ASSOCIATION OF PSYCHOLOGY POSTDOCTORAL AND INTERNSHIP CENTERS
APPIC
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Newsletter

Volume XXIX, Number 2 November 2004

Special Section:

♦ *SUPERVISION* ♦

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Special Article:

A STUDENT WITH A DISABILITY SPEAKS OUT ABOUT THE INTERNSHIP APPLICATION PROCESS

BY CARLA MESSENGER, M.A. &
KELLY ARNEMANN, M.S., APAGS MEMBER-AT-LARGE–DIVERSITY FOCUS

The following article is, in part, the story of one graduate student's recent experience as an internship applicant who participated in the Match. This part of the article was written from her perspective in order to illustrate some of the challenges faced by students with disabilities during this process. The second part of this article presents some guidelines and suggestions that may be of assistance to training programs in dealing with these issues sensitively and practically.

At this time last year, I began the arduous process of applying to internship programs; with both enthusiasm and anxiety. After all, there were no guarantees that I would match at all. I faced some additional challenges in finding an internship because of limitations posed by my disability. I wanted to be honest with myself in confronting these challenges so that I could minimize their potential effects. My ultimate goal was not different than that of any other applicant in that I wanted an internship that would provide good training and augment my professional development.

When selecting internship programs, I chose them in much the same way that any applicant would in terms of compatibility to my interests. However, other factors were important to consider, specific to my disability. My visual impairment prohibits me from driving, so accessible public transportation was essential, as was close proximity to an ophthalmologist. These two factors significantly limited my potential choices.

The greatest challenge was deciding how much, if anything, to say regarding my disability. My advisor agreed that it was best to disclose some information about my visual impairment in an effort to communicate that even with a severe visual impairment I had been successful in graduate school and effectively dealt with the limitations imposed by my disability. My decision was based on two of my greatest fears: 1) that once the sites

Editor's Note: Statements, opinions, and recommendations of the authors are their own and do not necessarily represent APPIC policies or concurrence with specifics of the article.

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Chair's Column

BY GREG KEILIN, PH.D.
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I'm not exactly sure where the time went, but here I am in my sixth and final year on the APPIC Board. I am very honored to be serving as the APPIC Chair, and I'm wondering how I'm going to fill the very big shoes left by the previous occupants of this position.

I would like to take this opportunity to update you on some of the issues and priorities that APPIC will be focusing on in the coming year.

ADVOCACY: Just a few months ago, I would never have dreamed that this topic would lead my first Chair's column in the newsletter. Since then, a number of state and national issues have arisen that have required APPIC's attention and action, thus highlighting the importance of our continued involvement in advocating for psychology training.

One of the first issues to land in my lap was the recent revision to the Fair Labor Standards Act (FLSA), which established that overtime pay must be provided to certain employees who earn less than $23,660 per year. This quickly became a very hot issue on the MEMBERS-NETWORK e-mail discussion list, with Training Directors reporting that they received a variety of interpretations as to whether or not these rules apply to psychology interns and postdoctoral residents. As of this writing, APPIC is working closely with APA in an attempt to get our members a consistent interpretation of these very complex and confusing regulations.

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ASSOCIATION OF PSYCHOLOGY POSTDOCTORAL AND INTERNSHIP CENTERS

The Association of Psychology Postdoctoral and Internship Centers (APPIC) was formed in 1968 to foster the sharing of information about mutual concerns and to provide a uniform voice with respect to pre- and postdoctoral internship training interests within psychology.

We publish a newsletter three times per year for our members. We are recognized by APA as the primary organization to consult about internship training. Since our inception, we have maintained a formal liaison with APA's Education Directorate.

We publish an annual *Directory of Internship and Postdoctoral Programs in Professional Psychology,* which is intended in part as a service to students. Approximately 1,500 copies of the *Directory* are now distributed each year. The *Directory* is updated every year in late summer, and is free to APPIC members.

We also are responsible for establishing with our members a standardized procedure and a uniform date and time span for matching internship applicants and internship programs. The procedural guidelines are published annually in both the *Newsletter* and the *APPIC Directory.*

Additionally APPIC operates a Clearinghouse to facilitate the placement of unmatched predoctoral internship applicants with unfilled positions at APPIC member programs. The Clearinghouse starts its operation after the Uniform Notification date for predoctoral matching. Please see the current APPIC Directory for detailed information on the Clearinghouse.

APPIC Membership is by institution rather than by individual. In order to be a member of APPIC, an internship program must be one year full-time or two years half time, accept only applicants enrolled in a regionally accredited doctoral degree granting program in professional psychology, be directed by a licensed professional psychologist, meet other relevant membership criteria, and provide annual updates of descriptions of its program for the *APPIC Directory.*

Membership dues are $400 for predoctoral internship programs, $400 for free-standing post-doctoral training programs, and $650 for pre-doctoral and postdoctoral programs at the same agency/institution. Application fees are $250 per application. Non-APA-accredited internship programs, and post-doctoral training programs are reviewed in order to determine whether they meet APPIC membership criteria. For further information write to APPIC, c/o Ms. Connie Hercey, MPA, 10 G. Street, NE, Suite 440, Washington, DC 20002, or call (202) 589-0600.

IN THIS ISSUE

REMARKS FROM THE EDITOR

BY ROBERT W. GOLDBERG, PH.D., ABPP

Special Section on Supervision

Response to the electronic call for articles for this Special Section was swift and gratifying, resulting in the quickest assemblage of quality theme articles that I have had the pleasure of editing. In addition to the articles in that section, Associate Editors Kristee L. Haggins, Sharon Berry and Valerie Holms have discussed supervision in their columns and new ASARC Chair Anna Beth Payne has also addressed the topic in The ASARC Corner. Special thanks to all these contributors.

Associate Editor for Postdoctoral Issues Wanted

This particularly important Associate Editorship continues unfilled in a time of mushrooming interest in postdoctoral training. Someone, please, take up the challenge!

Interested applicants should please send a brief paragraph statement of interest with attached vita to emu34@aol.com.

Other Articles Wanted

Articles are still sought on the following topics:

Testing: Pre-Internship Preparation and Training on Internship
Special Needs of Interns
Competencies
Diversity in Training
Interviewing Applicants to Internships and Postdoctoral Programs

At the Annual Membership Meeting and elsewhere, the above topics are discussed with considerable vigor in the aisles and between the rows. Please put your ideas in paper, or in electronic cyberspace, and send us some articles!

Chair's Column

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In addition, APPIC Board members have recently: (1) written letters to various California legislators regarding a Bill that could negatively affect the viability of internship and postdoctoral programs in certain non-public schools in the state; (2) participated in visits to various congressional offices in Washington D.C. in an attempt to secure additional funding for the Graduate Psychology Education (GPE) program; (3) been extensively involved in supporting the "Campus Care and Counseling Act" (renamed the Garrett Lee Smith Memorial Act) that currently awaits the President's signature; (4) written letters to the Washington Board of Psychology regarding its proposal to eliminate the postdoctoral requirement for licensure; and (5) watched as the National Residency Matching Program, which operates the Match for medical residencies, received special protection from Congress against antitrust litigation.

Clearly, advocacy will be an increasingly important focus of all of our professional activities as psychologists. APPIC has been fortunate to have two Past Chairs, Nadine Kaslow and Emil Rodolfa, who have been very involved and effective in this area. Furthermore, the APA Public Policy Office (www.apa.org/ppo) and the Education and Practice Directorates have been very active in working on issues that directly affect internship and postdoctoral programs. Special thanks go to Nina Levitt, Sheila Forsyth, and Cynthia Belar for their continued efforts on our behalf. Stay tuned for more information about advocacy-related activities at the APPIC Membership conference next year.

I recently participated in a number of visits to Capitol Hill and, once I got over my initial apprehension about the process, I was amazed at how easy it was and how much of a difference we were able to make. Even with a very tight federal budget and a tense political climate, we were pleased to receive some very positive responses from congressional staff to our requests for an increase in GPE funding. This experience has challenged me to question my own resistance to engaging in these types of activities (particularly my "What difference could I make?" type of thinking), and to recognize that there are many opportunities to be an effective advocate for psychology education and training.

POSTDOCTORAL TRAINING: APPIC intends to increase its focus on, and services to, postdoctoral training programs. The Board has waived, through September 30, 2005, the application fee for postdoctoral programs that wish to join APPIC. Please feel free to contact me if you have ideas about how APPIC can better serve the needs of these programs.

SUPPLY AND DEMAND: The 2004 Match witnessed a jump in the number of applicants participating in the APPIC Match, resulting in the largest imbalance since the first APPIC Match in 1999. Using data from previous Matches, APPIC will be conducting research this Fall which focuses on the Supply and Demand problem. We hope that this research will yield a more in-depth understanding of the problem and help us to identify ways in which this problem can be addressed.

MATCH RATES FOR CERTAIN POPULATIONS: Over the years, APPIC has heard concerns from students and faculty about whether certain sub-populations (e.g., older students, applicants with disabilities, ethnic minorities) are experiencing bias or discrimination in the internship selection process. APPIC and APA embarked on a joint research effort in 2000 to explore these issues; however, analyses of the data have been complicated by less-than-desirable response rates, small n's, and understaffing at the APA Research Office. However, we just completed our third bi-annual survey, and I am hopeful that we now have sufficient data to be able to distribute some results before the end of the year. I would like to thank Jessica Kohout and William Pate from the APA Research Office for their continued support of this project (not to mention their countless hours of work).

MEMBERSHIP CONFERENCE: Dr. Jeanette Hsu and the APPIC Conference Committee are actively planning our bi-annual membership conference, to be held from March 31 through April 2, 2005 at Disney Coronado Springs in Orlando. This year's conference theme will be "Supervision: Training, Ethics, and Competence," and Rodney Goodyear and Madonna Constantine will be our keynote and plenary speakers. We have been very pleased with the quality and quantity of programs that have been submitted for this conference. In addition to the focus on supervision, other conference highlights include: a workshop for new Training Directors, advocacy training, APA site visitor training, and a panel from the APA Committee on Accreditation. We hope that you will plan to join us for what we believe will be an interesting and stimulating experience.

CENTRALIZED APPLICATION SERVICE: APPIC has spent considerable time over the past year exploring the possibility of implementing a Centralized

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SPECIAL SECTION: SUPERVISION

Use of Self Supervision Model: Relational, Ethical and Cultural Issues

BY MAROLYN WELLS, PH.D. AND VIRGINIA BELL PRINGLE, PH.D.
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Introduction

"An implicit assumption in most psychotherapy supervision models is that…the supervisee must disclose descriptive information about the client, the therapeutic interaction, the supervisory interaction, and personal information about himself or herself (e.g., Bernard, 1979; Blocher, 1983; Bordin, 1983; Hess, 1980; Littrell, Lee, Borden, & Lorenz, 1979; Loganbill, Hardy & Delworth, 1982; Patterson, 1983; Schmidt, 1979; Stroltenberg, 1981; Stroltenberg & Delworth, 1987)" (Ladany & Hill, Corbett, & Nutt, 1996, p.10) in order to maximally benefit from supervision. Despite this emphasis, little attention has focused on helping supervisors develop skills in how and when to self-disclose or otherwise use their emotional reactions, cognitive associations, or life experiences to further this supervisory process. The Use of Self Supervision Model described in this article places the supervisory relationship, the person of the supervisor, the person of the therapist and the therapy relationship at the center of focus. In particular, this paradigm emphasizes the importance of supervisors modeling self awareness, a multi-cultural perspective and conceptually informed, ethically guided use of self-disclosure.

This article will describe some of the more salient cultural and ethical issues imbedded in the use of self supervision model. In particular we will focus on use of self issues associated with self-disclosure. Use of self supervision encompasses much more than self-disclosure, but the issues of self-disclosure and exposure of the self are central to its expression. Such a supervisory approach thus requires personal risk-taking for the purposes of learning and furthering the supervisory action. Both supervisor and supervisee enter a collaborative process based on the valuing of mutuality or learning from each other, the process of co-creating meaning, and corrective of facilitative relating. Supervisor and supervisee reciprocally observe and evaluate each other's use of self-knowledge to inform therapeutic uses of emotional reactions, cognitive associations and life experiences.

Therefore, both supervisor and therapist in the use of self model need to be able to tolerate enhanced levels of anxiety when aspects of their character become exposed and examined by supervisees and/or clients (Peterson, 2002; Wosket, 1999). Learning and healing occurs through the exploration and examination of the interaction, in the intersubjective space surrounding the supervisor and supervisee, therapist and client. In order to facilitate this process supervisors "attempt to develop an atmosphere of openness to discovery about the patient and the therapist" (Talbot, 1995, p. 342).

