one of their supervisors, to ensure that they don’t engage in any unprofessional or compromising behaviors. Interns should be made to feel comfortable to come forth with problems and concerns as staff are aware that they have the potential to be manipulated. Supervisors should normalize feelings of wanting to believe the offender, help them, and care for them in a more personal way, while making sure that the intern is safe from manipulation or coercion by the offender.

Psychology interns benefit from learning where their offenders hide dangerous “contraband;” how they make “shanks” (i.e. sharp objects), “hooch” (i.e. alcohol), and find loose tobacco to smoke. Not only does this teach the intern about the offender’s motivations, mind, and environment, it assists them in deterring dangerous items from being created within the institution. For example, something as simple as throwing a piece of fruit or putting a piece of garbage in a trash can that an offender has access to can provide items to offenders that can be used to create contraband.

Supervisors should be aware of offenders who may have a history of compromising staff or making inappropriate comments to staff. These offenders, when enrolled in therapy, should be monitored, with supervisors observing the therapeutic interaction if possible. Moreover, offenders’ emails and phone calls can be listened to and viewed to see if they are really in distress or have other motivations in seeking therapy.

Psychologists generally believe that others, to include their patients, have good intentions. This belief is essential to gain progress in therapy as the clinician’s optimism and support helps patients meet their objectives. However, there are people both within the confines of prison, as well as outside of prison, who generally don’t have good intentions and may even have desires to be hurtful to others. This bad side of others is important to be aware of, accept, and appropriately confront in order to clarify goals of therapy and ensure that they are reachable. Moreover, an awareness and acceptance of the degree of perniciousness and malintentions that some others may possess assists with preventing bad things from occurring, and helps to create the safe environment that is incumbent upon all workers, to include psychologists and psychology interns, within the confines of prison.

Note: The views expressed in this paper are those of the author only and they do not necessarily reflect the views or opinions of the Department of Justice or the Federal Bureau of Prisons.
Geropsychology

By Andrew L. Heck, Psy.D., ABPP

Geropsychology continues to make great strides as a specialty across many domains. The major geropsychology entities (APA’s Committee on Aging, the Council of Professional Geropsychology Training Programs [CoPGTP], APA’s Division 20 [Adult Development and Aging], APA’s Division 12-II [Society for Clinical Geropsychology], and Psychologists in Long-Term Care) remain active in advancing policy, practice, and knowledge about mental health and older adults. These are some key recent endeavors:

• Geropsychology ABPP: As of September 2014, the American Board of Geropsychology (ABGERO) has conducted almost all of the required number of board certification examinations to become eligible to be the newest board within the American Board of Professional Psychology. It is anticipated that all requirements for board formation will have been met at the time of the formal ABPP Board of Trustees vote in December 2014. ABGERO continues to accept applications for ABGERO certification; information can be found at www.copgtp.org and www.gerocentral.org, and application materials can be found at www.abpp.org. Questions about ABGERO’s progress, candidate eligibility, and the application process should be directed to Victor Molinari, Ph.D., ABPP, ABGERO President. He can be reached at vmolinari@usf.edu.

• APA task force to reduce antipsychotics in long-term care: APA’s Office on Aging has assembled a workgroup of geropsychologists to work closely with the Centers for Medicare and Medicaid Services (CMS) on their national initiative to reduce the use of antipsychotic medication in individuals with dementia in nursing homes. Workgroup members have held conferences with key CMS administration officials about psychology’s importance in developing and implementing nonpharmacological interventions in place of using antipsychotics—which research has found to have inordinately harmful side effects in individuals with dementia. The workgroup is also gathering data on these interventions’ therapeutic and cost effectiveness, and integrating it into educational materials and programs for local, regional, and national stakeholders.

• Policy issues: Geropsychologists continue to advocate for other important practice-related policy changes, including the incorporation of psychologists into the Medicare definition of ‘physician,’ and broadening the categories for which psychologists may be reimbursed in long-term care settings (e.g., consultation and staff inservices regarding specific residents).

International Issues: CCPPP

By Susan Jerrott, Ph.D.

The Canadian Council of Professional Psychology Programs (CCPPP) represents university psychology programs and psychology internship settings in Canada that train doctoral level clinical psychologists, counseling psychologists, and clinical neuropsychologists. Current membership includes 87 sites from across Canada (46 university sites and 41 internship sites). Our priorities as a group are to address the match imbalance and to advocate for doctoral level education and training as the standard for professional psychology programs across Canada.

