APPIC e-newsletter
NOVEMBER 2011
VOLUME IV, NUMBER 2

APPIC 2011 Annual Meeting

The APPIC Board on the dais.

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

Another successful and well-attended APPIC Annual Membership Meeting (the 'business meeting') was held on Thursday, August 4, during the APA Convention in Washington, D.C.

The highlight of the meeting was presentation of the first Connie Hercey Award for Distinguished Service to APPIC to none other than our immediate past Executive Director, Ms. Connie Hercey, in whose honor the award has been named. Ms. Hercey transformed the organization, whose former part-time director was conducting business from a spare room in an apartment, to an efficient and effective professional office operation which quickly gained the respect of the field. Ms. Hercey effectively worked with a succession of Board Chairs with different organizational requirements and work styles. Her fair and efficient office management resulted in a loyal and committed office staff. Her administrative leadership will be missed.

Ms. Hercey receives the first Hercey Award from outgoing Chair Dr. Berry

Outgoing Chair Dr. Sharon Berry was also recognized for her six years of tireless service on the Board in a succession of roles and, in particular, for raising the organization's and membership's consciousness regarding the need for sustained and systematic advocacy efforts on behalf of our profession and its trainees.

Incoming Chair Dr. Eugene D'Angelo was customarily eloquent in presenting the annual APPIC Awards. For 2011, the recipients were:

Award for Excellence in Training

Roger P. Greenberg, Ph.D., Department of Psychiatry and Behavioral Science, SUNY Upstate Medical University, Syracuse, NY

Award for Excellence in Diversity Training

Kermit A. Crawford, Ph.D., Center for Multicultural Mental Health, Division of Psychiatry, Boston University School of Medicine, Boston, MA

MORE PHOTOS ON PAGE 7

CHAIR'S COLUMN

On Fairness, Quality, and Access in Psychology Training Programs

By Eugene J. D'Angelo, Ph.D., ABPP

It is my pleasure to introduce myself to you as the new Chair of the APPIC Board of Directors. I see this position as a privilege to serve the APPIC community and to work with the Board on the range of activities it seeks to undertake. I would like to express my sincere appreciation to Dr. Sharon Berry, Past Chair, who guided APPIC through numerous changes both within our organization and in its relationship with a variety of training councils. She steps down from this position with APPIC organizationally stronger and with excellent relationships with other training organizations. Thank you, Sharon.

As I reflect on APPIC's role in the history of psychology training, three virtues, namely, a commitment to fairness, the unbridle support for quality standards, and the quest for increased access to training opportunities, come to mind. The commitment to fairness has been a hallmark of the APPIC tradition. APPIC originated out of the desire to make the internship application and admissions process one that was fair to applicants and programs alike.

CONTINUED ON PAGE 3

ASSOCIATION OF PSYCHOLOGY POSTDOCTORAL AND INTERNSHIP CENTERS (APPIC)

APPIC E-NEWSLETTER

NOVEMBER 2011 Volume IV Number 2

IN THIS ISSUE

ARTICLES

ALSO IN THIS ISSUE

Registration Open Soon!

All APPIC member programs are invited to the **APPIC BIANNUAL CONFERENCE** to be held **April 26-28, 2012 in Tempe, Arizona.** This year Directors of Clinical Training (DCTs) have also been invited and the program also includes special workshops for new training directors as well as supervision, ABPP, and site visitor training.

Registration costs are expected to be $345 and will include an opening reception, a full breakfast and lunch for Friday and Saturday as well as complimentary transportation to/from the Phoenix Airport and wireless internet access in your room and the large meeting room for all those staying at the Tempe Mission Palms located in beautiful downtown Tempe, Arizona. APPIC will also provide CE credit for most of the presentations. Room rates are expected to be $159. APPIC will open the conference this year on Thursday evening at 5pm with a welcome reception and a keynote presentation by Dr. Cynthia Belar regarding the Future of Psychology. Plan to be at the hotel before 5pm on Thursday.

In addition, the APA Commission on Accreditation is expected to provide a site visitor workshop on Thursday from 8-5 and a self-study workshop on Saturday afternoon from 12-5.

This has always been a very good conference with time for interaction with other training directors (two receptions!) and time for some important updates on what is happening in the world of training and education in psychology. We hope there is a large turnout of members as well as DCTs.

We look forward to seeing you there!

Chair's column

Continued from Page 1

Throughout its history, it has been at the forefront in internship training by developing universal application procedures leading up to the creation of the AAPI Online, uniform dates of notification for acceptance offers to candidates, the development of the computerized Phases I & II of the Match, and the Post Match Vacancy Service. Now APPIC turns its attention to the needs of the postdoctoral training programs. There has been a longstanding concern about the need to create a more organized and less chaotic postdoctoral training program admissions process. As the number of postdoctoral programs increased over the past several years, positions have been offered anywhere between the fourth to the eleventh month of internship, creating concerns for candidates who felt pressured to make a decision about accepting an offer from a program that they had secondary interest in attending because their first choice program was not prepared to make an offer. Similarly, postdoctoral programs complained that preferred candidates were lost to their competitor programs because of early offers. At the recommendation of APPIC member Dr. Russell Lemle, a survey was conducted with the APPIC membership which reflected support for the development of a uniform notification date for APPIC postdoctoral programs. The APPIC Board has organized a pilot project whereby there will be a uniform notification date of March 14, 2012 for all APPIC member postdoctoral programs. While we are vigorously seeking to get non-APPIC programs to adhere to the uniform notification date, APPIC programs will be able to make a reciprocal offer if a non-APPIC program has made an early offer. I encourage everyone involved in postdoctoral training to visit the APPIC website (www.appic.org) and to attend to announcements on the Member and Postdoctoral listservs for ongoing developments. The APPIC Board will be seeking feedback from participants about the experience of the uniform notification date, hence, when the survey is distributed after the date, we look forward to your comments.

Fairness also extends to ways in which the APPIC community interacts with other individuals and on issues of social importance. While recognizing that there are some political and legislative initiatives in Arizona that may be of concern to some of our members, the APPIC Board has carefully deliberated whether it was appropriate to hold the 2012 APPIC Conference in Arizona on April 26-28th as initially planned. While recognizing the concerns that do exist, the Board decided to keep the conference at the Mission Palms Resort in Tempe, Arizona. This decision is based on the recognition that our discipline is founded on the belief and evidence that problem-solving occurs through dialogue with others when conflict and/or disagreement may occur. As such, the Board felt that it was important to show support for the psychology community in Arizona who have been involved in these issues and discussions.

The support for quality in psychology training has also been a prominent focus for APPIC. In that regard, a very interesting article has recently been published in the APPIC co-sponsored journal, *Training and Education in Professional Psychology*, written by Dr. Robert Hatcher titled, "The internship supply as a common-pool resource: A pathway to managing the imbalance problem." about the multiple sources that have resulted in creating the internship imbalance. This article, and the two thoughtful commentaries by Drs. Stephen McCutcheon and Stephen DeMers. In this article, Hatcher underscores the fact that the internship imbalance is not a problem created by APPIC and that its solution will require a multi-faceted series of efforts by the entire training community in order to reach a resolution. The article also offers support for the efforts to establish quality criteria for APPIC membership for internships and also for programs who seek to send candidates into the Match. These quality standards are not immutable and are subject to ongoing revision as the needs and expectations of the psychology training community continue to evolve. The APPIC Board is committed to reviewing these measures of quality to assure that they are consistent with the ongoing needs of psychology training in the 21st century.

Finally, there remains an unqualified commitment to increased access to internship training. This remains a complicated and aspirational process. Clearly, there is a need to create programs of highest quality in their training, with the adequate breadth of curriculum and supervisory support to sustain them. However, with the funding for internships coming from multiple sources based on program type and resources, a single strategy to increase internship positions would likely prove to be quite challenging. The 2011 APPIC Survey of member programs indicated that 65% of the responding programs did not receive compensation for intern services. They do not bill for the care provided by interns. This suggests that funding for the majority of training programs likely comes from sources other than direct service revenues for the various sites. This has significant implications for how existing programs might be able to develop additional training positions and for the creation of new programs. The CCTC Internship Toolkit is an excellent resource that explains some of the funding that can be identified in an effort to support the development of programs. Similarly, creative efforts for funding, such as the Hogg Foundation support for the creation of internship programs in Texas, may also be an important type of resource. Graduate Psychology Education (GPE) funding remains an ongoing effort for the psychology training community, however, in the current economic and political climate, may represent a longer term goal. The APPIC Board remains committed to providing support for the development of quality training programs at both the internship and postdoctoral level. It recognizes that such support is not provided in a"one size fits all" model of assistance, but must be tailored to the specific needs of a particular program. To that end, the Mentoring Committee, under the leadership of Dr. Arnie Abels, offers individualized advice about training program development leading to APPIC membership and onward to accreditation by the American Psychological Association. Arnie is always in need of responsive mentors, hence, feel free to contact him through the APPIC Central Office if you would like to volunteer. It is easily one of the more rewarding experiences someone can have as an APPIC member.