Self Disclosure

Supervisor self-disclosures regarding the successes and failures of their own clinical work, training experiences and/or personal reactions to the client or supervisee can facilitate the creation of a trusting atmosphere (Norcross & Halgin, 1997) to the extent that the impact on the supervisee includes: 1) normalizing the supervisee's feelings, concerns, temporary "failures" or struggles, 2) modeling learning from mistakes, 3) providing examples for handling difficult situations, 4) demonstrating healthy ways to express emotions, 5) encouraging further supervisee self-disclosure, 6) increasing supervisee self-awareness or understanding, 7) developing a broader perspective and/or 8) fostering a safe and supportive supervisory alliance (Glickauf-Hughes, 1994; Hutt, Scott & King, 1983; Norcross & Halgin, 1997; Weiner, 1983; Worthen & NcNeill, 1996). Training and practice in how, not just what, one offers in terms of self-disclosure remains critical so that the supervisor maintains an alliance with the supervisee while still able to broach sensitive or difficult dialogues (Wachtel, 1993). Sharing both sides of the supervisor's ambivalence or both sides of any bind the supervisor identifies can sometimes accomplish this aim. For example, one supervisor shared with her supervisee that she both wanted to maintain the mutual admiration they seemed to genuinely have for each other and she wanted to raise a topic that she thought could be meaningful to their work together but which would probably rock their boat.

Where supervisees are expected to openly share their clinical work and self-disclose their negative as well as positive reactions to clients in order to better understand enacted or latent communications, supervisor self-disclosures are intended in part, to demonstrate mutual vulnerability to the supervisee, thus mitigating some of the shame stimulus associated with the evaluative and potentially voyeuristic nature of supervision (Hahn, 2001). For example, when working with supervisees who are anxious about sharing their tapes in supervision, use of self supervisors might share some of their own fears about having been taped as a trainee or even about sharing one of their own tapes in the present (Bradley & Ladany, 2001).

Admitting to their anxieties can help supervisor and supervisee strengthen their relationship through the similarity of their experience, especially if the supervisor can feel comfortable with a mutual learning format and has faith in his or her overall level of advanced competence or in the process itself. In this model, anxiety is assumed to be part of the learning and familiarization experience, especially when individuals are trying to stretch themselves in some way. Supervisor self-disclosures that help supervisees feel generally well regarded as well as identify their clinical strengths and weaknesses can be especially helpful in further mitigating the

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Supervision: A Model and Approach to Feedback

BY ANDIEA H. HARRIS, PH.D.
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I. A Developmental And Relational Model Of Supervision

There are numerous supervision models that people use. Some approach supervision from a didactic point of view while others are more focused on the process and relational aspects of the supervision. The way I think of the supervision process is similar in many ways to the way I conceptualize the process of therapy. In my view, there are mainly two aspects of the process: a developmental phase and a relational one. Let me say from the outset, although I talk about these points separately, the relational aspect is embedded within and develops throughout the developmental phase.

Developmentally, similar to the therapy process, I think of the supervision process as having a beginning, middle and an end. In the beginning of therapy, the basic rules of therapy need to be established such as the time, length of the session, late and missed appointments, and fee arrangements. Similarly in establishing a new supervisory relationship, some of the above needs to be discussed in the "first" session(s). In addition, one must establish a "contract" as to what to discuss, why is the patient/supervisor in therapy/supervision, the areas that need to be addressed, improved and/or changed and competencies of the therapist/supervisor in treating/supervising the patient/supervisee.

The middle phase of the supervision, similar to therapy is focused on using skills and interventions to strengthen the relationship and facilitate change in areas that need improvement and building confidence on skills and areas of strength.

The end stage being the termination phase, the supervisor and the supervisee give feedback to each other regarding the process, the relationship and the impact of supervision as well as perhaps areas to work on in the future, just as one would review the course of treatment in therapy and it's impact on the patient and talk about future work if the patient should want to go back to therapy.

In terms of the relational aspect, the way one develops supervision rapport is similar to therapeutic rapport. Usually in the beginning phase of the supervision, the supervisor and the supervisee are aware and perhaps anxious about their own skills and competence. They want to be liked and think about how they're being perceived by the other, as a person and a clinician. Comparable to therapy, supervision transference and countertransference begins to develop. As supervision progresses, usually in the middle phase, the supervisor and supervisee become more focused on techniques and skills and their "supervision alliance". Are they similar in their conceptualization of the patient and how well do the supervisor and supervisee work together, despite differences. Lastly as the supervision comes to a close, as mentioned above, much the same way in therapy, the impact of the relationship and the work is reviewed.

Despite many differences between supervision process and therapy process, the similarities have helped me supervise and teach supervision to new supervisees much easier and effectively.

II. Feedback In Supervision

As the training director, supervisors often ask how to give "constructive feedback". Most of us agree that it's much easier to give positive feedback. However, giving feedback regarding areas of improvement is more challenging particularly if it needs to address areas other than the clinical work. Below is a summation of feedback from our interns and our experience that might help in this challenge:

1. In the first supervision session establish an "open communication" policy for both the supervisor and the supervisee. Give clear, explicit examples, both positive and negative, of the kind of feedback you might give in areas of clinical work, ethical issues, professionalism and personality. Establish "how" you want to receive feedback from each other.
2. Develop a supervision contract. Some prefer written contracts others verbal, regarding the goals of supervision, expectations of the supervisor of the supervisee and the supervisee of the supervisor and supervision boundaries, for example, ways in which supervision is different than therapy. Clarify terms together such as "constructive criticism". Supervisor's definition might be quite different than supervisee's.
3. Give feedback as early as possible. Give specific and clear examples of the issues. Early discussion will give the intern an opportunity to work on the issues.
4. Be aware of the way you give feedback. Regardless of the content, the "way" feedback is presented makes all the difference. As supervisors we often fall into an authoritative position, which might make it difficult for the supervisee to engage in the process.
5. Give the supervisee an opportunity to respond to the feedback. The supervisor must listen with an open mind and not with a defensive and judgmental stance.
6. Together develop a way of addressing the issues
7. Set a time frame when you will reevaluate the issues together
8. Revisit the supervision contract and open communication policy on an ongoing basis

It could not be emphasized enough that this process is impossible if the supervisor does not have an open and objective stance. If approached from a more equalitarian point of view, I often find that both the supervisor and supervisee learn about themselves and each other tremendously from this experience.

Use of the Term "Impairment" in Psychology Supervision

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Abstract

The use of the term "impairment" to refer to psychology trainees who are not meeting performance requirements is fraught with legal risk. Specific uses of the term "impairment" under the Americans With Disabilities Act are described in the context of why this term should not be used in psychology settings.

"Impairment" is a term that has been used widely in descriptions of problematic behavior of trainees or of psychologists. However, with the introduction of the Americans with Disabilities Act, there was introduced a legal risk associated with use of the term "impairment" (Falender & Shafranske, 2004). The word "impairment" has a specific legal meaning akin to "disabled" in certain statutes that (i) prohibit discrimination against an individual with an actual or perceived substantially limiting impairment, and (ii) require employers to make certain accommodations to the "impaired" or disabled. The use of the word "impairment" in other instances can subject employers and others to particular legal risks.

Under the Americans with Disabilities Act (ADA), the legal significance and relationship between "impairment" and "disabled" is established in the text of the statute, and further developed in the ADA implementing regulations. The statute defines an individual with a "disability" as one who has "a physical or mental impairment that substantially limits one or more major life activities; a record of such an impairment; or [is] regarded as having such an impairment." 42 U.S.C. § 12102(2). The ADA regulations define "major life activities" as those functions an average person can perform with little or no difficulty such as "walking, breathing, seeing, hearing, speaking, learning, and working." (EEOC, 2004). Further, the ADA regulations define "physical or mental impairment" as:

> (a.) any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine, or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. 29 C.F.R. § 1630.2(h)

It is no longer an option for psychologists to use "impairment" as a general term to refer to trainees who are functioning below expected performance levels. Use of the term "impairment" creates legal jeopardy in several ways. First, there is the possibility that the trainee actually *does* have an ADA disability or impairment of which the supervisor may or may not be aware. Thus, use of the term "impairment" or "impaired" in the context of providing adverse or negative feedback or performance evaluation suggests that the evaluation was based on the physical or mental impairment (a potentially discriminatory act under the ADA), rather than on objective evaluation of performance tasks. Moreover, if the trainee has not informed the supervisor of the impairment, it is improper for the supervisor to identify it as an "impairment" or to question the supervisee beyond the context of whether the individual can in fact perform the tasks included within the internship or traineeship with or without reasonable accommodations (EEOC, 1992). Second, regardless of whether the trainee has an actual ADA impairment or disability, use of the term, "impairment" indicates that the supervisor "regards" the trainee as impaired under ADA, and is thus potentially discriminatory. Because, as explained above, the definition of "disability" under the ADA includes both actual impairments and perceived impairment, use of the term "impairment" creates an issue of fact of whether the supervisor regards the trainee as disabled. In one recent case (*Adams v. Master Carvers of Jamestown Ltd.,* 2004), the court found that the employee did *not* have an actual ADA disability, but nonetheless concluded that statements made by the supervisor about the employee were evidence that the employer *perceived* the employee as disabled. Under the ADA, a supervisor cannot discriminate on the basis of perception of disability. If a trainee were terminated after being labeled as impaired, he or she could assert a claim under ADA that the termination was based on a perceived impairment that qualifies as a disability under the ADA, and would point to performance feedback and evaluation that used the term "impairment" or "impaired" as evidence of this perception.

Finally, if the supervisor labels the trainee as impaired, the trainee could argue that, in fact, the supervisor knew of his or her impairment status, knew that the impairment was making it difficult to satisfy performance expectations, but nevertheless failed to consider whether a "reasonable accommodation"

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Editor's Note: Statements, opinions, and recommendations of the authors are their own and do not necessarily reflect APPIC policies or concurrence with content specifics of the article.

Supervision in a Complex Ethical Situation

BY ERICA H. WISE, PH.D.
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As supervisors in training clinics and internship sites we have responsibility for fostering the professional growth and development of our graduate students in training and for ensuring the provision of high quality services to the public. This task becomes even more challenging when we are confronted with a complex ethical dilemma. Effective supervision in such situations involves managing both our supervisee's and our own emotional reactions, understanding the relevant ethical and legal issues and standards and being able to assist the supervisee in the application of this understanding to the care of the client.

The following is a vignette which touches on complex clinical and ethical issues. I would suggest that you read the vignette, reflect on the questions that follow and determine what your course of action might be before reading my analysis. I would also encourage you to use the 2002 APA Ethics Code as a source of guidance:

You work as a supervisor for interns who are assigned to the outpatient clinic in a medical center. One of your supervisees has begun to treat a 28 year-old female client in the clinic who has presented with low self-esteem and recurrent depression. During the 2nd session she reveals to your supervisee that she had been sexually abused by her maternal uncle during joint family summer vacations during her early teen years and has never revealed this to the family. You have been helping your intern to work with this client to explore the impact of the sexual abuse that occurred during her teens and to increase her interpersonal assertiveness. The intern and the client have also been using a CBT approach to address the depression and low self-esteem; this work has been going well and they have established an effective working alliance. Several months into treatment the client very hesitantly reveals that she had a sexual relationship with her previous psychologist who is a well-respected member of the professional community in your town. In fact, this psychologist is a frequent recipient of referrals from your clinic for clients who can afford full fee treatment. The client had denied at the time of intake that she had ever received psychotherapy in the past. She now tells your supervisee that she was ashamed to discuss what had occurred and therefore had denied that she had ever been in treatment before. The reported sexual relationship occurred just after she graduated from the local university and was beginning to work in the community. Based on the work she has been doing on the familial sexual abuse, she is now wondering if this relationship with the psychologist may have been "wrong" and may not have been her fault. She also wonders if the relationship may have even worsened her problems. In fact, the depression began shortly after she terminated that treatment with that psychologist approximately 4 years prior to her coming to your clinic. The client has already told your supervisee that she is unwilling to consider filing a complaint with the state psychology board or with the APA Ethics Committee. Your supervisee presents this latter revelation to you with a high level of dismay and distress. She is convinced that you need to "do something to make sure that this doesn't happen to any other clients".

1. What are the ethical issues and standards related to the conduct of the previous psychologist?
2. What are the ethical issues and standards related to the current treatment context?
3. What action(s) can your supervisee take on behalf of the client?
4. What action(s) can your supervisee take in the interest of public protection?
5. How would you put all of the issues together in order to help this intern understand the complex clinical and ethical issues that are presented in this vignette and to develop an effective treatment plan?

In discussions of ethical and legal issues we frequently neglect to address our emotional reactions. Clearly, in this case, it would be important to address the intense emotional reaction of the intern and to validate the dismay and distress that she is experiencing. From a clinical and supervision perspective, this is very similar to other situations in which we may be feeling a level of anger that our clients are unable to experience or express. This can be very useful for the intern to explore and discuss in supervision. Also, for the intern, there may be a powerful sense of betrayal, in that a respected member of their chosen profession is reported by the client to engaged in a particularly unethical and harmful behavior. Being able to reflect and validate the intern's emotional reactions is a critical first step in helping the intern to effectively manage the situation. As the supervisor, we may also be having strong reactions of our own and would benefit from finding a trusted colleague with whom we can talk for support and debriefing (this would need to be undertaken in a manner that doesn't violate confidentiality; see Ethical Standard 4.06: Consultations).