In the past year the CCPPP executive contacted most Canadian non-accredited training sites which could be developed and accredited. CCPPP provided mentorship to interested members and helped several of them work towards their goal of CPA accreditation. The executive has also had conversations with most DCTs of non-accredited programs to determine barriers for accreditation, so that our organization can begin to address these difficulties.

Our organization is currently planning for the 2015 CPA Pre-Conference Workshop and we encourage APPIC members to attend. The title of this year’s workshop on June 3rd, 2014 is Fighting Fires and Solving Problems and will focus on methods for dealing with unexpected difficulties that arise with our students and interns. This workshop will be followed by the AGM.
SMI Issues: How about a career serving severely mentally ill patients?

A psychology intern discusses her choice

By Edward Hunter, Ph.D.

Brandy Baczwaski, M.A. is a psychology intern at the University of Kansas Medical Center in Kansas City, Kansas. She anticipates a career in the field of severe mental illness (SMI). The choice to pursue this career trajectory occurred “almost by accident” when there was a change in the practicum structure in her graduate program which placed her on a crisis stabilization unit. She had not had this patient population in mind until then. Always interested in underserved populations, she envisioned previously a career perhaps in a mental health center. As with many other graduate schools in clinical psychology, Ms. Baczwaski trained in a program which provided a good deal of emphasis on outpatient care and less severe conditions (cf. APA, 2015). While on her practicum, she worked with more severely disturbed individuals who were psychotic. She found that the conditions in these patients were not readily responsive to symptomatic change. It was easy to see her patients were quite ill and in need of help. It appeared that attention to more basic goals such as personal care, illness education, and adherence to follow up treatment and medication was more appropriate. This is consistent with much of the extensive and growing evidence for the efficacy of empirically-supported interventions described below. Her compassion for the level of suffering she saw in these individuals drew her to the field.

Ms. Baczwaski intends to train for a career working with severe mental illness in an inpatient facility, medical center, crisis center and/or a state hospital as she is interested in working with a range of patients with very acute to long-term care needs. When applying for internships, she was able to find a 12 well-established and accredited programs that attracted her interest and were within the regions of the country where she wanted to be. A number of these were state hospitals. These included Arkansas State Hospital, Northeast Florida State Hospital, Mississippi State Hospital, Utah State Hospital, Fulton State Hospital (Missouri), and Wyoming State Hospital. She also found opportunities for SMI training which seemed to be a good fit for her at Appalachian Regional Healthcare (Kentucky), Center for Behavioral Medicine (Kansas City, Missouri), South Arkansas Regional Center, Spring Grove Hospital Center (Maryland), Hennepin County Medical Center (Minnesota), and Denver Health. She matched with The University of Kansas Medical Center where she could receive a wide range of exposures from outpatient to long-term inpatient care within an academic medical center setting.

Another consideration in her career choice is her dedication to a population that is underserved. She noted that many individuals with SMI have limited financial resources. Thus, funding is a big problem in caring for them. She found that many insurance plans, if the person has health coverage at all, do not cover the cost of the extensive needs of SMI patients, such as prolonged inpatient care.

What attracts a program to an intern interested in this field? From our experience, a very good graduate training program, practicum experience working with the SMI patient population, and excellent interpersonal skills are important. However, for us, experience with the SMI population is less relevant in considering a candidate for this field than is an interest in SMI as well as a desire to also train in a broader range of medical center exposures. In fact, we find that many graduate school curriculums include an abnormal psychology course as the main didactic exposure to SMI. Thus, for many people, the expectation of a great deal of training prior to internship could be unrealistic. We also find that interns’ career goals become modified by new experiences on their rotations. We have “converted” some to an interest in SMI! We find that, while respecting the seriousness of these disorders, many interns nevertheless find that the symptom presentations are quite fascinating and that the establishment of a treatment alliance is an intriguing challenge. Ms. Baczwaski’s interest, as noted above, was not something she anticipated when she entered graduate school. Once an interest is developed into more experience and competence, Brandy noted that there are quite a number of opportunities to pursue.

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postdoctoral training in SMI. We have had success in placing interns in state hospitals and county inpatient facilities where training can be excellent. An APPIC directory search turned up 16 “hits” for severe mental illness and four for state hospital; and we also know of a number of programs which are not listed but provide good training.