I would also like to offer my willingness to hear from you throughout the year. If you would ever like to be in contact with me, please feel free to do so at eugene.dangelo@childrens.harvard.edu.

From the Executive Director

By Jeff Baker, Ph.D., ABPP

I am coming up on my first year anniversary as Executive Director for APPIC and wanted to share some thoughts with APPIC. There have been a number of changes in the past 12 months, some big, some visible, some not-so-big and some behind the scenes changes that will be important to APPIC.

The first big change is the move to Houston, Texas and what that might mean. APPIC had a 7 year lease with the American Psychological Association for our offices in Washington DC and these were ably negotiated by Emil Rodolfa, the former Chair of APPIC and Connie Hercey, the former Executive Director of APPIC. This lease had APPIC paying a reasonable amount of rent for an ideal location in DC. It was so reasonable that the first 6 months I was at APPIC I was reminded by the APA Rental/Leasing Company that our space was incredibly under priced and they had no choice but to raise our rent by about 40%. That seemed like a stiff increase and that was enough for the board to consider moving APPIC somewhere else in DC or possibly to another location. Around April APPIC was informed that it was highly unlikely our leased would be renewed as another tenant wanted our space but no deal had been finalized. This was appreciated as early notice and they made it clear the writing was on the wall. At that point I began looking for new space and began seriously considering space in Texas since that is where I had been commuting from with the understanding APPIC would most likely relocate, though this was never finalized until around May or June. Danielle Lane, coordinator of membership services could possibly relocate though in the end she stated she had family in DC and wanted to stay. AMTRAK wanted APPIC space and there was no additional space in our current building. APPIC was told that we would be let out of our

lease early if at all possible but definitely had to leave at the end of July. APPIC found space in Houston for less than half what our rent would be in DC and it was approved by the board as a good move which would allow me to continue as Executive Director in a part-time position. Moving is not easy and we all have funny and not-so funny stories to tell. Luckily APPIC had only funny stories to tell and no major problems occurred during the move. The move was set at a reasonable price and these days the fuel surcharge is almost as expensive as the movers, but it was calculated we would still save significant money in the move. APPIC fully relocated to Houston, Texas on July 8 and the new space is slightly smaller but is more than adequate than what we need for now. One of our projects prior to the move was to hire a temporary person to scan all of our member programs folders. This was 90% completed as of the move and all internships have now been scanned with only about 140 postdocs left to be scanned. In addition, at least 50% of our total records have been scanned and stored and a number of outdated documents (travel receipts, cancelled checks, and other documents that were more than 7 years old) have either been scanned or shredded but keeping and storing all personnel and tax records. Going through these documents was like a stroll down memory lane. It was great seeing the names of those who came before us and the since of dedication and gratitude of the thousands of hours of volunteer work provided by APPIC Boards, Committees and volunteers. It was very heartening to see how so many had given so much for this organization. It was also fun to get a sense of the early APPIC Board meetings by going through the agenda books for every board meeting since the late 60's. Connie Hercey kept accurate and complete records of just about everything in hard copy. More recently, the board uses electronic agendas and those are stored but they take up a lot less space. It may not be surprising to many of you but early board discussions included the problem with not enough internships for the number of doctoral applicants. As early as 1980 the board was very concerned about the number of 1/2 time internships disappearing as that was a fairly common model with medical schools and doctoral psychology training programs that were housed nearby. There are still two or three of those programs still in existence and still thriving. APPIC and the Doctoral Training Programs will continue to find innovative training opportunities while keeping in mind quality assurance for their students.

In addition to the physical move, APPIC has hired two new employees who each (at this time) are working 1/2 time. Reagan Riquelmy has a bachelor's degree from the University of Texas at Tyler and Kruti Bhakta is completing her master's degree in family therapy from the University of Houston Clear Lake. Both are wonderful employees, hard workers and highly interested in learning what is needed to be done at APPIC. The job duties have not been totally assigned as both are being cross-trained and will eventually begin taking on specific tasks with the other one helping out as needed. APPIC is moving forward with an eMembership where new internship programs will be able to apply online, similar to the AAPI Online. The APPIC review committees will be able to access the information from anywhere with programs being responsible for uploading their information (program description, due process procedure, faculty CVs, etc). APPIC manages the process fairly well, but it has been too easy for materials to get lost on email, the mail or be left

CONTINUED ON NEXT PAGE

on someone's desktop. The new eMembership should solve a lot of these problems.

There are many other exciting developments happening as we move forward. All checking, payroll, retirement, and vendor information has been put online which has reduced the amount of paperwork tremendously. We still have many file cabinets full of paper and the plan is to phase out the majority of our paperwork but for now most things are being duplicated as a backup though all computers at APPIC are backed up each night this is just part of our transition process. I'm still not the most trusting person when it comes to computers and get a little frustrated when technology does not work or in my case when my right brain can't remember what my left brain did with that password.

The behind the scenes information has to do with all the business that APPIC has to manage as a non-profit organization. Non-profits have as much bureaucracy as for-profit organizations and Texas has requested many, many forms that have now been completed and submitted verifying our financial and mission status. In addition to the transition, all the previous business completed by APPIC in Washington DC also includes notifying all of those businesses regarding our move and relocation information. It is amazing how repeated requests go unheard and the chains of bureaucracy slow down to glacier speed. However, being on the Commission on Accreditation for 6 years makes me appreciate that things take time and persistence pays off. I was a business major for the first year or so of my undergraduate degree and have a minor in business administration and my mother owned a successful construction business that started in 1950. I had worked for her company during graduate school and had forgotten the issues the business world has with all the tax forms for the federal government and the Texas state government. These tasks take up significant blocks of time in regulation and compliance though I also have experience in trying to meet all the regulations of our university and their requirements for compliance and documentation.

Other exciting news includes APPIC is in the process of planning for the 2012 Conference which is chaired by Dr. Arnold Abels. The conference will take place in Tempe, Arizona at the Mission Palms Resort Hotel, which I believe the membership will find more than adequate. Your registration includes free transportation to/from the Phoenix Airport; free wireless access in your room and in most meeting rooms; free morning newspaper; breakfast and lunch on both Friday and Saturday and the hotel is within walking distance of beautiful downtown Tempe which is the home of Arizona State University (you can see the Sun Devils stadium from the hotel). I think everyone will like the location and enjoy their time in Tempe.

Details about the conference will appear on the website. And speaking of the APPIC website, it is hoped the new website will be up and running by the time this newsletter appears in your email inbox. The new web has been a challenge (as all new websites and webmasters can attest) and it is likely a work in progress, though most everything should be working as expected. APPIC continues to move forward and we look forward to many of you joining the APPIC Board at the 2012 Conference to hear the latest updates.

Please do not hesitate to contact appic@appic.org if you find something that is not working properly. We think you will like the new functionality and easy to read pages. If not, please contact me at jeffbaker@appic.org!

Remarks from the Editor:

A Chronic Illness Model for the Match Imbalance

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

For over a decade now, the Match Imbalance – formerly known as the Supply and Demand Problem – has plagued professional psychology education. Doctoral programs and their students proliferate while internships face reduction of positions or even total elimination for cost-cutting reasons. This situation is most frequently characterized as a "crisis." However, it has persisted and become part of the landscape of training. It is time to acknowledge that this is a situation which will continue into the foreseeable future unless systematic action is taken.

In my opinion, a strategic approach to the Imbalance is to consider it as a chronic illness and to apply principles of disease amelioration to it. The field has been treating this situation as if we were suffering from an acute illness, which entails the sudden appearance of very serious symptoms which are then treated, wane more or less gradually, and then disappear - if the patient survives! A chronic illness model needs to identify strategies of primary, secondary, and tertiary prevention in a systematic fashion but simultaneously. Potential solutions have in the past been divided into 'short-term' and 'long-term' proposals. However, I believe that applying the public health concept of chronic illness would permit a more ordered approach

CONTINUED ON NEXT PAGE

to planning, distribution of efforts, and allocation of professional and advocacy resources. Herewith some suggestions:

Primary prevention: This entails educative efforts to reduce the prevalence of the illness and decrease the future incidence of new cases. In my opinion, psychology has been oversold. I learned at last spring's Board of Educational Affairs meeting that we are trying to introduce psychology to third graders. This is part of an APA strategy to have psychology accepted as a 'stem science,' and thus eligible for all sorts of research and curricular funding. I understand the importance and rationale for this effort. However, it is a potential future contributor to a continuing training imbalance. In addition, both high school students of psychology and undergraduates are insufficiently informed of career alternatives into which to channel their desires for helping profession careers. Many, if not most, of these potential professional students have little or no interest in research, a cardinal feature of psychology doctoral training. They would be a better fit for other professions.