Once the feelings have been explored and understood, the transition can be made to a consideration of the ethical and clinical issues. Let's begin our discussion with a consideration of the sources of guidance that would be relevant. These sources include the 2002 APA Ethics Code, HIPAA, relevant mental health statutes in your state and any relevant agency policies.

Response to question #1: It is clear that previous psychologist's behavior would constitute a violation of Ethical Standard 10.05: "Psychologists do not engage in sexual intimacies with current therapy clients/patients". This would be an opportunity to discuss with your client the impact of sexual abuse by therapists and to understand the underlying dynamics of why such behavior is unethical. Also, many training programs and supervisors fail to assist their students in managing sexual feelings that may occur in treatment situations.

Response to question #2: In the treatment context our primary obligation is to the interests of the client. This is supported by General Principle A: Beneficence and Nonmaleficence and General Principle B: Fidelity and Responsibility. In terms of our general duty to safeguard the privacy of clients' communications to us, Ethical Standard 4.01 states, "Psychologists have a primary obligation and take reasonable precautions to protect confidential information…" In terms of potential exceptions to the rule of confidentiality, Ethical Standard 4.05(b) states that "Psychologists disclose

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Clinical Supervsion: Questions and Reflections of a New Supervisor

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Clinical supervision is arguably the most important component of training for psychology trainees preparing to become therapists and counselors. Johnson and Stewart (2000) propose that clinical supervision is the aspect of graduate training with the greatest impact on the applied competencies of clinical psychology trainees. Good supervision is clearly essential to ensuring that the new clinician entering the field is properly prepared for her role.

As a psychologist still relatively new to the role of supervisor, I am in the process of developing my own style and a useful approach to this very important task. How can I be the best supervisor possible? What are the qualities of good supervisors? What kinds of things do they *do*? In a survey of the relevant literature, Carifo and Hess (1987) attempted to shed light on similar questions, summarizing both the personal qualities and professional behaviors of the "ideal supervisor." Not surprisingly, the authors highlight that the qualities of a good supervisor are similar to those of a good therapist. The personal characteristics of empathy, respect, genuineness and concreteness (sometimes referred to collectively as "facilitative conditions") were noted as highly desirable in supervisory encounters. In terms of behavior, ideal supervisors were found to set clear goals, use a variety of teaching techniques and modes of collecting data, and refrained from conducting psychotherapy with their supervisees.

In addition to becoming familiar with the relevant literature, it seems natural that preparation to supervise also include some amount of reflection upon *one's own* experiences as a supervisee. With regard to my supervision, I first and foremost feel gratitude for the competent and ethical professionals who assisted me along my own path. I also note the way in which what I needed from supervision changed as I progressed through the developmental stages of becoming a psychologist and therapist.

During the practicum year, when seeing therapy clients for the very first time, I benefited from my supervisor's routinely patient and supportive approach. His kindness calmed the jitters of a beginner, provided motivation to continue, and allowed for learning to occur. By the mid-stages of training however, as I began to gain a bit of confidence and clinical skill, I found I needed less "nurturing" from supervision and more practical information and feedback. At this point, I recall supervision that was "overly supportive" and complimentary (yes, I think that this is possible), to the point of lacking critical feedback, was an occasional source of frustration. By the later stages of formal training, my personal style and identity as a therapist began to more firmly take shape. I was learning to trust my instincts and clinical judgment more, and the opportunity to operate more independently was highly valuable as I prepared to step into a professional role. Being a therapist began to feel like a part of me, rather than a part I was playing and, as this transformation took place, I was also ready to utilize supervision in more sophisticated ways. For instance, I began to notice that relating details of a client's "story" to my supervisor often no longer seemed necessary or helpful, and I was pleased to find that it also seemed less expected with greater attention given to such matters as the process dynamics occurring in the session and my own experience of being with the client.

What it seems that my supervisors shared in common was a sensitivity and responsiveness to my position in the developmental process of becoming a psychologist, along with some idea about where I might go next. Each one "met me where I was at" and simultaneously encouraged me to take a step toward the next stage of development. And now I am the supervisor. Entrusted with the responsibility of supervising the work of other clinicians, I expect to use all the relevant knowledge, skills and resources at my disposal to inform my approach. Obviously, remaining current with the relevant literature, as well as utilizing a theoretical model of supervision to structure and guide the work, is essential—but perhaps not sufficient. Among other considerations, there seems to me a true value in remembering one's own experiences as the supervisee. I am not suggesting that individual experiences can be generalized. But perhaps those who supervise, from entry-level to the most seasoned in our profession, would serve their students well just to remember what it felt like to be the practicum student, the intern, or the post-doc. Even if only as a means of better empathizing with those putting this important trust in us.

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Clinical Supervision: The Intern Perspective

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Many would agree that clinical supervision is a major method through which an individual learns to become a psychologist. Throughout supervision a psychologist in training, whether a practicum student, intern or postdoctoral fellow, develops the practical skills such as assessment, case conceptualization and intervention that are necessary for professional practice as a psychologist. Bernard and Goodyear (2004) define supervision as a relationship between a senior professional and a junior professional in which the senior professional provides support, education, consultation, and evaluation in relation to a junior professional's practice. Thus, supervisors assume many different roles. This understanding of supervision piqued my curiosity about how students view the supervision process and what they want from their supervisors. As a result, I posed the question "What do students want from their supervisors?" to an APAGS list serve for interns. The 5 highest endorsed responses are listed below. My goal in sharing this information with you is to help you see how today's interns view supervision and what we hope to gain from supervisors.

1. *Mentoring*: Most respondents stated that they sought mentoring in some form from a supervisor. Not only are interns interested in receiving guidance in developing their clinical "bag of tricks," they also hope that a supervisor takes an interest in guiding them professionally and personally throughout their careers as psychologists. Specifically, intern's stated that they appreciate supervisors who discuss issues such as how she or he developed professionally, how the existing supervisory relationship fits with long range career aspirations, advocating on the supervisee's behalf, and the ability to talk about life events and interests outside of psychology. For example, politics and football games are common desirable topics.
2. *Regular and consistent meeting time*: Although a difficult need to satisfy, many interns stated that meeting regularly and having an uninterrupted consistent meeting time is highly valued. Interns stated that establishing a consistent meeting time communicated that the supervisor enjoys and prizes training, as well as the supervisee.
3. *Meet the intern's developmental level:* Students in general, and interns specifically, are obviously at various developmental levels in relation to their clinical skills. Several interns responded that they appreciate a supervisor who recognizes their developmental level and can provide them with an appropriate level of autonomy, while respecting their evolving clinical skills.
4. *Supervisor qualities*: Interns appreciate a supervisor's flexibility, ability to accept them and be non-judgmental, timelines in providing feedback (e.g., reports), clearly articulating the supervisor's therapeutic and supervisory approach, being a good clinician to emulate, the ability to accept feedback from supervisees, and demonstrating a genuine interest in training. Obviously there are many more qualities of a good supervisor; however, it is interesting to note those qualities that are the most highly regarded by the interns who responded to my query.
5. *Addresses and raises diversity issues*: We live in an increasingly diverse world. Therefore, supervisee's need to learn how to work therapeutically with clients from diverse backgrounds. Several respondents indicated that they found supervisors who raised diversity issues in relation to clinical cases and the supervision relationship to be extremely useful to their development, both professionally and personally.

Although this list is not exhaustive, the information I have gleaned provides us with an idea of what current interns value in supervision. Supervision is no doubt one of the most important aspects of a psychologist's clinical training and one that is very important those en route to becoming psychologist. As shown, the process of supervision entails more that simply discussing clinical cases. It also involves the active process of assisting supervisees equally in their personal and professional growth.

Chair's Column
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Application Service, which would provide applicants with the ability to complete their internship application via the internet and have it electronically transmitted to internship sites. While such a service may seem relatively easy to implement, it is in fact a very complex and expensive endeavor. In fact, other disciplines (e.g., medicine, veterinary medicine) have recently attempted to implement such systems, often with disastrous results. At this point, APPIC continues to investigate possibilities, but will not move forward until the technology has progressed enough to avoid putting our members and students through similar nightmares.

JOURNAL OF TRAINING: APPIC continues to explore the possibility of establishing a new journal focused on training issues. The Board is currently evaluating several possibilities, but is proceeding cautiously primarily due to cost considerations.

PART-TIME TRAINING: The lack of part-time internship and postdoctoral opportunities continues to be a very serious problem for students with family, financial, or other obligations that prevent them from engaging in a full-time training experience. These students essentially "hit a brick wall" in their doctoral training, as it can take several years just to secure a placement (if they can find one at all). In a survey conducted earlier this year, approximately 5% of internship applicants (approximately 150 each year) would prefer a half-time internship experience; this compares to only about two dozen funded half-time internship positions that are typically available at APPIC member sites. While implementing a half-time curriculum can present a number of challenges for a Training Director, I hope to see us make more progress in this area.

While APPIC continues to move forward in many areas, we continue to provide a variety of services to members and students, including the Directory, Match, Clearinghouse, Informal Problem Resolution, Web Site, AAPI, Standards and Review Committee, E-mail Lists, etc. And, as you know, APPIC continues to serve as the voice of internship and postdoctoral programs within the psychological community. The talented and hard-working APPIC Central Office staff, Connie Hercey, Shertia (Tia) Clark, and Danielle Lane, have successfully relocated to their new offices and are ready to assist you if needed. Please don't hesitate to contact any of us with your ideas, questions, and concerns.

Student with a Disability

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learned that I was disabled, after not disclosing this information in the application or interview process, they would be concerned that I would be unable to fulfill my responsibilities and 2) that not disclosing before interviews would make doing so later more awkward, as it would become obvious upon meeting me that I have a vision impairment. I knew that I would feel less anxious if I discussed the issue up front. However, I wanted the focus of my application to be on my strengths and accomplishments. I viewed the inclusion of any information about my disability as a part of the total application packet, just as my disability is one part of my life that has shaped my overall identity.

In return for my honesty, I hoped for the same response from interviewers. I hoped that my openness would afford these interviewers the opportunity to ask questions about how and if my disability might if they desired. Conversely, I wanted to avoid sites where my disability would be more important that my professional credentials and personal strengths. I was pleased to receive five interviews out of the ten sites to which I applied. Of course, I approached each interview with enthusiasm.

During the interviews I was surprised that I was not asked any questions regarding my eyesight. I can only generate my own hypotheses as to why: 1) All questions were answered within the application I submitted. (Since I did not provide much information, I would be surprised if this were the case); 2) Sites were afraid of violating the law for asking questions specific to a person's disability; or 3) Perhaps sites only wanted to discuss the issue further if I matched at their site. Nonetheless, the fact that no one asked any questions concerned me. If they had asked questions, I would have had the chance to evaluate their reactions to this information. It was unclear if sites did not know if they needed more information, or if they had already eliminated me as a candidate. As a result, I did not mention any additional information about my vision in the interview. I felt that I had already opened the door for that discussion and did not want to push the issue.

Now that the process is over, I do not know if I made the right decisions about what to disclose and at what time. I believe that applicants must be proactive during the internship application process; however, the communication must be reciprocal so that everyone involved can collaborate to resolve potential concerns. Here are two general suggestions that may begin to facilitate communication:

1) Internship training programs should include information in their brochures regarding the accessibility to public transportation and other important information about the site's physical location (e.g. Are offices only accessible by staircase?, etc.). Not only would this information help applicants with disabilities, but it would also communicate awareness, sensitivity, and an interest in disabled applicants. Statements used to advertise other job applicants provides a good example: "Women, minorities, and disabled candidates are strongly urged to apply."
2) When applicants disclose information about their disability, sites should provide some type of acknowledgment that they understand, rather than no response at all.

Permissible Inquiries (from the APAGS/APA Resource Guide for Psychology Graduate Students With Disabilities)

During the interview, questions can be asked to determine whether or not a candidate is qualified to do the job. Interviewers may ask if an applicant can perform essential functions of the position, as well as ask the applicant to describe or demonstrate how he or she would perform the essential functions of the position with or without reasonable accommodation.

Consider this vignette: Your position may require that telephone calls be made. A candidate with a hearing loss applies for the position. She states that she can perform the essential functions of making telephone calls with a volume control for the telephone. Therefore, the candidate can perform that essential function of the position with a reasonable accommodation. If the candidate states that he or she *cannot* perform the essential functions of your position with or without reasonable accommodations, then that person is not qualified for the position. While not required, it is strongly encouraged that you repeat the question and ensure that the candidate understands the meaning of "with or without reasonable accommodation."