Psychology careers focused on SMI also place interns at the forefront of the neuroscience of behavior. Furthermore, the research opportunities in the field are considerable. Ms. Baczwaski is interested in genetic research and the hope for more effective treatments at the biological level for these conditions. The 2014 Nature article referenced below, using a sample of over 36,000 cases, reveals the level of success being achieved through multidisciplinary efforts. Behavioral research has also made great recent advances in identifying empirically-supported treatments for persons with SMI. For instance, while Chambliss et al. (1998) identified no well-established treatment for schizophrenia, the Society for Clinical Psychology (APA Division 12), now identifies six interventions for which there is strong research support: Social Skills Training, Cognitive Behavioral Therapy, Assertive Community Treatment, Family Psychoeducation, Supported Employment, Social Learning/Token Economy Programs, and Cognitive Remediation. As well, this group identified Acceptance and Commitment Therapy, Cognitive Adaptation Training, and Illness Management and Recovery as interventions with modest research support.

The list of useful psychological interventions for SMI as noted above makes it obvious that psychology can do a great deal for people with SMI. Further, it is clear that many psychologists have made careers through research in this field. As well, the opportunity to collaborate at both the clinical and research levels in order to help people with these often quite disabling illnesses can make a choice of career in the field of SMI stimulating and fruitful.

REFERENCES

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output was sparse this year, in fact, the lowest since I started doing this column. My usual Psych Info search turned up little, so I looked specifically at Training and Education in Professional Psychology. That procedure produced only a little more. This probably means that a deluge will cascade down next year. And, speaking of next year, I may still be around but maybe not. I’m taking it a year at a time at this point. I’m way “past due” for retirement.

1. Callahan et al. (2014) took a look at predictors of successful match for 601 students. Variables in the predictor set included academic achievement, clinical training, and personality. The number of interview offers topped the list for successful match. Entering the match a second our more times was associated with NOT matching. Sub analyses found that intervention and assessment hours are associated with more interview offers (those variables have been shown to be crucial for 25+ years). Personality showed up as associated with more interviews. Finally, there was an interaction effect between research and practice variables which the authors interpreted as support for the Boulder model. TEPP, 8, 68 – 82.
2. D”Angelo (2014) contributed to TEPP’s special issue, “Blueprint for Health Service Psychology Education and Training”, with ideas about the role of the internship in the training sequence. TEPP, 8, 34 – 37.
3. Menefee el al. (2014) described a new scale, the Supervisee Attachment Strategies Scale, which measures types of attachment to supervisors, internship supervisors in this case. Factor analysis produced two factors: avoidance vs. engagement and rejection concern vs. security. Results say high avoidance of supervisors is not good but rejection concern did not predict in this sample. Nevertheless, engagement and secure attachment work best. J of Counseling Psychology, 6, 232 – 240.
4. Wells et al. (2014) produced the only imbalance article I could find, but the problem, or should I say the crisis, is still here. This paper updates APAGS’ efforts to help alleviate the crisis, which the authors define as “one of the most critical facing psychology graduate students today”. IMO, I’d drop the “one” from the quote.
Many psychology graduates experience guidance and support from their doctoral programs regarding the daunting task of applying to internship programs. However, once internship is completed, students are essentially shoved out of the nest to fly solo, without any direction of what to do next. Students have often said to me, “Where do I begin? I don’t even know where to start looking,” in reference to finding supervised experience or a formal post-doctoral fellowship to meet licensure requirements and obtain advanced or specialized training. The confusion and disorientation recent graduates feel about this next stage in their career is a reflection of the disorganization and lack of uniformity of the post-doctoral fellowship process in the field of psychology as a whole.

Why isn’t there a uniform process, with a regulating body to monitor the quality of supervised experience in this vital last year of training? To answer this, we need to look at the history and development of psychology as a profession. As much as psychology is a young field, the concept of a post-doctoral experience in psychology is even newer. Dr. Wayne Siegel, licensed psychologist, training director at the Minneapolis VA Medical Center, and APPIC board member, provided a historical perspective on this complex issue. In a phone interview with Dr. Siegel he noted, “In the past, post-doctoral fellowships were mainly research positions that were grant-funded and primarily for those looking for an academic position. That started to change in the late 80’s/ early 90’s.” Dr. Siegel attributed this shift to a change in the field when psychologists began to specialize. The first of these specialties to require advanced training was Neuropsychology. Thus, the post-doctoral fellowship also moved from a strictly research position and broadened to include clinical experiences. As Dr. Siegel described, the APA also attempted to implement some level of quality assurance for post-doctoral fellowships by offering formal accreditation in the late 1990’s, early 2000’s. An ancillary gain to having accredited programs was a uniform start and end date for formal fellowships, which would potentially decrease the amount of “stealing” of applicants from one another, a practice in which sites were routinely engaging. Dr. Siegel stated, “This was a very confusing time for the profession. While it lead to a wide variety of clinical experiences for applicants, many programs developed fellowships that did not fit the somewhat narrow description that the CoA [Commission of Accreditation] defined as an accredited post-doctoral fellowship.”