Secondary prevention: This entails beginning treatment of an illness that has manifested itself but before it becomes acutely and floridly evident. Doctoral programs, particularly 'for-profit' programs, need voluntarily to restrict the number of students admitted in the first place, years before they add to the Imbalance. Many of these individuals are destined never to be able to obtain an internship, no matter how many years and to however many internship programs they apply. Fewer doctoral students, of course, means fewer applicants, thus reducing the 'demand' for internships.

Tertiary prevention: Tertiary prevention means direct intervention or treatment of the acute illness right now. For the Imbalance, this entails creation of new internships. The Department of Veterans Affairs has been fortunate to have the funding to create a significant number of new internship programs and expand some existing programs. Opportunities such as the Hogg Foundation/University of Texas at Austin initiative also constitute 'treatment' of the Imbalance.

While my suggested chronic illness model does not entail any truly new or unique proposals, I believe that conceptualizing the Match Imbalance in this fashion provides a more useful conceptual framework for approaching the problem.

APPIC 2011 Annual Meeting

At the APPIC Board Meeting preceding the Convention

Excellence in Training Awardee Dr. Greenberg with Board Member Dr. Cornish

Excellence in Diversity Training Awardee Dr. Crawford with Dr Cornish.

Drs. Liz Klonoff, Rick Seime, Susan Zlotlow, and Joyce Illfelder-Kaye.

2011 APPIC Match
Survey of Internship Applicants

May, 2011 | By Greg Keilin, Ph.D., APPIC Match Coordinator

PART 1: SUMMARY OF SURVEY RESULTS

This survey of applicants who were registered for the 2011 APPIC Match was conducted via the internet between February 26 and April 17, 2011. All 4,199 applicants who registered for the APPIC Match were sent an e-mail message (along with two reminder e-mails) about the availability of the survey at a specific internet address.

A total of 2,731 internship applicants (65%) completed some or all of the survey. Results of the survey are presented below. Missing data and "Not Applicable" responses were eliminated, and percentages do not necessarily total 100% due to rounding. Some survey items requested open-ended comments about the AAPI, APPIC Directory Online, the Match, etc. that are not reported below; however, these anonymous comments were reviewed by the appropriate APPIC Board and/or committee members who are responsible for each area.

Some of the more interesting findings from this survey include:

1. DEBT: Applicants' mean reported debt load related to graduate level study in psychology was $85,545 (SD = 73,572, median = $80,000), a 9.8% increase from 2010 (see question 11). Approximately 44% reported debt of $100,000 or higher (compared to 39% in 2010), while 22% reported debt exceeding $150,000 (compared to 18% in 2010).

Please note that these figures do not include any additional debt that these students may accrue during the remainder of their graduate training (e.g., during internship).

2. COST: The average total cost of participating in the selection process rose 6.3% as compared to 2010 (see question 20).

As seen in previous years, the cost of participation varied dramatically across applicants. While the average applicant spent $1,812 (SD = $1,483, median = $1,425), many applicants spent considerably less while many spent considerably more.

3. NUMBER OF APPLICATIONS: Applicants submitted an average of 16.0 internship applications (see question 15), as compared to 15.1 applications last year, and received an average of 6.4 interviews (see question 17). Despite the increase in the mean number of applications submitted, the number of interviews received was unchanged from the last two years .

Last year's introduction of the AAPI Online service provided a financial incentive for applicants to submit no more than 15 applications.

4. PREVIOUS PARTICIPATION: Approximately 9% of applicants reported having participated in a previous APPIC Match (see question 13).

5. GENDER: Approximately 79% of internship applicants in the 2011 Match were female (see question 38). Questions 33-41 provide additional demographic information.

6. PRACTICUM HOURS: Median doctoral hours reported by applicants from the 2011 APPIC Match (see question 46):

Doctoral Intervention: Median = 573	
Doctoral Assessment: Median = 148	
Doctoral Supervision: Median = 303	

Question 46 also provides the median numbers of masters practicum hours reported by applicants.

APPIC recommends that applicants interpret these numbers cautiously. Applicants should NOT assume that the numbers of practicum hours reported are necessary to successfully obtain an internship, as many Training Directors have told us that they consider these raw numbers to be one of the less important aspects of an application.

7. SALARY: Matched applicants reported a mean internship salary of $24,218, an increase of 2.2% from 2010 (see question 26).

8. GEOGRAPHIC RESTRICTIONS: Approximately 41% of applicants reported having geographic restrictions on their internship search (see question 43 for specific definitions). This compares to 45% in 2010 and 51% in 2009.

1. Type of Doctoral Program

Clinical	2161	79 %
Counseling	343	13 %
School	123	5 %
Combined	80	3 %
Other	20	1 %

INTERPRETATION NOTE: A "combined" program could mean: (a) a doctoral program that defines itself as a "combined" program (e.g., clinical-school), or (b) an arrangement negotiated by a student in which he/she integrates the curricula of two separate doctoral programs at his/her school.

CONTINUED ON PAGE 22

Recruitment and Diversity Issues

By Jesse Bell, Ph.D., ABPP

Recruiting diverse students into psychology training programs has become an increasingly important issue according to Rogers and Molina (2006) in the *American Psychologist*. It has become apparent that enrollment by underrepresented minority groups into doctoral level psychology training programs has been dropping and has not kept pace with the growth of minority groups in the general population (Maton et al., 2006). Special methods of recruitment have been suggested to increase the efforts of psychology graduate schools pursuit of diverse minority students. Diversity within the ranks of the faculty and student body is a primary criterion for accreditation put forth by the American Psychological Association (APA) and is consistently monitored annually. The pressure to recruit minority students has increased exponentially. The APA has been sending out a list of minority students enrolled in graduate psychology programs nationally, to all internship training programs in an effort to actively assist in minority recruitment.

This article will attempt to delineate additional issues that need to be addressed by our governing regulating bodies and our accrediting bodies:

1) Redefining minority status: According to the U.S. Census Bureau there are five categories of recognized ethnic status 1) African American/Black, 2) Caucasian/White, 3) Native American Indian, 4) Asian American including Pacific Islanders, 5) Hispanic origins including Mexican/Puerto Rican/Latinos. Racial group membership was confined to one of these categories until recently in the year 2000, the Census Bureau added a Biracial category for those individuals whose parental origins were from two different racial groups. Minority status has been legally and culturally defined as those racial groups that are underrepresented in the general population leading to a cultural disadvantage in terms of access to opportunities leading to greater assimilation and upward socioeconomic mobility. These traditional definitions of minority status in terms of racial representation is rather narrow and we would argue that expanding the definition beyond simply racial identification would be more consistent with the concept of diversity. Over the past five years our training program has accepted interns who were of middle-eastern Arabic origins as well as foreign nationals from Russia and the Ukraine. These students could not be classified as minorities because they do not fit into any of the above defined minority racial categories, however, they can be defined as Caucasian or white. Culturally however, being a foreign national and having a different country of origin they bring a wealth of diversity issues and exposure to the training program. The middle-eastern Arabic students are somewhat marginal in their identification with American minority groups, and they do not view themselves as "white", however, they must be classified as such. Even though Arabic students assimilate in the process of obtaining their education they also retain their cultural identity and culture of origin. A psychology training program needs to address worldviews which may be fundamentally different from American mainstream thinking in psychology, particularly how these different worldviews can impact mental health practices. While APA does have an other/foreign national category, it does not refer to this category in its definition of diversity, and we would argue that this category of international students bring as much or more diversity issues to the training program as traditional minority groups and therefore should be included in the definition of diversity. This is particularly true when some international students have as their goal to take back their acquired skills from internship to update and inform the mental health practices and delivery systems in their respective countries of origin. Their goals may also include setting up and organizing culturally sensitive mental health care delivery systems in their own respective communities within the United States. Looking at these potential outcomes of training could certainly argue the position that foreign nationals be included in APA's definition of diversity.

2) The meaning of diversity needs to be more inclusive (i.e. Multiculturalism, Biracial, LGBT, Disabilities, Foreign National) to include other definitions of diversity such as cultural and religious diversity (Jewish, Muslim, Christian) as well as ethnic/racial definitions. Religious identification that includes a cultural lifestyle can also influence one's worldview and ultimately impact service delivery. This can be seen in various forms of religious counseling and faith- based programs of care particularly in the substance abuse and drug rehabilitation arenas. While APA does recognize gay-lesbian students and physically disabled students as meeting the criteria of diversity, they do not address religious diversity. The definition of diversity has broadened to include sexual orientation and disability presumably because of the special unique needs of these groups when providing services to them. Sexual orientation and disability has also resulted in discrimination that has barred these groups from access to educational opportunities similar to racial minorities in this country. Giving them minority status with the same kind of political push as "affir-

CONTINUED ON NEXT PAGE

mative action" may give them greater access to training opportunities and increase the numbers of "providers of service" represented from "special needs populations". Biracial and multicultural subgroups are growing in this country and need to be included in the definition of diversity. The recognition of the biracial status as a growing minority group has led to its inclusion by the Census Bureau as a minority category. Biracial individuals historically were forced to choose or endorse one of the traditional racial categories or exclude themselves altogether. If they chose to endorse one of the racial categories in so doing they had to reject or deny one of their parents' heritage. This led to a significant psychological issue and perhaps even "harm" because biracial persons cannot identify solely with only one parent's heritage and be forced to reject the other. It would mean denying/rejecting a significant part of their identity.