In another example, a candidate for your intern position arrives for the interview accompanied by a guide dog; thus we are aware that the person has a disability and is protected by the American's with Disabilities Act. This person is interviewing for a position involving the opportunity to perform career counseling as part of their regular responsibilities. Such counseling would be integrated with personal-social psychotherapy and would include vocational testing. You may ask the applicant how she/he would administer such tests as the Strong Interest Inventory and the Myers-Briggs Type Indicator with an accommodation. On the other hand, it would not be appropriate to ask how the applicant might handle a hypothetical situation in which a patient tries to attack the intern and the intern does not see him coming (not essential to the intern role), or how long the person has been blind (question will elicit information about a disability).

Information that may be requested on application forms or in interviews includes the following:

- You may ask questions to determine whether an applicant can perform specific job functions. The questions should focus on the applicant's ability to perform the job, not on a disability.
- You may ask a candidate to describe or demonstrate how he/she would perform specific job functions with or without an accommodation.
- When there is reason to believe that a candidate will not be able to perform a job function because of a known disability, you may ask that particular person to describe or demonstrate how he/she would perform a job-related function. A candidate's disability would be a "known disability" either because it is obvious (for example, the applicant uses a wheelchair), or because the candidate has voluntarily disclosed that s/he has a hidden disability.
- You may ask about a candidate's nonmedical qualifications and skills, such as his/her education, work history, and required certifications and licenses.
- You may ask if the candidate can meet attendance requirements.

Requests for Accommodations (from the APAGS/APA Resource Guide for Psychology Graduate Students With Disabilities)

Prior to acceptance by an internship site, applicants with disabilities are not required to declare, nor may institutions inquire about the presence of a disability. The applicant is not required to inform the internship director or other staff about his or her disability at any time before, during, or after the application process. Should the applicant need an accommodation during an interview (a sign language interpreter, for example), he/she should make this accommodation request well in advance of the meeting.

If a student knows that he or she will require accommodations at the internship site, it is best that the student disclose as early as possible, either orally or in writing, to the appropriate person early in the process. Internship programs must make reasonable accommodations or adjustments for qualified individuals with known disabilities. An institution is not liable for failing to make accommodations or adjustments for a student's disability if the individual does not disclose the disability and request assistance.

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Student with a Disability
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The process of providing reasonable accommodations should proceed in an individualized, rational and systematic fashion. If a qualified intern with a disability identifies the need for an accommodation, the training site should make a fair attempt to provide an accommodation that will give the individual an opportunity to be equally effective in performing the position's essential functions and to enjoy benefits and privileges equal to those enjoyed by other individuals.

Resources (from the APAGS/APA Resource Guide for Psychology Graduate Students With Disabilities)

There are many resources available that provide information about how to acquire reasonable accommodations for individuals with disabilities. Although it is the individual's responsibility to be forthcoming if any accommodations are needed, assistance may be needed in obtaining certain items, and support the training director and staff is essential in this process.

ADA Information Center

(800) 949-4232 (voice, tty)
http://www.adainfo.org

Ten regional centers funded by the National Institute on Disability and Rehabilitation Research provide information, materials, and technical assistance on the ADA. Calling the 800 number automatically connects with the center that serves the local region of the caller.

American Psychological Association

Disability Issues Office
(202) 336-6038 (voice)
(202) 336-5662 (tty)
http://www.apa.org/pi/cdip

The Office provides information about and referrals to disability organizations, offers technical assistance, and develops and disseminates reports, pamphlets, and other written materials on student, professional, and consumer issues.

Association on Higher Education and Disability

617-287-3880 (voice)
617-287-3882 (tty)
http://www.ahead.org

The Association on Higher Education and Disability (*AHEAD*) is an international, multicultural organization of professionals committed to full participation in higher education for persons with disabilities. The web site offers many helpful links to different universities and programs, and to information on a range of specific disabilities.

Job Accommodation Network

(800) 526-7234 (voice/tty) or
(800) ADA-WORK
http://janweb.icdi.wvu.edu

The Job Accommodation Network (JAN) is an international toll-free consulting service that provides information about job accommodations and the employability of people with disabilities.

State Vocational and Rehabilitation Agencies

http://janweb.icdi.wvu.edu/SBSES/VOCREHAB.HTM

State vocational and rehabilitation agencies coordinate and provide a number of services for people with disabilities. For more information, call or write the office nearest you. Refer to the web site for a listing of agencies by state.

Equal Employment Opportunity Commission

800-669-4000
www.eeoc.gov

The EEOC coordinates all federal equal employment opportunity regulations, practices, and policies. It contains a wealth of information about ADA requirements affecting employment.

HEATH Resource Center

202-994-8770/800-544-3284
www.heath.gwu.edu

The Heath Resource Center of the American Council on Education is the national clearinghouse on postsecondary education for individuals with disabilities.

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Self Supervision Model
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shame proneness so easily induced by the training format in supervision (Hahn, 2001).

The problem is that "there is always a theme of stifle yourself juxtaposed with encouragement to be authentic" in training (Kottler, 1986, p. 52). While the use of immediacy, the deepening of relationship, modeling techniques, and the address of alliance ruptures often raise the issue of supervisor or therapist self-disclosures, supervisors and therapists-in-training often feel discouraged from self-disclosing as the safer default position. Supervisors in training as well as novice counselors can thus feel confused by these double messages and find it difficult to determine which aspects of self are legitimate to express and which are not (Wosket, 1999).

Ethical Mindfulness

Wells (1994) identified four different kinds of therapist self-disclosure, which can also apply to supervision. These four categories include:1) information about the supervisor's (or therapist's) training and practice; 2) revelations about personal life circumstances , experiences and attitudes; 3) personal reactions to or feelings about the supervisee (or client); and 4) admission of mistakes. In the use of self model any of these self-disclosure categories can meet the criteria for ethical principles (APA, 2002) such as beneficence (of benefit to the recipient), nonmaleficence (do no harm), integrity (truth-telling), justice (fairness), respect for people's right to self-determination (informed consent) and fidelity (trustfulness). On the other hand, any self-disclosure can be detrimental depending on the reasons behind the self-disclosure and the impact on the supervisee or client. The use of self model thus requires supervisors and therapists to remain particularly mindful of these ethical principles as they consider self-disclosing.

For example, in order to honor the ethical principles of respecting supervisee self-determination and informed consent, the new ethical guidelines require training programs to explicitly advertise a program's expectation of trainee's self-disclosure of personal information as part of the training (APA, 2002). Supervisors ask trainees to verify informed consent regarding such expectations before beginning supervision. The profession supports supervisees' right to know, but what if a supervisor's underlying motivation in engaging trainees in a use of self model is more out of their own need for intimacy and connection, or is employed to gratify voyeuristic needs? If the supervisee experiences supervisor self-disclosures as manipulative, exploitative, or intrusive, then the learning alliance is jeopardized.

Even with solid theoretical grounding, empathy, and the intent of beneficence, supervisor self-disclosure can fail or backfire because "it is inappropriate, causes hurt feelings, disrupts the flow… Then it is time for the (supervisor) to candidly acknowledge

the error, apologize, make correction, and learn valuable lessons" (Wosket, 1999, p.72)

Supervisors thus need to carefully and honestly self-monitor for their own semi-conscious, self-serving intentions and attend to any negative impact on their supervisees. For example, one supervisor who was consistently late to sessions, apologized to her supervisee, but did so in a weary and self-denigrating way, partially out of guilt and out of wanting to mitigate the supervisee's understandable annoyance with her. In response, the supervisee felt pressured to stifle her annoyance and care-take the supervisor by empathizing with how busy she knew the supervisor was.

How supervisors handle these ruptures makes a significant difference. If the supervisor uses the opportunity to explore with the supervisee how the supervisee experienced the self-disclosure, empathizing with the supervisee's world view and validating his or her experience, the rupture may be mended and the relationship strengthened. In the previous example, the supervisor stayed honest with herself, realized she was feeling especially needy and overwhelmed, and needed to consult with and get support from her colleagues. At the next supervision session she let the supervisee know that she realized she had apologized in a way that put pressure on the supervisee to take care of her, expressed appreciation for the supervisee's sensitivity, and made it clear she thought the supervisee's annoyance was appropriate and justified.

Both supervisors and supervisees may benefit from being introduced to Peterson's (2002) recommended considerations prior to self-disclosing: "(a) Is this information necessary to protect the client's informed consent? (b) Is my purpose in disclosing this information to benefit the client or to benefit myself? (c) Will this particular client use this information in a way that is helpful? (d) Will disclosing this information interfere with our therapeutic progress, such as by contaminating the client's therapeutic transference?" (p.30), (e) Do I know the client well enough to speculate about the potential consequences or impact of self-disclosure? Discussing these questions with supervisees and applying them to critical junctures in the therapeutic process can facilitate ethical mindfulness.

Cultural Interface with Use of Self

Effective supervisor self-disclosures take the supervisee's cultural values into account. More specifically, supervisors are advised to attend to the supervisee's unique individual as well as cultural group values in tailoring the format of the supervisory learning environment, including the kind of self-disclosures that may be most effective in creating a safe, supportive and optimally challenging learning alliance. For example, a White female supervisor's self-disclosure of her own clinical struggles or openly exploring her contribution (e.g., value system, bias, prejudice) to an interpersonal struggle in the supervision may be particularly effective with minority supervisees who view supervisor self-disclosure as a sign of authenticity and trustworthiness (Sue & Sue, 2003).

Additionally, supervisors sensitive to their own multi-cultural identity development can use this awareness to further a supervisee's self-exploration. Female supervisors might share how they dealt with the competing cultural demands associated with power issues related to being a female in a role of authority. Beginning female supervisors working with male supervisees in the author's supervision of supervision seminar often note that they find themselves giving their power away to the supervisee, assuming a supportive, less challenging role. While this role matches cultural values associated with being female, it often denies the supervisor's evaluative or accountability responsibilities and misses opportunities to appropriately challenge the supervisee. Such discussions are particularly important as they address recent empirical findings (Bradley & Ladany, 2001; Ladany, Ellis, & Friedlander, 1999) indicating that supervisees cite one of the most common supervisor ethical failures as giving insufficient feedback regarding areas of deficiency or weakness in the supervisee.

"Becoming culturally competent means acknowledging biases and preconceived notions; being open and honest with one another; hearing the hopes, fears, and concerns of all groups in this society; recognizing how prejudice and discrimination hurt everyone…" (Sue, 2001). The willingness of supervisors to model the open examination of their own internalized cultural biases and prejudices, including internalized racism and homophobia, can help to invite the active participation of trainees who fear evaluative repercussions around making politically incorrect blunders or being seen as troublesome. Additionally, minority supervisees can find it particularly helpful for supervisors of the dominant culture to discuss the potential impact of their unearned privileges as well as to admit to when they are not as competent in the area of multiculturalism as their supervisee, and to invite mutual learning in all competency areas (Cook, 1994).

Risks and Contraindications for Self-Disclosure

The risks of supervisor or therapist self-disclosure included saying too much, saying the wrong thing at the wrong time or saying too little. For example, supervisors can err by putting the onus on the supervisee for bringing up diversity issues, often because such a discussion is out of their comfort zone, and too often because the supervisee has had more training in multiculturalism than the supervisor. In addition, supervisors and therapists often err by saying too little when they want to buy time.

Of the most frequently cited supervisor self-disclosures (personal issues, neutral counseling experiences, and counseling struggles), the wisdom of disclosing personal issues is the one most often and seriously questioned (Ladany & Lehrman-Waterman, 1999). In particular, while such self-disclosure can increase trust, supervisors who self-disclose personal issues are advised to watch closely for any signs of role reversal, whereby the supervisee is supporting the supervisor, or the time devoted to supervisee concerns is diverted or diminished (Woskett, 1999).

Supervisor's empathic failures in use of self are "often related to their shadow side, represented by arrogance, grandiosity or narcissism" (Brightman, 1984, p. 189). Supervisors who are unaware of or deny their shadow side, but act out of those energies in a self-serving fashion, are most likely to do harm. Knowing one's dark side can actually be an asset, however, as it can help supervisors to empathize with the dark side of supervisees and clients and stimulate compassion for the human condition. We all have our dark sides. What we do with those energies is what matters. This is one reason the supervisors own therapy is so encouraged. Self-knowledge rests at the cornerstone and is imperative for the use of self supervisor and therapist.

Being real and immediate supervisees harbors inherent risks. A full listing of contraindictions or cautions is beyond the scope of this article. However, supervisors are advised to resist self-disclosure if it represents: 1) an attempt to manipulate the supervisee; 2) an expression of the supervisor's feelings without direct relevance to the supervisor's needs; 3) the supervisor's attempt to rationalize, deny or minimize a mistake or deficiency; or 4) an effort to push supervisees into making an intervention that they are not ready for or that invalidates their or their client's cultural value system (Woskett, 1999).

Teaching supervisees when self-disclosure is contraindicted is thus just as important as teaching them when it is. Goldstein (1994) suggested a noninclusive list of contraindications, including when: 1) the client demonstrates poor boundaries and poor reality testing and so manifests tendencies to distort self-disclosures or use them as excuse to act out or attack therapist; 2) the client tends to caretake the needs of others; 3) the client fears strong affect or intimacy; 4) the therapist is needy, stressed, deprived, lonely; 5) the therapist is experiencing an intense countertransference reaction.