Post-doctoral fellowship programs use many terms interchangeably, such as focused training or area of emphasis which is often confused with defined areas of specialty that have accepted Education and Training Guidelines. These distinctions need to be clearly defined so applicants have a better understanding of what kind of training experience they will be receiving at these sites. The biggest hurdle to making progress towards a standardized process is getting programs to participate in a unified system. Many programs want the flexibility and control to determine what they offer for fellowships, without a regulating entity. Additionally, if regulated, there would naturally follow fees and formal paperwork/applications to review to ensure programs are meeting standards. This is a very costly and time-consuming process, as many APA-accredited internship programs are well aware.

Where is the buy-in for programs to want to be part of a centralized, standardized process? How might this be different from having a unifying system from an organization such as APPIC? APPIC currently has guidelines and criteria that are required to be a member, but they do not have the same rigorous review standards as the APA.

APPIC is attempting to answer these questions by providing a Post-doctoral Fellowship Directory for its members. This provides a centralized location for post-doctoral fellowships to post information about various training programs throughout the country. Additionally, in order for programs to be members of the Directory, APPIC has minimum criteria for quality of training. However, as Dr. Siegel admits, this is a preliminary and cursory review of these programs; there is no site visit or self-study component to this process to ensure programs have fidelity. To address the issue of uniformity, APPIC has also posted suggested selection guidelines for programs to adopt such as notification deadlines and procedures. Currently, this directory is only available for APPIC members and lists approximately 130 post-doctoral fellowships. However, no one truly knows the number of fellowship positions available across the country, but one would venture that it is much more that the APPIC Directory currently represents. APPIC has recently announced the launch of an online application process called, APPA CAS (APPA Psychology Postdoctoral Application), which has been developed to provide an easy to use, unified application system for programs and applicants. This platform

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is similar to the AAPI but seems to be a simpler, more flexible version in which programs can ask for basic applicant information and applicants can upload documents. Currently, APPA CAS is free to APPIC members and non-APPIC members for the first year. There is a nominal charge for each application that applicants submit. APPIC hopes that this will lead to an increase in APPIC membership over time, which may then lend to implementing a formal match or selection process in the future.

While APPIC is attempting to move the field forward in helping to support graduates in the Post-doc search, as well as taking preliminary steps to provide uniformity to the process, there is still a long way to go.

So we come full circle to the intern, sitting in my office, asking me where to begin. Until we as a profession can look at this as a systemic and universal issue, my answer remains the same: reach-out. Ask mentors, professors, and professionals you know in the field if they are aware of any post-doc positions that are available. Put yourself on the APPIC Post-doc Network listserv, the APA Division listservs, and listservs with your state psychology associations. If you are not finding any leads in these areas, look to the back of the Monitor or search job sites. This is also a call to internship programs to review the process of licensure in your state. Discuss the application process and requirements with your interns so that they feel prepared to begin their search. Warn them of the common pitfalls such as lack of reciprocity in certain states, how difficult it may be to get licensed in other states if supervised experience after internship is not required in your current state, and that quality of training varies given many programs are not accredited or APPIC members. We owe it to our field and future psychologists to pave the way for a more formalized application process and to ensure high-quality post-doctoral training if this is becoming the norm for licensure in most states, as well as a means for obtaining focused, specialized training prior to becoming independent practitioners.

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As the movement towards more widespread approval of psychologist medication prescribing seems to be gaining momentum, with more states joining the several that have already endorsed such an arrangement, we might well pause to reflect on an issue that has already become a hot potato for our physician colleagues. How should we engage with the marketing pressures that are constantly being applied by the pharmaceutical industry and its representatives?

This is both a matter of ethics as well as a problem of scientific integrity. It has been amply demonstrated that the enticements of small gifts, dinners, logo-emblazoned gizmos and subtle or even blatant personal stroking by attractive and articulate “detail people” can have an insidious impact on the medication-prescribing behaviors of professionals who are granted such a privilege.

Even though the recipients of such attentions tend to maintain that they remain impervious to the effects of the salesmanship showered upon them, study after study show that prescribing choices are indeed shifted in the direction desired by the marketing representatives. The pitchmen or women are highly trained to establish warm and cordial relationships with those whose offices they visit. They then aim to use the kind of friendship/collegial type of interaction they have worked at establishing as the basis for convincing the clinician that the product they represent is indeed superior to what may have been used in the past. A number of surveys have indicated that such office visits are a primary source of continuing education for the prescribers.