Those individuals who are able to identify fully with both parent's cultural origins can feel whole, however, those that feel they must reject or deny one parent's racial identity may feel divided, split or even unintegrated. To the extent that these individuals are not accepted by the racial/cultural group that they have chosen to identify with may lead to a marginal adjustment and can put them at a disadvantage in terms of gaining the support from traditional racial/cultural resources within the community. It is important therefore, that biracial or multiethnic persons be given a special minority category that would allow them to identify with both parental origins and be included in the definition of diversity.

These are a few issues to consider when defining diversity from a broader perspective, particularly when recruiting for psychology training programs that are sensitive to the impact of these issues in training providers of care which can impact the delivery of services.

References

American Psychological Association, (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists, *American Psychologist, 5, 377-402.*

Maton, K.I., Kohout, J.L., Wicherski, M., Leary, G.E., & Vinokurov, A. (2006). Minority students of color and the graduate pipeline. Disquieting and encouraging trends. 1989-1999. *American Psychologist, 61, 117-131.*

Rogers, M.R. & Molina, I., (2006). Exemplary efforts in psychology to recruit and retain graduate students of color. *American Psychologist, 61, 143-156.*

Tips for Trainers: A Place for Pregnancy in Psychology Training

By Marla Eby, Ph.D., APPIC Board

There is a way in which time can seem to be frozen in the training years, despite the progression from practicum to internship to postdoctoral experience. For women who enter into this system, by the time they emerge with doctorate in hand, they are often in their early thirties. They are suddenly against a different kind of clock, and despite great organizational skills and planning, luck may work against them and it may become, as Chodorow (2003) notes, "too late."

As a postdoctoral training director, a teacher of interns and a supervisor of psychiatry residents, I have worked with a good number of pregnant trainees, as well as some who have delayed pregnancy. Psychiatry residents, whose training is generally continuous over several years at a single institution, may well have an advantage here, because the greater amount of time allows for more flexibility. In contrast, psychology trainees often train in one year increments, so a pregnancy is hard to fit in and may subtly be discouraged by an institution that sees them only as one-year "temporary" trainees.

As trainers, it is important that we be sensitive to this dilemma. Research on medical residents has demonstrated that trainees are more likely to feel free to become pregnant if an articulated policy is present (Willet et al, 2010). For this reason, every program should have a clear-cut pregnancy leave policy that is both outlined in a trainee handbook and discussed with incoming trainees. However, since the Family and Medical Leave Act only applies to trainees employed for more than a year, this can be difficult to sort out both with the institution and its Human Resources department. The FMLA provides for a 12-week unpaid job-protected pregnancy leave; internships and postdoctoral programs might consider at least a 6-week leave, or a 4-week leave with a temporary return to part-time work. Paid vacation time could be used for at least part of this leave.

Supervising the pregnant intern can be complex, especially around the issue of how to handle pregnancy with patients. Because pregnancies sometimes end in the first trimester, it is generally better not to bring the issue up with patients at that time. However, by the beginning of the third trimester, the pregnancy is usually obvious, and some patients may resent the therapist who waits that long to bring up the subject. And while pregnancy in the therapist may provide an opportunity for some patients to engage in new material at a deeper level, others may back away, either froma wish to protect the therapist or from discomfort with their own fertility issues. Pregnancy may also bring up issues for the therapist herself- her wish to care for others, so key in psychological work, may be turned inward as the pregnancy develops, and she may at times feel depleted and impatient. And a trainee working in an inpatient or emergency room setting may become worried for the safety of herself and her pregnancy, and those settings (which can sometimes be in denial about the dangers involved) will need to work with the trainee to ensure that she is not placed at risk.

Finally, training programs by definition involve groups. Tensions can arise if other interns are expected to take call or otherwise fill in for an absent trainee. A carefully planned sequence of training can be disrupted when a trainee is gone for a period of time. It is hardly surprising that many training directors view pregnancy as a liability, rather than a benefit to the program. However, in my experience, if structures are in place in advance, the matter of pregnancy becomes less of a problem, and more of an opportunity for continued growth. To that end, training directors may also benefit from consultation around specific situations pertaining to pregnancy, both from colleagues and through APPIC's Informal Consultation Service. In addition, helpful links to guidelines for both trainees and training directors are provided below.

References

Chodorow, N. (2003). "Too Late": Ambivalence about Motherhood, Choice and Time. *Journal of the American Psychoanalytic Association*, 51, 1181-1198.

Dyson, E and King, G (2008).The Pregnant Therapist. *Psychodynamic Practice*, 14, 27-42.

Ehm, K.F. and Linnemann, A. A Postdoc's Guide to Pregnancy and Maternity Leave. http://www.national-postdoc.org/publications/563-maternity-guide

Kaslow, N, Garfield, N, Illfelder-Kaye, J, and Mitnick, M (2007). APPIC Guidance for Pregnancy and Family Care Issues During Internship and Postdoctoral Residency Training. http://www.appic.org/downloads/Family_care_and_pregnancy-6-20-07.doc

Willet, L et.al.(2010). Do Women Residents Delay Childbearing Due to Perceived Career Threats? *Academic Medicine*, 85, 640-646.

FROM THE ASSOCIATE EDITORS

Adult General Psychology

When your Supervisee becomes your Colleague: Thoughts on Managing Transitions in Professional Relationships

By Evelyn Sandeen, Ph.D., ABPP
Director of Psychology Training,
New Mexico VA Healthcare System
evelyn.sandeen@va.gov

Many institutions view the purpose of training programs in psychology as preparing professional psychologists to join the workforce of that institution. Therefore, it is not uncommon for supervisor-supervisee relationships to change over time. In some training settings, supervisors might first know an individual as a practicum student, then an intern, and then a post-doctoral resident or a licensed colleague. In reflecting on the professional transitions among former trainees at my site, it appeared that some former students made the transition to colleague extremely well while others seemed to remain in a student role long after being hired as licensed psychologists. I became curious about potential pitfalls in negotiating these transitions, as well as points of awareness that might make these transitions rewarding for all concerned.

I informally surveyed some colleagues about their experiences with changing professional relationships. All of the folks who talked to me had been in more than one status at a given institution or workplace. A few themes emerged around situations and behaviors that led to a more difficult professional transition experience, as well as situations and behaviors that produced a more positive outcome.

Difficult Situations and Behaviors:

1) Failure of the supervisor to acknowledge the change of status and the changing competencies that accompany it.

The simple lack of verbal acknowledgement and discussion of the change of status was a common complaint. Some supervisors simply continue their prior relationship without taking on the appropriate responsibility (as the individual with greater power in the relationship) to discuss changing roles and their implications for the former supervisee. This can result in the (inappropriate) continuation of duties and tasks that no longer meet the former supervisee's training or professional growth needs.

2) Supervisors who, at an interpersonal level, do not change their behavior toward the former trainee.

This was seen as a more subtle, and therefore, more difficult issue to address. This could show up as not being invited to lunch with other colleagues, or not being addressed as "Doctor" when others are, or being given orders rather than requests when the former supervisor was distributing workload in a team meeting.

3) Supervisors who seem threatened and actively undermine the junior colleague.

Fortunately this was only cited by a small minority of psychologists I spoke with. However, it may be worth mentioning the obvious: there do exist some psychologists who feel insecure in their settings and may experience difficulty promoting the professional growth of junior colleagues because of their own internal psychological dynamics. Relationships that worked well when the power dynamics were clearly in the favor of the senior person sometimes could crash and burn when the roles shifted.

4) Beliefs on the part of the trainees that were unhelpful to their own professional growth.

This is a speculative category on my part. No one explicitly told me that they had discovered they held beliefs unhelpful to their growth. However, in conversations with former trainees over the years I have observed behaviors that appear to spring from the common feeling that one is an imposter in one's professional role. The belief here appears to be one of "I need to wait to _____ (speak up in meetings, be more assertive with colleagues, take on new professional tasks) until I _____ (have more experience, am older, feel more comfortable, have more power)." In contrast, the former trainees who have become most successful in their professional transitions appear to me to have taken their power (in an interpersonally charming way) rather than waiting for it to be given to them.

Helpful Strategies or Behaviors:

In parallel to the unhelpful behaviors were several types of behaviors/situations cited that made the professional transition easier.