Summary

In the model, supervisors are responsible for fostering the development of the supervisee's consistent application of ethical and conceptual principles to the culturally informed use of self, and in particular, to the use of self-disclosures. Supervisors are always encouraged to check to see how their self-disclosures, especially personal comments, impact their supervisees. The timing, content and appropriateness of self-disclosures depend in large measure on the supervisor's conceptualization of the supervisee's needs in the moment, the values underlying this model of supervision, the supervisor's intent, and the impact on the supervisee.

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The ASARC Corner

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Supervision is often experienced as the heart of the internship. As such, excellent supervision often allows interns to "forgive" a program for its weaknesses. By the same token, inadequate supervision sometimes seems to exacerbate any other program flaws. APPIC guidelines specify that internship and postdoctoral programs must provide two hours weekly of individual supervision, and that the staff include at least two FTE licensed doctoral level psychologists. Supervisors are expected to have clinical responsibility for the intern's case load. Additionally, postdoctoral programs are expected to have "a training faculty which includes at least one psychologist with expertise in each area of postdoctoral training offered." These faculty should be providing supervision to the Fellows.

I would like to address two issues with respect to meeting APPIC criteria regarding supervision. The first is attention to the "numbers", and the second is attention to issues of providing high-quality supervision.

The requirement to provide a minimum of two hours of individual supervision weekly means that every effort must be made to safeguard this supervision contact. In the event of illness, vacation, or other absence interrupting supervision, every effort should be made to either reschedule supervision or arrange for a substitute. There are numerous reasons to do this, including safeguarding clients, ensuring continuity of training, emphasizing to the intern that his training experience is a priority, and ensuring that the intern has a forum for addressing immediate concerns that may arise during a supervisor's absence. Programs that document interns' activities are at an advantage, in that they are able to support their interns in documenting supervision for licensing boards, as well as in the event that a concern is raised regarding supervision hours.

Although APPIC guidelines do not specifically define what constitutes quality supervision, part of the membership policy is as follows:

1. APPIC member programs conform to the basic ethical requirements of the profession as set forth in the current APA Ethical Principles for Psychologists.
2. APPIC member programs demonstrate high regard for human dignity. Dehumanizing practices or other restrictions on the exercise of the civil and human rights in any part of the activities of APPIC members is unacceptable. As members of APPIC, training agencies have practices which are nondiscriminatory in regard to race/ethnic background, gender, age, sexual orientation, lifestyle, and disabilities.

Our ethical guidelines require us to practice within our areas of competency and to be familiar with the scientific literature in the area of practice. There is an increasingly large body of literature regarding supervision practices and models.

As a result, ethical practice would suggest becoming familiar with this literature and conducting supervision in a manner consistent with it. Although it seems unlikely that an intern will complain specifically because the supervision does or does not follow a particular supervision model, supervisors who disregard ethical considerations raised by supervisees, who fail to show respect towards their supervisees and indeed all interns, who have "favorites," whose evaluations are experienced as capricious, and who in other ways lead interns to feel dehumanized or excessively powerless, place the program at risk of having interns file a complaint. In this case, while the supervision itself may be within the guidelines established by APPIC, the general relationship may expose the program to the possibility of a violation of APPIC guidelines based on the above policy. If a trainee brings concerns about this to the attention of the Training Director, taking these concerns seriously and at a minimum discussing them with the supervisor is imperative. Programs should also help the intern or postdoctoral fellow understand and use procedures that are in the place for making complaints in an appropriate manner.

It is easy to see from even this brief discussion how a problem in supervision can grow large. Treating supervision as the heart of the internship, and a heart that deserves attention, can help prevent programmatic "heart attacks."

Term "Impairment"

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might enable the trainee to improve performance. Although the law recognizes that it is generally incumbent on the impaired individual to request an accommodation, the ADA requires employees to provide reasonable accommodation to the "known physical or mental limitations of an otherwise qualified individual with a disability." 42 U.S.C. § 12112(b) (5)(A). A failure to make such an accommodation is itself an act of discrimination under the ADA. 42 U.S.C. § 12112(b)(5)(A). The ADA, in fact, contemplates an "interactive process" with an impaired individual to explore possible accommodations to a known disability, and some courts have concluded that the failure to engage in such an interactive is a violation of the ADA (*Humphrey v. Memorial Hospitals Association,* 2001). Using the terms "impairment" or "impaired" in the traditional manner suggests that the supervisor may have known of an impairment that was inhibiting performance, but nonetheless failed to engage in the required interactive process. Moreover, the trainee could also argue that supervision was itself deficient because it did not adequately address the known "impairment" and potential need for accommodation. The ADA recognizes that adjustment of supervisory methods can be one form of reasonable accommodation under ADA. EEOC, 2004b.

In terms of the use of the general term "impairment," the supervisor has the responsibility to give adequate notice, and thus, if there was a performance issue(s) (late paperwork, attendance problem, for example) and the supervisor simply recorded the performance as "impaired" this would not be giving the trainee adequate notice of the inadequate performance. If a supervisor has given adverse employment action—even a negative evaluation—and the evidence shows the supervisor made decisions for discriminatory reasons or perceived disability, there is strict liability for the employer.

In general, using the term "impaired" in the pre-ADA manner confuses what the employer knows or perceives, and therefore whether there was an obligation to commence the interactive process with the impaired/disabled employee. Distinguishing professional from legal impairment does not provide comfort in a legal context, as it is the word "impairment" which has legal status. In short, both in terms of avoiding legal risk, and providing meaningful feedback to trainees, there is no value in maintaining use the traditional terms "impairment" or "impaired" to describe poor performing trainees.

The ADA also provides clear definition regarding inquiries by supervisors concerning "impairment" or whether a trainee has any conditions that might be considered "impairment." It is not acceptable to ask disability-related questions or to conduct a medical examination prior to conditional offering of the position 42 U.S.C. § 12112(d)(4). Some sources (Khubchandani, 2004) advise asking all applicants before an interview if they need accommodations; however, this is not a correct action as it it is tantamount to asking if the interviewee has a disability (i.e., only an impaired or disabled applicant will respond "yes" to such a question). (EEOC, 1992). An applicant may be questioned about whether he/she can perform the essential functions of the job, describing or demonstrating how those functions would be performed with or without reasonable accommodations, and about whether he/she can meet attendance requirements. The disability may be "known" because it is obvious (a wheelchair or seeing eye dog, for example) or although "hidden" having been voluntarily disclosed by the trainee. It is the right of the trainee to disclose any impairment and to request reasonable accommodations. If the impairment is visible, the supervisor may discuss whether the trainee would be able to perform the job responsibilities with or without reasonable accommodations. Once this has occurred, it is the responsibility of the supervisor or employer to discuss the essential job functions and discuss the reasonable accommodations needed. An informal process should ensue in which individual needs are clarified and reasonable accommodations are identified. The supervisor/employer may ask for documentation that the individual has a disability and that the disability necessitates whatever reasonable accommodations (EEOC, 2004b).

Mitnick (2002) clarified that "even when an applicant/intern/postdoc claims he/she is a qualified disabled person, entitled to protection under the Rehabilitation Act or ADA, the internship/program site has no obligation to do so, unless the applicant/intern/postdoc also shows he/she can perform the essential functions of his/her position, with or without reasonable accommodation" (p. 27). Should the trainee meet the ADA definition, the site must either reasonably accommodate the individual *or* show that even with accommodation the trainee cannot perform essential job functions, or show that that the "requested accommodation would impose an undue hardship, based on the site's size; and the nature and cost of the accommodation" (Mitnick, p. 27; 42 U.S.C. § 12112(b)(5). "Undue hardship" refers to a level of significant difficulty or expense relating to the resources and circumstances of the particular employer in relationship to the cost or difficulty of providing a specific accommodation. "Undue hardship refers not only to financial difficulty, but to reasonable accommodations that are unduly extensive, substantial, or disruptive, or those that would fundamentally alter the nature or operation of the business" (EEOC, 2004b).

Understanding of the spectrum of accommodations and "reasonable" quality of such is an important component of supervision as is the understanding of the ADA meaning of "impairment." Through this understanding, the supervisor models legal and ethical proficiency.

Recommendations:

- Do not use the word "impairment" in mental health training settings except to describe individuals who qualify under ADA "disability". Identify a new label for students who are not meeting performance standards. Suggested terms are trainees with problematic behavior, trainees not meeting performance standards, or difficult students.
- In cases of problematic students, it is best to use behavioral terms yoked to the evaluation tools in place for the traineeship. Do not diagnose. Simply identify and quantify problematic behaviors. Independent of avoiding legal risk, effective feedback would be fostered by more specific descriptive terms that provide more information to the supervisee. "Impairment" lacks useful information as a word to describe inadequate performance.
- Fulfill the supervisory obligation to give timely feedback with attention to strengths and areas of weakness as they arise.
- Supervisory training should address prevention of feedback or discussion that suggests a "perception" of "impairment" or disability when in fact the supervisor is dealing with a performance issue.

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Complex Ethical Situation

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confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services: (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment…"

So, we would need to question whether the information that the client has presented us with constitutes a mandated or permitted exception to confidentiality. HIPAA sets a very high standard, as do the laws in most states, of "imminent harm" when disclosures are made without client permission. I would argue that, while there is the very real possibility that the community psychologist might be engaging in a sexual relationship with one or more of his other clients, that this does not constitute sufficient cause for you to make a disclosure without the client's permission. It would be important to be aware of statutes in your state regarding exceptions to confidentiality that involve potential harm to the public.

Response to question #3: As stated above, the primary obligation is to the client. Assisting the intern to work with her to understand that both her uncle and her previous psychologist were engaging in harmful behaviors from a position of power would be an important piece of this work. Helping the client to understand the impact of these abuse situations, to begin the healing process, and to see options that she has for telling other family members about her uncle and/or reporting the psychologist would be important aspects of the work.

Response to question #4: In my opinion, there is no direct action that you can take to protect the public without the client's consent and participation. In reference to Ethical Standard 1: Resolving Ethical Issues, both 1.04: Informal Resolution of Ethical Violations and 1.05: Reporting Ethical Violations state that any actions taken by an intervening or reporting psychologist cannot violate confidentiality. However, as was discussed above, an essential goal of treatment might be to empower the client to see self-assertion, disclosure and public protection as valid and realistic choices for her. Also, in terms of public protection, it might be difficult to change the clinic referral patterns without violating the client's privacy or the community psychologist's basic right to due process in the absence of a formal complaint and an opportunity to refute the allegations.

Response to question #5: In summary, I would suggest that this vignette situation would provide an opportunity to educate the intern regarding the importance of recognizing emotional reactions and impulses on the part of the therapist, and then being able to stand back and gain perspective on the underlying ethical and clinical dilemmas. I have made the argument that, in this case, there would not be sufficient grounds to make a disclosure without your client's permission. However, high quality supervision would include using the supervisory sessions to teach and support your supervisee in working with the client so that the client might be empowered to willingly come forward and file a complaint on her own behalf or to give you permission to do so. Even though she is initially unwilling to file a complaint doesn't mean that she may not change her position based on what transpires in the treatment. However, it is critical to remain mindful of your primary obligation to the client and her welfare, which includes her right to privacy. Conversely, instructing your supervisee to report the previous psychologist without the client's permission would be a violation of the client's trust, most likely impair the treatment relationship and be a legally and ethically risky undertaking.

Ask CoA

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This is the fifth in a series of columns anticipated over the next year to address ongoing questions and issues of concern related to the Committee on Accreditation (CoA). As training directors well know, each of us has a powerful relationship with this entity (sometimes as an ally and sometimes as a force to be reckoned with), and it is hoped that your questions will be answered; in addition, this column will serve as a way to keep all of us informed about changes with the CoA or any new expectations for training directors. Please email either of us with your questions and concerns to be addressed in upcoming newsletters.

Training Directors often express concern that the data from the self-study, site visitor report, program response and the CoA final decision letter are often contradictory and incongruent with each other. Why does this happen?

The differences between reviews completed at different times in the review process is reflective of the following: (1) differences in what is being reviewed in terms of the material before the reviewer; (2) differences in the goal of the review; and, (3) differences in the perspective of the reviewer in terms of her/his knowledge of the quality of training, both across levels of training and institutions. These differences occur at the different levels of the review process.

First, the self-study represents the program's best effort to review itself in relationship to a set of guidelines. The purpose of review at that level is to enable the program to ask itself a set of consistent questions to produce data that allows the evaluation of the program against a commonly accepted set of criteria. This self-study document is submitted to the Committee on Accreditation.

The next step, the preliminary review process, is conducted by either staff or CoA members to determine whether or not the program has responded to all of the areas needed in preparation for the site visit in the self-study document. The goals of this review is to identify missing information or information that is not clear in the self-study prior to the visit. It is not a review of the quality of the program.