To be fair, there can be much positive benefit from these office visits. A common practice is to provide the clinician with a generous supply of free medication samples, which are greatly welcomed by the prescribers, and which can be dispensed as “starter” medications that allow for a trial to see how the particular drug may work for a patient. Also, these samples are of great benefit when patients with limited resources are in need of treatment they could not otherwise afford.

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The problem of how to manage these sales relationships has been well recognized by many medical teaching institutions, and a variety of restrictions and limitations on access to medical trainees have been put in place. Both the AMA and the American Psychiatric Association have established policies that attempt to isolate medical students and residents from contact with the sources of sales pitches. The value of gifts that can be given has been set by many centers at a level that it is hoped will prevent at least the appearance of “bribery.” It is not clear, however, that these quantitative restrictions do, in fact, achieve their intended goal, and the jury still seems to be out on how well such an approach actually works.

Now, it’s not that organized psychology has ignored this issue. In 2007, an APA task force issued a series of recommendations under the general topic of “Corporate Funding and Conflicts of Interest” in which it was noted that the powerful influence of the pharmaceutical industry’s millions of advertising dollars needs to be recognized for what it is. This report, published in the December 2007 American Psychologist, included specific proposals dealing with psychology–Pharma relationships in such areas as convention funding and advertising, education and continuing education, practice and ethics. Reviewing the by then substantial body of research on how prescriber behavior is likely to be influenced by advertising and marketing techniques, the panel suggested some guidelines with respect to how psychologists might best respond to the proffering of gifts and other marketing inducements.

Subsequent to that report, an APA task force from Division 55 (American Society for the Advancement of Pharmacology) published in the December 2011 American Psychologist a series of “Practice Guidelines” concerning psychologists’ involvement in pharmacological issues. Psychologists were encouraged to “engage in activities likely to improve their awareness of the impact of pharmaceutical” marketing on prescriptive practice. Examples were given of the types of issues to which attention should be paid. It should be noted that these were “guidelines”, not “standards”, the latter carrying a much higher level of expectation of adherence. These guidelines, did not, moreover, speak specifically to the matter of limitations on the size and/or the nature of marketing exchanges between psychologist prescribers and detailers. As noted, other professional organizations have been much more explicit in setting such limitations, and it is widely reported that many teaching hospitals, medical schools and other clinical training sites have been encouraged to and, in fact, have imposed severe restrictions on contacts between drug representatives and trainees.

So, the question then arises, should internship and post-doc training centers be more active with respect to this matter? While it would be nice to believe that our trainees are less likely to be influenced by the marketing efforts that are likely to be directed towards them, reality would suggest otherwise. As psychology trainees move towards the completion of their formal educational preparation, do we not need to alert them to the kinds of situations that they are perhaps going to be encountering, particularly as psychology prescribing advances and increasing numbers of our newly minted psychologists opt for additional psychopharm training that would expand their scope of practice.

Now, having said all that, a small confession is in order. Several months ago, I accepted an invitation to attend a dinner cum lecture sponsored by one of the very nice detail ladies who regularly visit several of the psychiatrists with whom I share an office suite. My ostensible reason for doing so was to learn what I could about a relatively new medication which had been prescribed to several of my own patients. The real truth was that I think I was curious to see how these “thought leaders” go about their business. The dinner in a fairly high-end restaurant was lovely and then the invited speaker, from out of town, presented a summary of some research comparing this new medication with another more traditional one. I don’t exactly consider myself a major maven regarding research design and statistical analysis, but the presentation was pretty weak. The design had flaws and the analysis, as I heard it, didn’t really seem to lead to the conclusion the speaker was advancing. It probably would not have earned an even close to passing grade for a second-year psychology grad student.

What was most striking was that the audience, which consisted almost entirely of advance practice RN’s and some psychiatrists, nodded and listened solemnly to this presentation, asked a couple of questions about some minor details and seemed prepared to leave the evening convinced of the benefits to be derived from what was being pitched. Unable to restrain myself, I began asking, as kindly as I could, a few gentle questions about the disconnect between the data that had been presented and the conclusions being drawn. The speaker, who was most likely presenting from a script that had been prepared for her, didn’t seem to fully grasp the implications of the points I was raising, and I called it quits after a few efforts at poking some small holes in the enterprise and perhaps raising a few doubts in the audience’s collective minds.

What’s the point of this story? It was rather frightening to observe how readily an intelligent but non-data-savvy group of clinicians could be convinced of something that appeared not to be valid, but which sounded superficially good. This kind of pitch probably wouldn’t have made it past a group of well trained psychologists, but one never knows what a nice meal and a little wine will do.