1) "Leaving home" before returning as a colleague.

Several of the folks I spoke with noted that their transition was made much easier because they left an institution where they interned to do post-doctoral work elsewhere before returning. People remarked that this process allowed for a clean break from the student role and those who had done this said uniformly that they had not felt any difficulties in the transition and felt fully accepted as colleagues by their former supervisors.

Of course, this trajectory (leaving an institution and returning) is not appropriate or feasible for everyone. What can supervisors do to help their supervisees who do stay at their site make a positive professional transition?

2) Supervisors who clearly acknowledge and mark the transition.

CONTINUED ON NEXT PAGE

These were some of the most heartening stories I heard. There were several methods that supervisors used to acknowledge the difference in status that the former supervisee had achieved.

Of course, a verbal acknowledgement of the new role situation is necessary and appreciated by the former supervisee. If this verbal acknowledgement is accompanied by actions supportive of the change in status, it is even more salient. Simple actions, like reinforcing a title change from "Ms." to "Dr." with other professional staff, can make a big impact. Changing tasks and assignments is certainly appropriate and should be done intentionally with the goal of matching these to the professional growth level of the person. Structural changes, such as attendance at different meetings, or beginning to take on supervision duties, should be facilitated by the former supervisor. An especially salient way for supervisors to acknowledge the change is to give the young professional time and space to demonstrate his or her expertise in an area of interest; for example, by providing didactic lectures in the intern seminar series.

Interpersonal changes, manifested by lowering the interpersonal boundaries that exist when one is in a supervisor/supervisee relationship can be appropriate as well. Including the new professional in conversations about team issues or personal issues from which they had previously been (appropriately) excluded may be a powerful method to note their changing status.

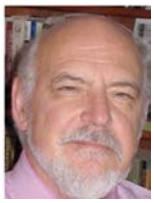
When all of these acknowledgements of changed status come together, it can pave the way for a very fruitful transition. For example, one psychologist told me that when she was hired as a staff member after internship, several of her supervisors invited her to lunch at one of the supervisors' homes. While there, her supervisors discussed the upcoming changes and mentored her on how to handle them. This psychologist told me that this one event helped her tremendously in her professional learning curve.

3) Assertive moves on the part of the former supervisee

If the former supervisor(s) fail to acknowledge the change in status in the ways described above, what is the former supervisee to do? Some psychologists said that it was necessary for them, using their best assertiveness skills, to gently remind former supervisors of their status and developmental level, and to initiate the necessary conversation on this topic. For those who felt able to do this, it was a most productive encounter.

Behavioral Emergencies

By Phillip M. Kleespies, Ph.D., ABPP
VA Boston Healthcare System



In recent years, when there were several high-profile cases of veterans who committed suicide after returning from the wars in Afghanistan and Iraq, the Department of Veterans Affairs (DVA) Healthcare System received significant criticism in the press for its apparent failure to be prepared to adequately assess and treat suicidal veterans (see, e.g., Sege, 2005 and Sennott, 2007). There is now some empirical evidence that both male and female veterans who use the DVA Healthcare System have an elevated rate of suicide when compared to males and females in the general population (McCarthy, et al., 2009). There are inconsistent results, however, with respect to the question of whether veteran status per se (i.e., including both veterans who use the VA and those who do not) confers an elevated risk of suicide (Kaplan, Huguet, McFarland, & Newsom, 2007; Miller, et al., 2009).

To the DVA Healthcare System's credit, it responded to the criticism noted above by initiating a comprehensive suicide prevention program that included a strategy to reduce patient suicide and suicidal behavior in the VA healthcare system (see Blue Ribbon Work Group on Suicide Prevention in the Veteran Population, 2008). Part of the strategy involved universal suicide awareness training for all VA clinical staff as well as continuing education and training in suicide risk assessment as a way of addressing deficits in this area of practice. The VA suicide prevention initiative is ongoing. If the reader, however, thinks that deficits in training for assessing and managing suicidality has been solely a VA or military problem, he or she is sadly mistaken. The VA was cast into the spotlight on this issue primarily because of the national concern for the men and women whom we ask to fight our wars. In fact, however, there have been longstanding, systemic problems with the education and training of mental health professionals in assessing and managing patient or client suicide risk, and psychology as a discipline has been no exception.

Suicide is the 11th leading cause of death in the United States, and the 3rd leading cause of death for youth between the ages of 15 and 24 (Centers for Disease Control and Prevention, 2010). Nearly every mental health clinician with an active practice encounters patients or clients with suicidal ideation or behavior, and a significant number of them have a patient or client, at some point in their career, who commits suicide (see Kleespies & Ponce, 2009, for a review of this issue). If a clinician has a patient or client suicide, aside from the tragedy of the event itself, there can be serious clinical, ethical, and legal repercussions. In spite of these facts, psychology and the other mental health professions (i.e., psychiatry, social work, and counseling) have placed very little emphasis on providing systematic training for their students, interns, and residents in the evaluation and management of suicidal patients.

In professional psychology, for example, there have been any number of surveys over the past 25 – 30 years that have demonstrated how inconsistent this training has been. In 1983, Berman found that the average amount

CONTINUED ON NEXT PAGE

of formal training for psychologists in assessing and treating suicidal patients was two hours. Bongar & Harmatz (1990) reported that only 40% of graduate programs in clinical psychology offered any formal training in the study of suicide. Kleespies, Penk, & Forsyth (1993), in their survey, noted that approximately 55% of graduate students in clinical psychology had some form of didactic instruction on suicide, but the instruction was quite limited (i.e., one or two lectures). Ellis & Dickey (1998) found that training in the study of suicide seemed to be lacking in both quantity and quality in many psychology internship and psychiatry residency programs. In the survey by Dexter-Mazza & Freeman (2003), approximately half of the psychology interns had been in graduate programs that did not offer training in the assessment and management of suicidal patients. Finally, Jahn, et al., (2011) reported that only 3.8% of graduate programs that responded to their survey had a suicide-specific course and that the majority of the responding programs relied on passive training in which information about suicide was mentioned in other courses or was gained in practicum experiences or workshops.

In 1999, the Surgeon General of the United States (Dr. David Satcher) declared suicide to be a public health problem and issued a document entitled The Surgeon General's Call to Action to Prevent Suicide (U.S. Public Health Service, 1999). As part of a comprehensive strategy to reduce the suicide rate in the U.S., one of the goals stated in this document was to increase the proportion of psychology graduate programs and medical residency programs that include training in the assessment and management of suicide risk by 2005.

In 2010, the Suicide Prevention Resource Center (SPRC) and the Suicide Prevention Action Network (SPAN) collaborated on a review of the Surgeon General's national strategy and published a report entitled 2010 Progress Review of the National Strategy for Suicide Prevention. Sadly, after reviewing the training standards for 11 different mental health professional groups (psychology included), it was found that only the Council for the Accreditation of Counseling and Related Educational Programs had placed increased attention on the issue of suicide in its 2009 standards as compared to its previous standards. In addition to the Surgeon General, The Joint Commission (2010), the Institute of Medicine (2002), the U.S. Department of Health and Human Services (2001), and the World Health Organization (1996) have all made statements about the critical need to improve the capabilities of mental health professionals in assessing and managing suicide risk. Yet, the writer sees little indication in the literature of a significant effort on the part of most mental health disciplines and their training programs to respond to these important statements and calls to action.

As I have noted in previous columns for this newsletter, psychology internship programs (where interns will almost inevitably see patients or clients who are at risk of suicide) are well placed to make a difference in terms of training in suicide risk assessment and management. There is growing evidence that empirically-based skills taught in lectures and workshops combined with the application of these skills during clinical experiences can improve risk assessments as well as confidence in the management of suicidal patients/clients (McNiel, et al., 2008; Oordt, Jobes, Fonseca, & Schmidt, 2009). I would encourage all psychology internship programs to consider whether they might benefit from increasing the educative component of their program with a greater emphasis on training in suicide risk assessment and management.

References

Berman, A. (1983). Training Committee Report. Unpublished manuscript. Washington, DC: American Association of Suicidology Blue Ribbon Work Group on Suicide Prevention in the Veteran Population. (2008).

Report to James B. Peake, MD, Secretary of Veterans Affairs. Unpublished manuscript, Department of Veterans Affairs, Washington, DC.