Once a site visit has been approved, the program is visited by a team of site visitors. These visitors are selected by the program from lists compiled by the

Office of Program Consultation and Accreditation. The site visitors first review the program's materials prior to their visit. The site visitors review the self-study and the response to any information requested at the time of the preliminary review. In some instances this may include a response to third-party comment. The purpose of the site visit is to determine if the program is consistent with its report of self-evaluation. The site visitors are not charged with rendering a decision about the program. Instead, they are charged with the responsibility of "being the eyes and ears" of the CoA. Their task is to provide the Committee with a report including observations on the functioning of the program in relationship to the self-study and the Guidelines and Principles for Accreditation. The site visitors generally have knowledge of other similar programs, but often do not have the same level of knowledge regarding other settings in terms of adherence to the guidelines and general quality assurance.

Finally, the Committee on Accreditation reviews the self-study document, the preliminary review and response, the site visitor's report, and the program's response to the site visitor's report, as well as any other related materials in the record to render an accreditation decision. A program's record only includes information that has been created by or responded to by the program. Members of the Committee review at least 250 programs a year. Their foundation for making accreditation decisions is based on a large number of programs that vary in terms of level of training, type of setting and quality.

Since these reviews are conducted by different or independent groups, reviewing different materials for different purposes, it is not surprising that there is variability. The task of the Committee on Accreditation is to review all of the documents to render a single decision. Reviewers on the Committee are careful to seek and find evidence for conclusions or to ask for further information. Although the levels of review can yield these variations, the CoA review is designed to resolve these differences and reach a decision on the program.

Concerns about any step of this process should be discussed with the Office of Accreditation, specifically Susan Zlotlow, Ph.D. We hope this discussion will aid programs in understanding the process while feeling that their concerns are being heard and addressed. Dr. Zlotlow can be reached by email at: szlotlow@apa.org or by phone at: 202-336-5979. Thanks to Dr. Zlotlow for her assistance with this column.

Tips for Trainers

BY JOYCE ILLFELDER-KAYE, PH.D.
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Recently on the APPIC Intern Network there have been some questions posted related to the submission of reference letters. Applicants noted that an increasing number of sites are requesting that all materials related to their application arrive in one envelope. These requests include not only Part 1 of the AAPI, but also Part 2 of the AAPI, letters of reference and transcripts. In addition, applicants are reporting that some sites are requesting multiple sets of all of their materials. These requests call into question the ability of training directors and references to provide confidential assessments of their students.

I imagine that sites are making these requests in order to reduce clerical staff time (or training director time) that would be needed for filing. We know that many sites complain that they do not have sufficient clerical staff support for their internship programs. When all pieces of the application arrive at different times, these concerns are very real, as the copying and filing for as many as 100 applicants or more can be very time consuming.

The purpose of this column is to highlight some of the perhaps unanticipated complications arising from these requests. Academic training directors and references may be less forthcoming if they know they are handing these materials directly to their students. As a result assessments of the student in Part 2 of the AAPI and reference letters may be even more diluted of anything critical than they would otherwise be, and we already know this is a concern regarding references. Some academic training directors have reported that when they provide the letters in a sealed envelope with a signature, they have had the experience that a student has then decided not to apply to a site and is left with these materials in their possession. Some references are frankly uncomfortable providing the student with these materials when they feel the assessment and reference should be confidential. Thus the student is left in a bind. If the student is unable to comply with the instructions from a site, it creates great concern and anxiety about how this will affect the student's application and yet the student is not really in a powerful enough position to demand that a reference and/or academic training director do something they are not comfortable doing. Alternatively, academic training directors and references are left in a situation where they are being "forced" to do something they are not comfortable with, by providing these materials, sometimes in triplicate, directly to the student.

As a result of these legitimate concerns, I would recommend that sites be flexible about the way in which they receive part 2 of the AAPI and reference letters. It seems to me that academic training directors and references should be allowed to send these materials directly to a site.

New APPIC Member Postdoctoral Program
Full Circle Program
San Rafael, CA

APAGS Guest Column

Interview Questions that Make Applicants Uncomfortable

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As you read this article you are most likely receiving and reviewing applications for the 2005–06 internship year. Training Directors often find that this is both an exciting and anxiety provoking time, as you begin the process of selecting whom you will invite for interviews. As you well know, internship applicants also find this time to be filled with a variety of contrasting emotions. After mailing their last application, applicants will relax momentarily, but are more likely thinking ahead and preparing for interviews. At the APPIC/APAGS symposium on Navigating the Internship Application Process during the 2004 APA Convention, a theme emerged about the importance of interviews in helping training directors make ranking decisions. Similarly, interviews are important to applicants because it gives them a chance to get a better sense of what the training may be like, and in some cases, visit the site. The purpose of this column is to raise awareness about several interview questions that cause many applicants discomfort during interviews.

After the last Match, I asked APAGS members and other applicants about their interview experiences, and specifically if they were asked any questions that made them uneasy. There were several topical areas that seemed to cause discomfort among applicants. What follows is a summary of these topics and questions. It is my hope that Training Directors will consider these issues while deciding what types of questions to ask in the future.

1. *Where have you applied*? Many students express that asking about other sites caused them to feel unsure about the intention behind the question, as well as how to answer so as not to provide any information about preferences or possible eventual rankings. Applicants were very concerned that their response to this question could have had an impact on how highly they were ranked by a site.
2. *How many sites have you applied to*? For similar reasons as those indicated above, students felt that although this question was seemingly benign and possibly used as a method to generate discussion and ease anxiety, students were unsure about the intent. They wondered how their answer would be interpreted and how it might affect the Training Director's interest in them as an intern. Overall, applicants felt that this was an inappropriate and unnecessary question.
3. *What obligations do you have outside of internship*? This question can certainly be interpreted in a variety of ways. For instance, one student might answer this question by providing information about their academic obligations and progress on their dissertation. However, most students believed that Training Directors were seeking information about their family or relationship obligations, childcare, and other professional obligations, which could be interpreted negatively — as an interference to the learning process and training environment. Viewed in this context, applicants may become nervous about how to appropriately respond to such questions, consequently wondering how poorly she or he is ranked as a result.
4. *Tell me about your family life*? This question is generally considered very personal and often inappropriate. Not every applicant may feel comfortable talking about her or his family. The internship interview is a job interview. In job interviews such questions are illegal. For many, this question was interpreted as a directive to the applicant to disclose family and personal matters. Revealing this type of information with a potential "employer," causes students to wonder how she or he will be evaluated and ultimately ranked due to his or her family situation. A better question might be, "Tell me about yourself outside of academics?" In my experience and in conversation with others, students expect to address this type of question and are prepared to talk about themselves in the ways they are most comfortable with.
5. *Personal questions that seem outside the scope of an interview:* Although self exploration and personal insight is a vital aspect of becoming a psychologist, it is not acceptable to ask demographic questions in an interview. For example, questions about age, marital or relationship status, number of children, and sexual orientation are generally off limits, unless this information is volunteered. More than that, students specifically mentioned that questions about citizenship in other countries, their use of alcohol, or how they respond to clients who are attracted to them, made them feel uncomfortable. That's not to say that these questions are inappropriate; rather, students were not always at ease discussing these issues with interviewers whom they did not know well and had not yet had the opportunity to establish a trusting supervisory relationship with. In short, they did not always feel safe expressing their views to strangers about these issues. Clearly there is a balance that must be met between learning more about the match between a potential supervisee and a Training Director's supervision style, and conforming to general interview protocol. However, an internship interview, which is likened to a job interview by many applicants, may not be the best place for these types of questions. The combination of questionable queries with an already high anxiety level among students can make for an intensely uncomfortable interview experience, and as one student indicated, result in a "lack of interest in the site."

The internship interview process can be an exciting time for both interns and training sites. I certainly enjoyed the opportunity to learn about innovative and interesting sites and what psychologists are doing across the country. However, this is also an anxiety-ridden time for applicants who have a strong investment in the outcome. Most applicants prepare and approach the situation as if it were a traditional job interview, not a supervision session. In that context, applicants may interpret questions in a different way other than intended, and become uncomfortable and more anxious as a result. I wish you all the best as you prepare for this year's interviews. As always, I appreciate the forum APPIC provides through their membership newsletter to share these and other thoughts on the behalf of psychology graduate students.

FROM THE ASSOCIATE EDITORS

ADULT GENERAL PSYCHOLOGY

BY DAVID ARONSON, PHD, FAACP
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I think that I am going to inadvertently cause my editor to have a coronary "event." I am normally a conscientious and timely fellow. I meet deadlines and take care of what I have to do in a reliable fashion. However, I have just started working on this column and the "deadline" was over two weeks ago. In fact, I even got an extension and was given a "drop dead" date that passed me by a week ago. I'm not too sure what happened except to blame it on preparation for, and arrival of, the JCAHO (they are wandering around our hospital right now, as I type). My column is actually so late that I don't know if it will make the issue of the Newsletter that it was intended for. If it shows up in the next issue, I apologize to all of you who opened your Newsletter with excited anticipation of reading my article, only to be disappointed.

Now that I have shared my apology, and made an attempt at humor, I will move onto my topic for the day: psychological testing. I am fearful that psychological testing will become a "lost art." There seem to be two main factors contributing to this, from my perspective. One factor has to do with training issues and the other has to do with practice issues. With regard to training, it has been my impression that psychology training programs are de-emphasizing psychological testing to an extent. With the exception of students who focus on neuropsychology, it seems that psychology interns have great difficulty in the area of test interpretation and how to integrate that data into a comprehensive psychological evaluation. Even at a very basic level, such as interpreting a single objective personality test like the MMPI-2, I am finding that I have to review issues pertaining to the meaning of scale elevations, how to determine validity, when you can (or cannot) interpret an exaggerated profile and how to integrate hypotheses offered by the MMPI-2 with clinically obtained data (such as diagnostic interviews).

When I get involved in discussing this with interns, it turns out that the methods used to teach this particular test are often overly simplistic. I was recently talking with a colleague who specializes in forensic psychology. She agreed with me that many people see the MMPI-2 as being a "simple test" because of the way it is structured. Many psychologists and trainees approach the test in a rather basic, simple manner and do not recognize the nuances and complexities of the test.

I do my best to address this through supervision meetings with psychology interns. I make it a point of going over as many profiles as we can. I tend to use a Socratic method by asking the intern for his/her interpretations first and then following up with questions that point to additional pieces of information suggested by the profile. I also make heavy use of information the intern has about the patient based on clinical interviews, chart review and observation on the unit. I point out that the MMPI-2 is only one source of data, just like each of the other sources just mentioned. The idea is to find out which hypotheses are most consistent across the various sources of data that are available. Placing emphasis on only those hypotheses that stand up across modalities leads, I believe, to the most accurate interpretations. Although I have had occasional interns who are already capable of implementing this type of interpretive strategy, for most interns, this is quite new and is very different from what they were taught in graduate school.

Earlier in this article, I alluded to practice-related issues that influenced the viability of psychological testing. This factor has to do with the great difficulty that managed care organizations (MCO) place on obtaining authorization for psychological testing. While these organizations have (for the most part) become somewhat more reasonable with regard to the extent of paperwork they require before authorizing psychotherapy sessions, they have not done so with regard to psychological testing. It is as though each MCO sees paying for psychological testing like it was a path to self-destruction. The typical form to request testing seems to be one that would take about an hour to fill out in order to obtain authorization for one hour of testing. Even when I have done that, I usually am required to talk to someone on the telephone (often a nurse) about why the testing is not needed and how a clinical interview could obtain the needed information just as easily. Unfortunately, this current practice of discouraging the appropriate use of testing will lead to the unhealthy practice of treating before a proper diagnosis is identified and will also lead to a loss of professionals capable of properly administering and interpreting psychological tests. I fear that the profession will gradually lose this talent. As that occurs, we will lose a unique aspect of our profession and a tool that can be of great benefit to our patients.

So, psychological testing is being attacked at both ends. The frequency with which I see interns who are well-trained in psychological testing is reduced. And, once those interns get out into professional practice, they are discouraged from using this tool by the "payers" of services. I don't think that I have a good solution to this problem. In my small way, I am trying to continue promoting psychological testing as a valued service by continuing to teach psychology interns how to use this tool properly, how to respect the nuances of test results and the importance of integrating this into their professional practices. Our Internship Program also emphasizes the use of psychological testing by requiring that every intern in our program, regardless of which sites he/she rotates through, completes a minimum of eight comprehensive psychological evaluations in which the intern demonstrates an ability to integrate test results from various domains with clinical results from interviews, history and record review. I explain to interns that this requirement is not meant to be a statement that this is the only way to write a proper psychological report. Rather, this is to ensure that, at minimum, the intern has demonstrated competency in the complex task of writing an integrated, comprehensive psychological report that makes proper use of appropriate psychological tests.

Thank you for taking the time to read my column today. Again, I apologize to my editor for my lateness (I am hoping he does not take me "out to the wood shed" because of this).

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CLINICAL CHILD PSYCHOLOGY

BY CATHERINE GRUS, PH.D.
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Outcomes. What training director does not have this word inextricably etched in their memory. We have training models to help us develop them, we define them, we measure them, and we report them. Outcomes are relevant to us in our efforts to provide quality training. The focus of this column will be on an outcome that reminded me that we can and do facilitate outcomes in our trainees that may not routinely or easily be measured, but are important in their own right.

Among a group of trainees at our center there was one who had been a source of much discussion among the training faculty throughout their tenure with us. Reports were late, weren't all that well written, work materials were very disorganized, these were some of our concerns. How best to help this student improve their skills? Would they be able to successfully complete the program? We had numerous discussions about this trainee and how to address their clinical deficits. We had also observed that the student entered the program much more anxious than one would expect and with almost no self-confidence. While this was recognized and attended to, it was overshad-

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owed by our focus on this person's clinical skills.

As we implemented and monitored our plan to help this trainee develop their clinical abilities a parallel process was unfolding that was less a consequence of a systematic intervention. Specifically, I am referring to the process of developing a sense of professional identity. At our center this is fostered through interactions with our numerous psychology faculty as well as members of other disciplines. In addition, each trainee has a primary supervisor who serves as a professional mentor and meets regularly with him or her. These interactions serve as a core mechanism to help trainees build professional identity.

The professional development of a trainee is an expected outcome of our program, but not one we generally measure. It is common to talk with a trainee and share in their growing sense of professional competence and confidence, but the experience I had with this trainee was qualitatively different. This occurred as I was completing end of the year administrative tasks. At that time, I like to spend a minute reflecting with trainees on their experiences. A typical conversation might include positive statements about the types of training experiences, the impact of their training on their clinical skills, or praise about the supervision received. However, my experience with this trainee gave me a moment's pause. With genuine positive affect the trainee reported to me what a significant impact internship had made on them, not so much with respect to clinical skills but more in terms of feeling comfortable with themselves and respected by others and how powerful this had been for them. Without exaggerating the experience was described as life-altering in that (unfortunately) it had been the exception to other professional experiences they had had and made the trainee feel confident that they had chosen the right career field. Now, if one were to look at this trainee's ratings on our program evaluation forms one would note generally mediocre ratings on program outcomes that we measure, but I would argue this was a very significant outcome for this person. As I reflected on this interaction, I wondered how often do we lose sight of training outcomes that might be considered as important as the other more measurable things training directors focus on.

ISSUES RELATED TO UNIVERSITY COUNSELING CENTERS

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Onions Have Layers (Just Like Supervision)

As I share with you that I am the mother of a 3 year old and a $4^1/_2$ year old it probably comes as no surprise for me to say I've seen *Shrek* (the movie) probably a good 15 times (I've only seen *Shrek 2* once, as it isn't out on DVD yet). In the film Shrek, who is a big green monster called an Ogre, describes Ogres as being like onions in that they both have layers. He goes on to try to explain to Donkey that the layers make up all the different parts of him. As I watched *Shrek* for about the 9th time, I realized that the layers of an onion or an Ogre could also be a good metaphor for clinical supervision. I mean think about it…supervision involves much more than just the therapist and his/her supervisor.

I intuitively always knew that supervision was complex and complicated but as I became training director a few years ago, it became very clear to me that supervision is a really big deal and it goes far beyond what occurs in the room between the supervisor and supervisee. If we think about the actual layers of supervision particularly within a university counseling center we can see there are many, many layers that include: the client, the therapist, the supervisor, the training director, the agency director, the center, the university, the training program, not to mention society at large. We must also add in the other factors that make up the "meat" of the layers of the onion and play a role in supervision, such as issues of power, evaluation, personality style, theoretical orientation, expectations, personal history, diversity, values, client welfare, training, legal and ethical issues, and so forth. Whew, it's a lot to deal with!

I'd like to talk about some of the layers of supervision that we as training directors have to sort through and that often are not the focus of what we traditionally think about regarding supervision. One of the things that struck me, as I became training director was how much perceived "power" I have—at least with current interns and particularly with intern applicants. As a "regular" supervisor, I felt it, but as the TD the power with trainees intensified tremendously. Quite honestly it can feel kind of exciting at times to be "THE TD", while at other times the perceived power feels like something I'd rather not have to carry. The question I continually ask myself is how do I (we) supervise and be a leader to trainees in a way that allows them to feel heard, to be comfortable enough to be vulnerable, to be real and to be open to learning? I truly do believe that our skills as clinicians provide us with some of our most valuable tools as supervisors, however as well all know there's much more to supervision than just being a good therapist.

As a TD another layer of our supervisory responsibilities may lie in working with our fellow psychologists who are involved in the training program and supervise interns. Some of us may be in roles where we are peers with the training staff while others of us may act as supervisors to them. Regardless of whether or not we are supervisors of the supervisors, I'm sure we've all faced challenges with our staff. Things like: supervisors not responding to deadlines that we've set for evaluations to be turned in, a supervisor providing a trainee with information that contradicts what you've told the trainee, or supervisors that you worry may be biased in some way. That "power" thing may have a totally different feel with our peers, as it might feel as though we have little or none!

Within the field of psychology there has been an increased focus on and in some states it is now a requirement that psychologists who provide supervision, receive training in how to be a supervisor. I personally believe it extremely important for us to learn about and think about how we supervise. However, when considering the supervision courses I've taken, the CEU's I've attended, the books and articles I've read, I realize that most of them have focused on individual supervision typically occurring between a professional and a student trainee and not necessarily on the process of coordinating the supervision of a group of trainees or on supervising or managing the supervisors of the trainees. That's what was missing from my graduate program and from my professional experience to date (and maybe yours too)—no specific coursework or training on "Management" or "Leadership." I'm guessing we could all benefit from learning more in this area, regardless of how long we've been a TD.

In terms of the other layers of supervision that I identified earlier such as: the agency director, the center, the university, the intern's graduate program, and society at large, we may not function in a supervisory capacity. In fact, it may be the case that in these instances, the layers themselves serve as our supervisor and we in turn either feel we have or literally do have less power. Regardless of the power structure, it seems critical to mention that these layers do interact with the work that we do as TD's and they definitely impact our interns. For instance, how many of us have directors that are supportive of our training program (thank goodness mine is!) versus other folks who are fighting to keep their internships funded? I'm sure there are plenty of us that are facing a demand to do more clinical work and spend less time on training. Others may work for a university that questions the utility of having a Counseling Center at all and is considering outsourcing clinical services. When I'm faced with such challenges, when it may feel that my power is low or politics are high, it is incredibly useful for me consult with my coworkers, to vent to my husband, to spend quality time with my girls (watching *Shrek*!), but it is particularly uplifting and rewarding for me to reach out to my fellow TD's. A place where I think we get and give "supervision" of sorts (and definitely receive support) is on the APPIC and ACCTA list serves. What a wonderful opportunity!

Layers upon layers with lots of onion meat in between, that's what supervision is all about. Given the limits of the *APPIC Newsletter* I only touched upon some of the layers that I felt were particularly relevant for TD's. As you might guess, to do supervision justice and to get to the meat of it, could mean writing volumes and volumes worth of information. Clearly, I don't have that kind of space, so I chose to give you something to think about, maybe something a little different from the norm. In closing let me share with you some important lessons I've learned over the years. These are values that I try to live by in my personal life, that in turn affect my professional life, particularly my role as a supervisor and a training director. They are:

- Lead By Example
- Take The Time To Get To Know People Personally
- Self Knowledge Is The Basis Of All Knowledge
- Respect Differences
- Always Keep Learning

Since this is my first stab at an article for the newsletter, I welcome any comments or thoughts that you may have at: klhaggins@ucdavis.edu

GEROPSYCHOLOGY

BY GREGORY A. HINRICHSEN, PH.D.
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Good News, Bad News

As the old saying goes, "I've got good news and bad news. What do you want to hear first?" The good news: APA's Commission for Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) recommended that Geropsychology's proficiency status be renewed. (Go to the CRSPP website for an overview of its mission and proficiency definition for geropsychology: http://www.apa.org/crsppp/). CRSPPP forwarded this recommendation for consideration by APA's Council of Representatives. Proficiency status for geropsychology was initially recognized in 1998 but was up for renewal. There is optimism that it will be reapproved by the Council.

The bad news is that a group of geropsychologists (including this author) sent an application to CRSPPP early this year requesting recognition of geropsychology as a specialty. CRSPPP did not approve the application. Among some of the concerns raised by CRSPPP were an assessment that geropsychology focused on practice within an age group that was not clearly distinct from other specialties that serve adult populations. The Commission did not feel that models of education and training in geropsychology were sufficiently developed and noted that only one doctoral program specifically focused on geropsychology. Other concerns included a perception that geropsychology specialty practice would not "make the availability and quality of services better than exists under present conditions of its recognition as a proficiency." However, CRSPP did note that other specialty criteria had been met in the application that was submitted.

Prior to submitting the application, a group of geropsychologists who are senior in the field had made the judgment that geropsychology had sufficiently developed so that it was time for specialty recognition. Ten doctoral programs in psychology currently offer substantive training in geropsychology; numerous doctoral internships offer geropsychology training; a variety of postdoctoral programs in geropsychology exist; a large body of gerontological and geropsychological literature undergirds the practice of geropsychology; and a variety of organizations including APA's Division 12, Section II, APA's Division 20, and Psychologists in Long Term Care are the professional home of geropsychologists. Members of the group that submitted the application for specialty recognition reconvened at the recent APA convention to do a bit of soul searching and consider options. The consensus of the group was that it made sense to call a national conference on geropsychology training to better articulate models of geropsychology training. With conference recommendations it might then be wise to resubmit a specialty petition. Some of the groundwork for geropsychology training models already exists. Two national conferences on geropsychology have been convened in the past. A Division 12, Section II and Division 20 workgroup crafted numerous drafts over ten years of what eventuated in the "Guidelines for Psychological Practice with Older Adults" that were adopted last year by APA's Council of Representative (a copy of these may be found in May's *American Psychologist)*. Earlier drafts of the Guidelines included recommendations for supervised training that were seen as appropriate for different levels of expertise in geropsychology—but, for a variety of reasons, these recommendations were not included in the final draft of the Guidelines document. The assessment of the group that submitted the application was that recommendations for supervised training from earlier drafts of the Guidelines were viable and could be included and likely refashioned by the hoped for national conference on geropsychology training.

More broadly within APA specialty recognition has been subject to debate. Some constituencies within APA are opposed to what they view as the balkanization of professional psychology into numerous specialty areas. The concern is that the generalist practitioner will be squeezed out of practice from a variety of areas as specialty groups lay claim to different populations and different programs. Geropsychologists have also raised these concerns. Initial discussions about proficiency and later discussion about specialty in geropsychology included the observation that such designation might discourage generalist psychologists from serving older adults. Given the pressing need to enlist as many psychologists into clinical and counseling work with what will soon be an exploding aged population, some have felt that specialty or even proficiency recognition might make it less likely that generalist psychologists would see the aged in clinical practice. Some geropsychologists privately complain that some neuropsychologists have laid claim to some of the neuropsychological assessments that geropsychologists make routinely—asserting that only neuropsychologists have the requisite expertise to do neuropsychological evaluations. However, others have observed that too many psychologists serving older adults do not have requisite knowledge of gerontology and the needed skills to optimally treat the aged—nor even have access to a well-articulated model of knowledge and training. (The recently adopted "Guidelines for Psychological Practice with Older Adults" partially fill that professional lacuna.) One frequently cited example of the need for professional "quality control" is the influx of psychologists into nursing homes following inclusion of psychologists in 1989 as independent providers in the Medicare program. Many (most?) of these psychologists appear to have had no prior training in geropsychology. Older adult nursing home residents often have very complex psychiatric and behavioral problems. A federal Inspector General's Report in the early 1990's, in fact, raised concerns about the quality and substance of care that was being provided by psychologists in nursing homes. Although some felt that psychologists were unduly singled out in this report, others felt that the report was a wake-up call for better professional education for nursing home psychologists and more careful monitoring of professional standards in geropsychology.

There is merit in all these arguments. Can bad news turn into good news? This author's sense is that eventually geropsychology will achieve specialty recognition and, in the end, such recognition will serve the interests of psychology and older clients who receive psychological services.

HEALTH PSYCHOLOGY

BY SHARON BERRY, PH.D.
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Supervision of interns and postdoctoral fellows in health psychology is of greater importance with APA's mission statement amendment to include: "*…to advance psychology as a science and a profession, and as a means of promoting health and human welfare.*" Guidelines will need to be established to guarantee appropriate training and supervision in the practice of health psychology, not only for pre- and post-doctoral trainees, but also for mid-career professionals desiring this new credential. As leaders in the field of health psychology research and practice, we can play a significant role in identifying baseline expectations for meeting this credential. Each of us is already clear about what this means at a basic training level (i.e., what expectations we have for interns and postdocs, what opportunities we provide, what skills we expect), but it is not yet clear that similar expectations have been outlined for career psychologists. Questions that come to mind: what basic knowledge is sufficient to practice health psychology, how many patients with medical concerns does one need to see in order to call themselves a "health psychologist," what kind of advertising is appropriate to appropriately advance this new credential?