Bongar, B., & Harmatz, M. (1991). Clinical psychology graduate education in the study of suicide: Availability, resources, and importance. *Suicide and Life-Threatening Behavior, 21, 231-244.*

Centers for Disease Control and Prevention. (2010). Fast Stats: Assault or homicide. Retrieved on September 5, 2011 from https://www.cdc.gov/nchs/fastats/homicide.htm

Dexter-Mazza, E., & Freeman, K. (2003). Graduate training and the treatment of suicidal clients: The students' perspective. *Suicide and Life-Threatening Behavior, 33, 211-218.*

Ellis, T., & Dickey, T. (1998). Procedures surrounding the suicide of a trainee's patient: A national survey of psychology internships and psychiatry residency programs. *Professional Psychology: Research and Practice, 29, 492-497.*

Institute of Medicine. (2002). Reducing suicide: A national imperative. Washington, DC: The National Academic Press. Jahn, D., Wacha-Montes, A., Drapeau, C., Grant, B., Nadorff, M., Pusateri, M., Cukrowicz, K. (2011). Suicide-specific courses and training: Prevalence, beliefs, and barriers. Part I: Graduate psychology programs and professional schools of psychology. Manuscript in preparation.

Kaplan, M., Huguet, N., McFarland, B., & Newsom, J. (2007). Suicide among male veterans: A prospective population-based study. *Journal of Epidemiology and Community Health, 61, 619-624.*

Kleespies, P., & Ponce, A. (2009). The stress and emotional impact of clinical work with the patient at risk. In P. Kleespies (Ed.): *Behavioral emergencies: An evidence-based resource for evaluating and managing risk of suicide, violence, and victimization* (pp.431-448). Washington, DC: APA Books.

Kleespies, P., Penk, W., & Forsyth J. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice, 24, 293-303*

McCarthy, J., Valenstein, M., Myra Kim, H., Ilgen, M., Zivin, K., & Blow, F. (2009). Suicide mortality among patients receiving care in the Veterans Health Administration Health System. *American Journal of Epidemiology, 169, 1033-1038.*

McNiel, D., Fordwood, S., Weaver, C., Chamberlain, J., Hall, S., & Binder, R. (2008). Effects of training on suicide risk assessment. *Psychiatric Services, 59, 1462-1465.*

Miller, M., Barber, C., Azrael,D., Calle, E., Lawler, E., & Mukamal, K. (2009). Suicide among U.S. veterans: A prospective study of 500,000 middle-aged and elderly men. *American Journal of Epidemiology, 170, 494-500.*

Oordt, M., Jobes, D., Fonseca, V., & Schmidt, S. (2009). Trtaining mental health professionals to assess and manage suicidal behavior: Can provider confidence and practice behaviors be altered? *Suicide and Life-Threatening Behavior, 39, 21-32.*

Sege, I. (2005, March 1). 'Something happened to Jeff': Jeff Lucey returned from Iraq a changed man. Then he killed himself. *The Boston Globe. Retrieved March 20, 2007, from http://www.boston.com/yourlife/health/mental/articles/2005/03/01/*

Sennott, C. (2007, February 11). Told to wait, a Marine dies: VA care in spotlight after Iraq War veteran's suicide. *The Boston Globe, pp. A1, A10.*

Suicide Prevention Resource Center & Suicide Prevention Action Netork USA. (2010). Changing the future of suicide prevention: A 2010 progress review of the national strategy and recommendations for the decade ahead. Retrieved on September 5, 2011 from *http://www.sprc.org/library/ChartinThe Future_Fullbook.pdf.*

The Joint Commission. (2010). Sentinel event alert: A follow-up report on preventing suicide. Focus on medical/surgical units and the emergency department. Retrieved on September 5, 2011 from *http://www.jointcommiccion.org/assets/1/18/SEA_46.pdf*

United Nations/World Health Organization. (1996). Prevention of suicide: Guidelines for the formulation and implementation of national strategies (ST/ESA/245). Geneva. Switzerland: World Health Organization.U.S. Department of Health and Human Services. (2001). National strategy for suicide prevention: Goals and objectives for action. Retrieved on September 5, 2011 from *http://www.ncbi.nim.nih.gov/books/NBK44281/pdf/TOC.pdf*

U.S. Public Health Service. (1999). The Surgeon General's call to action to prevent suicide. Retrieved on September 5, 2011 from *http://www.surgeongeneral.gov/library/calltoaction/calltoaction.pdf-*

Counseling Centers

By A. Glade Ellingson, Ph.D.

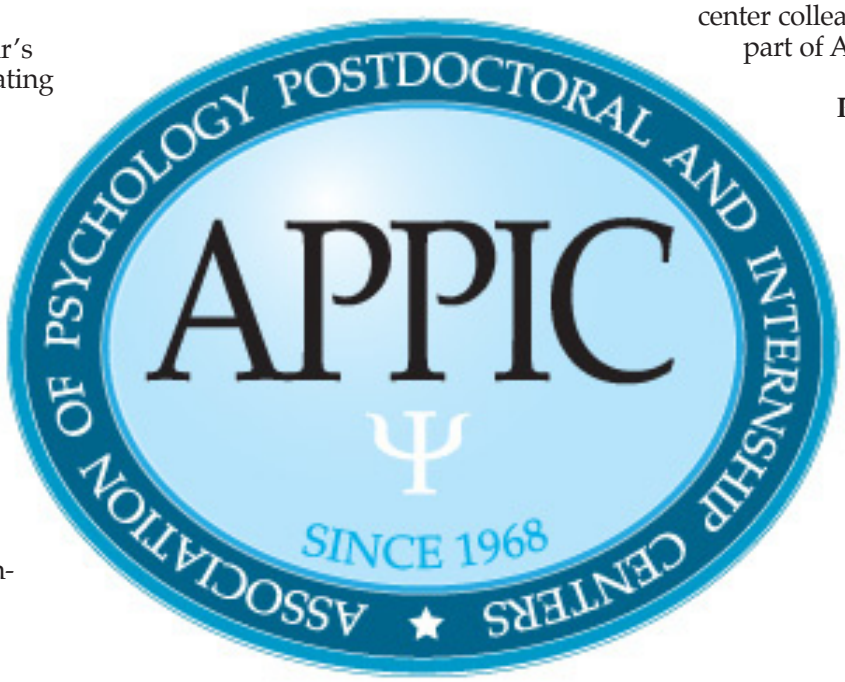
It is a pleasure to write my first column as Co-Associate Editor for Counseling Centers, and to share this space with Dr. Julia Phillips. As counseling center training directors, we attended the 34th annual conference for the Association of Counseling Center Training Agencies (ACCTA) held this year in Lake Geneva, Wisconsin from September 10-14.

For those who may not be familiar with ACCTA, I'll say a few words about the organization before discussing the conference. ACCTA is a dynamic, diverse group of training directors from university and college counseling centers across the country. Begun in 1978 with 17 individuals, it has evolved into an organization with 159 active, dues-paying member programs. Our current President is Dr. Maureen Lafferty (Notre Dame University). The primary purposes of ACCTA are: 1) To provide for the development and promotion of the professional training of psychology interns in university and college counseling center settings; 2) To provide for the enhancement of related counseling center activities; and 3) To promote diversity and the enrichment a multicultural community brings to our organization and the training profession (ACCTA, 2010). A fourth (and unofficial) purpose of the organization is to develop relationships with colleagues by working together, sharing ideas, and having some fun! These purposes are met via several ACCTA standing committees, ad hoc committees, special projects, and working groups, as well as an active listserv and our annual conference.

The theme of this year's conference was "Integrating Social Justice Issues into Internship Training: Expanding our Multicultural Competence." Our keynote speakers were Dr. Suzette Speight (University of Akron) and Dr. Elizabeth Vera (Loyola University Chicago), who challenged our membership to pursue social justice ideals in counseling center internship training. Each year ACCTA invites two aspiring training directors to attend the conference as Diversity Scholars; we were pleased this year to have Dr. Inge Hansen (Stanford University) and Dr. Agnes Kwong (University of Washington) present to us in this capacity. We were also pleased to be joined by invited liaisons from national organizations with whom ACCTA has strong working relationships: the Association for Coordination of Counseling Center Clinical Services (ACCCCS); the Association of Psychology Training Clinics (APTC); the Association of University and College Counseling Center Directors (AUCCCD); APA's Commission on Accreditation (CoA); the Council of Counseling Psychology Training Programs (CCPTP); and the National Council of Schools and Programs of Professional Psychology (NCSPP).

ACCTA's highest award is the Helen Roehlke Award for Excellence in Counseling Center Training. This year's award went to Dr. Kathlyn Dailey (Texas State University) for her exceptional contributions to ACCTA and her leadership in counseling center internship training over the past 18 years. Otherwise, the 2011 conference was notable for 18 CE credit-bearing presentations, Affinity Groups, Culture Sharing, business meetings, area sightseeing, lots of good food, and renewed friendships.

Finally, thanks to the efforts of several ACCTA Board Members, the organization launched a new website last June. Feel free to check us out online: https://www.accta.net/ . And to our counseling center colleagues who are not yet part of ACCTA: Please join us!



Reference:

Association of Counseling Center Training Agencies, (2010). Bylaws. *Retrieved from: https://www.accta.net/Portals/0/downloads/about/ACCTA%20Bylaws%2011-2010-1.pdf*

Counseling Centers

By Julia C. Phillips, Ph.D.