In March 2001, Division 54 (Pediatric Psychology) released a Task Force Report on "Recommendations for the Training of Pediatric Psychologists" which may serve as a guideline as we think through specialty training, especially for those professionals beyond internship and postdoctoral fellowship. As noted in this report, "*Pediatric psychology is a child subspecialty defined as 'an interdisciplinary field addressing physical, cognitive, social, and emotional functioning and development as related to health and illness issues in children, adolescents, and families' (American Psychological Association, 2000). Pediatric psychologists must be prepared to provide general psychological services to children, adolescents, and families but, in addition, need to receive training on health and illness and other areas related to pediatric populations.*"

Recommendations for health training typically involves direct observation, supervised practice, interdisciplinary team participation and training, didactic training in disease process/medical management, and mentoring. As highlighted by Michael Roberts and colleagues in a 1998 training article, three areas to consider: exposure, experience, and expertise. Our job now is to determine what criteria are necessary to meet these expectations for career psychologists adding health psychology as a credential. Cynthia Belar and colleagues, in a 2001 article in *Professional Psychology: Research and Practice*, proposed a model of self-assessment for individual practitioners to measure readiness to provide professional services in an expanded area of practice. They provided a sample template to guide this

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process for individuals, as well as recommendations for the field; for example, they suggested small working groups to use the template to develop core curricula for CE modules. In addition, there is much to be learned from the summaries and recommendations offered by the work groups participating in the 2002 Competencies Conference (see APPIC website).

Many of you may be asked to participate in planning for such guidelines, possibly through related divisions or task forces. I would recommend that as we become aware of these processes in place, that we share outcomes and resources with each other to avoid reinventing the wheel. I am hopeful that many from APPIC will have an opportunity to share their expertise in this area and many others will be asked to serve as individual mentors to career professionals seeking new credentials. Any thoughts or recommendations you have about this would be welcome and I would be happy to share these ideas with others.

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APPIC Website, Conference Work Group Summaries: 2002 Competencies: Future

Future Directions in Education & Credentialing in Professional Psychology.

INTERNATIONAL ISSUES

BY VALERIE HOLMS, PH.D.
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The 65th Annual Convention of the Canadian Psychological Association was held this past June in St. John's, Newfoundland. One of the highlights for our organization was the Preconvention Workshop presented by Dr. John Arnett, President of CPA. He provided a wealth of information on education, training, and advocacy in professional psychology.

Some of the many topics discussed by Canadian training programs at this year's CCPPP AGM included CPA-only accreditation for Canadian programs, internship supply and demand, increasing CCPPP membership, PIPEDA (Personal Information Protection and Electronic Documents Act) and how internships should handle information gathered on application forms, the number of students in Canada who relocate to attend internships, and internship funding in Canada.

Another one of the major issues became the new accreditation criteria requiring doctoral-level supervisors. New criteria were adopted in 2002 and members requested clarification regarding the requirement that "staff involved in the training programme as supervisors are registered in the province in which the programme is located, possess the doctoral degree in an area of professional psychology, and have met the standards in place at the time of their training-standards which ideally included a one-year internship." Members were particularly interested in whether there could be any 'grandfathering' of individuals who had already been supervisors for many years, whether other supervision could be recognized in some formal way, and how to support efforts to move toward the doctoral standard while keeping in mind the contribution of Master's-level practitioners.

A chance to discuss this with the CPA Accreditation panel occurred later in the conference. It became clear that the only supervision that counts toward the 4 hours/week is doctoral-level, registered psychologist supervision.

Thus, for some, the process of assigning supervisors has been made somewhat more complicated. Before the revision, doctoral level supervision of interns was a goal to aspire to, but not all supervisors needed to have Ph.D.'s/Psy.D's to supervise. A number of master's level practitioners were involved in training and education. This move to doctoral-only supervision is understandable, given that we are training doctoral-level psychologists. However, some training directors fear causing hard feelings amongst staff, especially those that have been supervising for many years and are an integral part of the training program. Directors need to make the difficult decision to either ask that these individuals, many of whom have many years of experience, and are active and valued supervisors, to no longer supervise, or to require that interns obtain additional hours under a registered psychologist. We need to find ways to recognize the contributions these supervisors have made, and allow interns the opportunity to benefit from their expertise, yet also move forward and ensure the highest levels in training.

Thoughts on Supervision at the Beginning of the Training Year

Most supervisors work with interns because they like to. Rarely, I believe, are supervisors overpaid for the time and energy they put into this work. Of course, supervising interns provides staff with variety, change, and an ongoing challenge to stay up-to-date. Interns bring with them new ideas, energy, and knowledge of up-to-date research and treatment techniques.

I believe that our supervisors make a huge impact on our careers. End of the year evaluations I've gathered over the last few years demonstrate this. When asked to point out the *highlights* of the year, interns say things like; "Supervision from experts who are open and give positive and helpful feedback." and "I enjoyed my supervisors a great deal."

I think it's important at the beginning of the year to think back to when we were interns ourselves—to the first weeks of internship and to the long awaited first day, after years of anticipation. My internship year was definitely a highlight of my graduate career. Supervisors were larger-than-life, yet human (and became more so over the year). My internship training director, Dr. Emil Rodolfa, had the biggest impact of all. His approach to his work and to his life made a lasting impression on me. I'd like to take this opportunity to thank Emil for his dedication to students, to APPIC these past six years, and to the field of psychology. He used to say that being training director was the 'best job' in the department. I've learned, first-hand, that it is. I might never have taken the job without him as a role model.

A new group of interns, eager and wide-eyed, has started. Incredible things happen over the course of a year. Interns transform from students into professionals and we, as supervisors, will play a major role in this transition. Besides the experiences and opportunities we provide them, we are capable of making this year one of their most memorable.

NEUROPSYCHOLOGY

BY BRAD ROPER, PH.D., ABPP
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The application of clinical neuropsychology to forensic settings has grown considerably in the last two decades. Attorneys are now the number one referral source for neuropsychologists in private practice (Sweet, Moberg, and Suchy, 2000). A few colleagues have trumpeted forensic neuropsychology as an attractive future growth area for neuropsychology, while others have described it as the beginning of the end of clinical neuropsychology as a "helping" clinical profession. I believe most of my colleagues are in the middle ground, in viewing forensic neuropsychology as one aspect of practice that many of us—either intentionally or unintentionally—seem to run into. I consider myself one of the middle-grounders, and in general my advice to interns and fellows has been to first strive to be competent neuropsychologists before venturing into potentially shark-infeasted forensic waters. In fact, I have been known to cringe internally when an internship or postdoc applicant tells me that they plan to focus on forensic neuropsychology or, worse yet, be a "forensic neuropsychologist."

Despite the discordant ring that "forensic neuropsychologist" has to my ears, I may need to change my tune regarding training those who may include forensic neuropschology as a component of their future practice. The adversarial nature of forensic settings coupled with various roles that neuropsychol-

ogists may assume in such settings make such practice unique. As such, challenging ethical dilemmas may emerge—indeed, they may sneak up unnoticed—and these issues can easily turn into trouble for unsuspecting clinicians. Perhaps, then, it is important for trainees to have some clinical and/or didactic exposure to forensic neuropsychology at some point in their training. In my own training setting of a VA Medical Center, we typically do not receive referrals from attorneys, essentially eliminating the possibility of hands-on training in forensic neuropsychology at this site. We may not be alone. In a recent survey, less than 10 percent of practice in institutional settings is forensic, whereas private practitioners spent on average over 25 percent their time on forensic practice (Sweet, Peck, Abramowitz, and Etzweiler, 2002). Surveys have also shown that private practice is now the modal setting for neuropsychologists, constituting approximately 39 percent of survey respondents (Sweet, et al., 2002). Because most internship and postdoctoral training is done at institutional settings, the discrepancy in forensic practice between institutional and private practice settings may leave trainees with little exposure to dilemmas they may face at a time when formal supervision is no longer available.

How are neuropsychology training settings to adapt to this increasingly common area of practice? There are no doubt several programs that provide at least some exposure to forensic settings. However, I know of no formal accounting of these. Moreover, in polling various colleagues regarding what prior discussions have occurred regarding internship or postdoctoral training in forensic applications of neuropsychology, the area appears to have been largely neglected. As such, guidelines for practical and didactic exposure to forensic neuropsychology appear to be absent. Why? Certainly the limited availability of forensic cases in institutional settings is a contributor. Additionally, perhaps some neuropsychologists eschew training in forensic neuropsychology because they find inherently adversarial systems to be distasteful. Perhaps, as well, we are not proud of some of those in our profession whose practice is largely forensic, and we do not wish to produce neuropsychologists who cozy up with well-heeled corporate defense attorneys or, alternatively, chase after ambulance chasers.

These biases and worries notwithstanding, there is no question that clinical neuropsychology has something to offer to our legal system. As such, forensic applications of neuropsychology constitute viable and appropriate areas of potential practice, and there is an increasing need to train clinicians who practice competently and responsibly in such settings. Indeed, if we believe that some of those who advertise themselves as forensic neuropsychologists do not practice competently, that should only increase our motivation to train others who do. As s postdoctoral training director, I have attempted to address such training by offering off-site rotations that provide at least some exposure to forensics, but I am aware that such exposure is currently minimal.

Currently, the lion's share of training in forensic applications of neuropsychology is offered as continuing education to those no longer within formal training programs. As a profession, can we afford to have most of the training in this important area "tacked on" at the end?

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SETTING-RELATED ISSUES

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A Modest Proposal

Having recently had occasion to prepare a case report paper for a journal, it occurred to me that it had been a long time since I'd written such a document. And it further occurred to me that it had been a very useful exercise, in that it forced me to organize my thinking about this particular case in a concise manner, but in a way that related this specific clinical experience to the broader context of what has appeared in the literature about the clinical issue under discussion. The format that the journal required was not a particularly unique one and probably similar to that suggested by most other professional publication sources when a case report type of article is submitted. And then it further occurred to me (and three "occurs" is perhaps a personal record for one morning) that this was an exercise from which trainees would probably benefit. Hence, this modest proposal.

I would propose that once during their training year trainees (interns or postdocs) be required to prepare a case report that follows the format for publication of such material in a reputable professional journal. This report would, of course, be about a clinical case with which the trainee is currently working or with which they have recently had to deal. Yes, I know that trainees are already up to their eyeballs, and perhaps beyond, in writing reports. There are testing reports, intake reports, admission reports, progress reports, discharge reports, case closing reports, case summary reports sent to referral sources or follow-up or continuing treatment sites and yet others ad infinitum Clinical charts and folders bulge with these reports.

All these reports, however, tend to be focused in a rather narrow functional way, directed towards the specific clinical status of the patient/client at the time or derived from the need of the institution for documentation of the care being or having been provided. I doubt, however, whether we ever require our trainees to put all that they know about the individual (or couple, or family or group) with whom they are working together with what they know about the theory, treatment method, clinical topic, diagnostic category or problem that is relevant to what they are doing.

Now, I realize that many settings do conduct clinical conferences of various sorts at which trainees have a chance to present a case. Often, this takes the form of a relatively brief summary that is presented, usually to a supervisor or other member of the training staff, and this may then be followed by a clinical sample, e.g. live interview, or audio or video recording, and following which discussion by the "consultant" or other conference attendees ensues. In medical settings, this may involve a "Grand Rounds" format widely attended by clinical staff or it may simply be part of a much less formal regular ward, unit or clinic conference procedure. In other settings, trainees may present cases to one another or they may prepare a case report for discussion with a faculty member or clinical supervisor.

What I am proposing, however, is something that goes beyond the task-oriented nature of these kinds of presentations. It is a way of returning to the original idea behind the internship experience as this was originally proposed by David Shakow and others back in the dim distant past when the "Boulder Model" of the scientist/clinician was emerging within psychology. The idea then was that an internship would allow a student the opportunity to integrate what they had learned in the academic setting with the actual clinical experience of patient contact.

So, I would suggest a presentation format that begins with a brief review of the relevant literature, then proceeds to the clinical history and a description of the clinical intervention (assessment, treatment, or whatever has been done) and concludes with a discussion of the way in which this particular experience is informed by, or illustrates, or contradicts or raises questions about what is generally believed about this topic. This presentation could take place in a conference or meeting format, or it could simply be a project that is prepared and handed in to the supervisor for comment and discussion.

Maybe many of us are already doing something of this sort. It's also possible that trainees may have done this type of exercise at some point in their graduate academic program. Still, it's something to think about. You may recall that the English (actually Irish, I believe) writer Jonathan Swift presented a "modest proposal" in which he sarcastically suggested that the problem of Irish poverty in the 18th century might be solved by having the poor Irish peasants sell their infants to the wealthy so that they might be cooked and eaten. I intend nothing so drastic with this proposal, but hope it will give you something to chew over as you think about what might be helpful in fostering your trainees' professional development.

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