Recent research out of the University of Utah (Rudd, Goulding, & Byran, 2011) made headlines as researchers reported on the increased rate of suicidality by college students who are also veterans of the wars in Iraq and Afghanistan. This research points to the need for college and university counseling centers to attend to this population of students at risk. Over the past couple of years I have been increasingly involved with outreach and prevention efforts with veteran students, working to provide appropriate interventions when they access services at the Counseling Center (CC). Throughout this process, I have been especially attentive to working on increasing my own cross cultural competency and on training interns to do so, as well. At the recent ACCTA conference, our theme was social justice. Throughout the conference, I reflected on veterans in the context of social justice. They were mentioned as one group that is in need of attention during our keynote and identified as a group whose members also often have hidden disabilities during a program on this broader topic. I had some interesting informal conversations with others about veterans, as well. I hope to use this column to share some of what I have learned about veterans on college campuses, especially regarding resources, ideas for outreach, training and professional development, and to continue the meaningful conversations I began at ACCTA.

Many universities and colleges now have dedicated units that work with veterans. For example, at the University of Akron, students utilize the Military Services Center for services and resources, as well as our Adult Focus office, serving nontraditional students, of which veterans are included in the definition. As a Counseling Center, we have been cultivating our consultative relationships with personnel in these offices. CC staff have done suicide prevention training for staff and students specific to veterans, as well as outreach presentations to the veterans section of the orientation class each semester about our services. We tailor the presentation to why veterans would use our services in particular e.g., managing couples issues associated with re-entry, using military service as a strength in career decision making, study skills for persons with brain injury, etc. This semester, we are having the class come to the Counseling Center to become more familiar with our setting. We include a two hour training seminar on military culture for our interns at the beginning of the year and include veterans as a population of interest when we consider diversity issues. Last year, one of our interns, Tiffany Porter, focused energies on working with veteran students. As part of this emphasis, she organized a Veterans, Family and Friends Appreciation Day Event in which staff from various offices and groups presented information at tables, food was donated by local restaurants, and chair massages were offered by a local business. Veterans in UA's student group were enthusiastic about the event and became more familiar with Counseling Center personnel and other resources.

Many counseling centers also include information and resources for veterans on their websites. This information typically includes psychoeducation on specific mental health concerns faced by veterans, typical challenges faced in the transition from soldier to college student, unique stressors that veterans may face on college campuses, and tips for success. Websites also often include links to outside resources that are either specific to the military such as the Wounded Warrior Project at www.woundedwarriorproject.org , or specific to college students such as www.halfofus.com , an educational site on depression and college students which is inclusive of veterans.

An excellent resource for training current staff and interns is the Center for Deployment Psychology (www.deploymentpsych.org) whose purpose is to train both military and civilian psychologists, interns, and other providers on the mental health issues associated with deployment. In addition to 11 APA accredited internships at Air Force, Army, and Naval medical centers across the country, the CDP provides on-line and live trainings. Many of these trainings are free! Specific to counseling centers, the CDP offers a full day University and College Counseling Center Core Competency Program. Dr. Ted Bonar brings this program to campuses across the country. I encourage you to check out their website and talk with Dr. Bonar about this possibility for your campus. The University of Indiana had him out to their campus where he received rave reviews for his program, according to training director, Dr. Andrew Shea. The CDP also offers longer trainings, also very low cost to civilian providers (including, e.g., empirically validated treatments for diagnoses commonly seen amongst veteran populations). Similar to the Counseling Center Program, I have heard wonderful reviews of these trainings from those Counseling Center staff members who have attended.

I am sure that there are many other programs and services and means of training interns at university campuses across the country that I failed to mention or am not aware of. It is my hope that this column sparks further investment in dissemination of such information so as to benefit the veteran students who have served our country.

Rudd, D., Goulding, J., & Byran, C. (2011). Student veterans: A national survey exploring psychological symptoms and suicide risk. *Paper presented at the American Psychological Association Convention, Washington, DC.*

Forensic Psychology

The New Psychology Intern and the Criminal: A Commentary on Working with Difficult Patients

By Pamela Morris, Ph.D., Psychology Internship Program Coordinator, Federal Correctional Institution, Fort Worth, Texas

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

Although Psychologists, by the nature of their jobs, see not only the good in people but the bad as well, a Psychologist in a correctional setting will more likely experience the world of the "very bad" – for example, those convicted of murder and rape. It is both normal and healthy to be repulsed by this reality, and supervisors of interns in a correctional setting have the task of understanding and supporting the interns' impressions and reactions while training them on the therapeutic approach to implement during these situations.

Beyond the mood imperative, for a Psychologist in a correctional setting it is necessary to provide treatment not only because it is a job duty. It may facilitate safety to all within the institution. As with all patients it is necessary to focus on the goals of treatment, the means to achieve those goals, and address barriers to treatment as well. Goals in a correctional setting may vary from those on the streets, such as convincing an offender to submit to handcuffs or insuring they have the knowledge, skills and ability to promote their safety in a correctional setting. Reminding interns to focus on the goals of the therapeutic interaction, and the best way to achieve those goals (which usually requires establishing a rapport), helps to distract them from the unpleasant qualities some of their patients possess.

There are certain offender characteristics that seem to be most irritating for not only interns, but for seasoned Psychologists as well. Those offender characteristics usually include a sense of entitlement, being manipulative, being self-absorbed and psychopathy. In a correctional setting interns will experience patients that possess these characteristics to such a level that they are not able to function within societies rules and norms. When a patient acts with one of these characteristics it is usually experienced by the clinician, and others for that matter, as a violation of sorts, an act of crossing a basic interpersonal barrier. The intern has a right to feel violated by an entitled patient's statements and as a supervisor it is helpful to support the intern's reaction while reminding them their patient likely has a history of evoking this response in all of their personal relationships. As a therapist, it is necessary to respond in a manner differently from the people in the offender's past. Additionally, if there exists a positive therapeutic alliance between the intern and the offender, the intern would benefit from guidance from their supervisor for their genuine confrontation of their patient's self-defeating qualities, as well as the establishment of therapeutic boundaries with the patient in a supportive manner. Additionally, the intern would be helped by reminding them to treat the part of the offender that wants assistance, while acknowledging the sides that don't.

It is helpful to understand that sometimes the offender simply doesn't know or understand society's rules, and at other times they do understand the rules, but they've chosen to violate them anyway, or, at times, exploit them. Exploring the variables behind offender's negative qualities, in a supportive setting such as group supervision, helps the intern to have a safe buffer from the negative experiences they are having, and an arena in which they can express their reactions, explore them with others, and receive understanding and reflection.

All of our patients have "a story," and in all cases it is necessary to work with the patient's current experience and presentation, remember that a good rapport helps facilitate effective intervention, acknowledge the negative emotions that some patients evoke and seek support, supervision and assistance for them, maintain a genuine therapeutic alliance with the patient, and continue to focus on therapy goals. Sometimes it helps to remind the intern that their patient's presentation is a reflection on the patient, and it is alright to feel like it is good that the person is in prison so that their harm to those in society is minimized.

As supervisors of interns who likely will encounter patients with difficult characteristics, it is important not only to assist interns to be good therapists to these patients, but to assist them to handle their responses and reactions. Providing support and understanding for our interns' professional and personal growth is essential. Being supportive of intern's personal lives, outside of the correctional environment, and reminding them to place the highest value on their own personal relationships outside of work, will also assist them in being able to experience unpleasant encounters with their patients as an intern and as a Psychologist in the future.

Geropsychology

By Michele J. Karel, Ph.D.

The Council of Professional Geropsychology Training Programs (CoPGTP) continues to invite training programs to join. If you are providing Geropsychology training at the Fellowship and/or Internship levels, please consider joining the organization. The benefits include being recognized as a program providing training consistent with the Pikes Peak Model of Training in Professional Geropsychology (if that is so; see references below), access to training and research awards programs, sharing of resources and ideas on the listserv, and an annual dinner to network with Geropsychology training colleagues. There are many resources related to Geropsychology training at the CoPGTP website (see www.copgtp.org). At the website, you can also find a membership application and a list of individuals willing to serve as consultants regarding Geropsychology training program development. See partial list of Board members you can contact with questions, below.

The Geropsychology professional community is currently debating whether to pursue an ABPP in Professional Geropsychology. As Professional Geropsychology was recognized as a Specialty area of practice by APA in August, 2010, the Geropsychology professional and training organizations are considering pursuing ABPP as a way to recognize individual geropsychologists who have specialized competence in the field. Although there are a wide range of perspectives on this issue, a survey of membership of the Society of Clinical Geropsychology (APA 12-2), Psychologists in Long Term Care, and CoPGTP found a majority of respondents to favor their organizational support of creating an ABPP in the field; the majority of respondents (especially students and early career) stated they would pursue an ABPP in Geropsychology.

If you are developing or expanding your program's Geropsychology training focus, please see these recent publications as potential resources:

Hinrichsen, G. A., Zeiss, A. M., Karel, M. J., & Molinari, V. A. (2010). Competency-based geropsychology training in doctoral internships and postdoctoral fellowships. *Training and Education in Professional Psychology, 4(2), 91-98.*

Karel, M. J., Emery, E. E., Molinari, V., & CoPGTP Task Force on the Assessment of Geropsychology Competencies. (2010). Development of a tool to evaluate geropsychology knowledge and skill competencies. *International Psychogeriatrics, 22(6), 886-896.*

Karel, M. J., Holley, C. K., Whitbourne, S. K. Segal, D. L., Tazeau, Y. N., Emery, E. E., Molinari, V., Yang, J., & Zweig, R.A. (in press). Preliminary validation of a tool to assess competencies for professional geropsychology practice. *Professional Psychology: Research and Practice.*

Karel, M. J., Knight, B. G., Duffy, M., Hinrichsen, G. A., & Zeiss, A. M. (2010). Attitude, knowledge, and skill competencies for practice in professional geropsychology: Implications for training and building a geropsychology workforce. *Training and Education in Professional Psychology, 4(2), 75-84.*

Knight, B. G., Karel, M. J., Hinrichsen, G. A., Qualls, S. H., & Duffy, M. (2009). Pikes Peak model for training in professional geropsychology. *American Psychologist, 64(3), 205-214.*

Qualls, S. H., Scogin, F., Zweig, R., & Whitbourne, S. K. (2010). Predoctoral training models in professional geropsychology. *Training and Education in Professional Psychology, 4(2), 85-90.*

CoPGTP Board members to contact with questions:

Daniel L. Segal, Ph.D., Chair: dsegal@uccs.edu

Susan K. Whitbourne, Ph.D., Chair-Elect: swhitbo@psych.umass.edu

Michele Karel, Ph.D., Past-Chair: Michele.Karel@va.gov

Andrew Heck, Psy.D., ABPP, Internship program member-at-large: Andrew.Heck@dbhds.virginia.gov

Victor Molinari, Ph.D., ABPP, Postdoctoral program member-at-large: vmolinari@usf.edu

Literature Review: 2011

By James Stedman, PhD

If fewer internship related studies/essays/reviews appear in a given year, you can bet that the next year will double or come close. That is the case this year. There were 10 new offerings. As last year, I will use a format that presents the main themes of the articles but will not bother with the actual titles. I will give the exact reference however, so that interested readers can easily locate them. Also, as in the past, I will list only the first author if there are multiple authors.

1. Bangen et al. (2010) studied student perceptions of their preparation for the internship application process. Questionnaires assessed several variables, and results suggested that graduate faculty need to convey internship-related information earlier and introduce behaviors to reduce student anxiety (editor's note: this will not affect the imbalance issue). *Training and Education in Professional Psychology* , 4, 219 – 226.

2. Canady et. al. (2011) described a program for teaching interns cultural awareness, involving several steps including meeting with community representatives of a specific culture and doing a related project. They report positive responses to the program by interns. *Training and Education in Professional Psychology,* 5, 30 – 37.

3. Ginkel et al. (2010) revisited the topic of inclusion/exclusion criteria for acceptance into internship. They found most of the variables previously identified still hold – applicant fit, interview, supervised

CONTINUED ON NEXT PAGE

experience – but did detect more emphasis on personality traits of the candidate. Exclusion criteria included interview, fit, and letters (editor's note: it is rare to see a negative letter). *Training and Education in Professional Psychology,* 4, 213 – 218.

4. Kuentzel et al. (2011) investigated accuracy of IQ scoring by interns and found that students make many and significant errors in scoring and calculation of scores. They recommend that remediation be part of training and offer suggestion for implementation. *Journal of Psychoeducational Assessment,* 29, 39 – 46.

5. Hinrichsen et al. (2010) argued that there needs to be more geropsychology training as the population ages (I can be a recipient!) and recommend a model: the Pikes Peak Model for Training in Professional Geropsychology. *Training and Education in Professional Psychology,* 4, 91 – 98.

6. Power et al. (2011) developed a measure to screen intern candidates for readiness for internship. Factor analysis confirmed two factors: Factor I related to core competencies; Factor II related to experiences. *Journal of Clinical Psychology,* 67, 6 – 16.

7. Stader et al. (2010) followed up interns who graduated from the William S. Hall Institute, U of So Carolina Medical School. Graduates reported that their training was exceptional and was crucial in their development as practicing clinicians. This study, though limited to one program, speaks to the need for internships and against the suggestion that internships are outmoded. *Psychological Reports,* 107, 914 – 922.

8. Stedman and Schoenfeld (2011) also examined student readiness for internship (as Power above) from the perspective of knowledge competence. They argued for the use of the EPPP as a measure of readiness for internship and suggested that failure rates, predicted to be in the 15% range, would also affect the imbalance issue. *Journal of Clinical Psychology,* 67, 1 – 5.

9. Tracy (2011) et al. repeated an earlier study of supervised training hours during internship and found that internships currently report a range of 1,840 to 2,080 hours. They recommend a national standard of 1,800 hours for adoption by internships and state licensing boards. *Training and Education in Professional Psychology,* 5, 97 – 101.

10. Yozwiak et al. (2010) studied videoconferencing as a teaching/supervision method during internship. Interns gave mixed reviews, tending in the negative direction. *Journal of Clinical Psychology in Medical Settings,* 17, 238 – 248.

Neuropsychology Training in the VA

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

A few months ago, I completed a chapter on neuropsychology training for the soon-to-be released book *Neuropsychological Practice with Veterans,* published by Springer. (Joshua Caron, now at the Togus VA, is a coauthor on the chapter.) We covered the history of VA neuropsychology training, results of a survey of current practices, and comments on the future of neuropsychology training in the VA (Roper & Caron, in press). Of course, I would encourage those, especially those in the VA, to pick up a copy of the book. Below I list several observations that struck me while preparing the chapter.

VA training sites have offered training in clinical neuropsychology at the internship level for a long time, some programs for 40 years. In fact, the development of such training within the VA mirrors the development of the specialty itself. Goldstein (in press) wrote of the early centers for neuropsychology research and clinical activity within the VA, including sites in New York City, Boston, Oklahoma City, Portland, San Diego, Albuquerque, and Gainesville, among others. By 1988, 107 of 172 VA healthcare facilities surveyed had neuropsychology clinics in operation (Baker & Pickren, 2007, p.110), and we can bet that training was taking place in a substantial number of those clinics.

At the same time that many VA sites hosted neuropsychology training at the internship level, relatively few sites had postdoctoral training specifically devoted to clinical neuropsychology specialization. As late as 1987, the VA's Office of Academic Affiliations

(OAA), which funds VA training nationwide, was opposed to funding postdoctoral fellowships due to budget considerations (Baker & Pickren, 2007, p.46). Furthermore, VA's support of postdoctoral training in neuropsychology remained stagnant as the specialty developed Houston Conference Guidelines in the late 1990's, and two-year postdoc fellowships were housed largely in university-affiliated medical centers (Roper & Caron, in press). In the past decade, the VA made up for lost time, funding many new two-year neuropsychology fellowships, thirteen of which were established during a major expansion of VA psychology training in 2008 (Roper, 2008).

The first program to be awarded specialty accreditation in Clinical Neuropsychology was the Walter Reed Army Medical Center (Boake, 2008), in October 2002 (APA, 2003). However, the Boston VA has had two accredited postdoctoral programs, one in Clinical Psychology and one in Clinical Neuropsychology, since June 2002. If the Boston VA has been accredited longer than Walter Reed, why was Walter Reed the first to be awarded accreditation? The reason is that Boston's site visit was earlier, and although the accreditation decision was made later, accreditation is retroactive from the date of the site visit (APA Office of Program Consultation and Accreditation, personal communication, February 28, 2011). As such, one could say that Walter Reed and the Boston VA share in

CONTINUED ON NEXT PAGE

our specialty's postdoctoral accreditation milestones.

Based on our 2010 survey and review of public materials, all but one of 90 VA internship training sites offer some type of neuropsychology training experience, and about half have an internship track or concentration in clinical neuropsychology. Forty-one residency programs offered some type of neuropsychology training, and 28 sites have two-year specialty residencies (Roper & Caron, in press).

I expect that VA's expanded investment in clinical neuropsychology training has, and will continue to have, a positive effect on the specialty. Neuropsychology has traditionally been assessment-focused outside of neuro-rehab centers. Within the VA, neuropsychologists have increasingly broad roles in providing both assessment and interventions to patients returning from recent conflicts, spurring the development of new cognitive remediation techniques (e.g., e.g., Twamley, Jak, Thomas, & Delis, 2009). It is my hope that these and other efforts continue, as the VA, through its generous support of training, continues to help our specialty chart its course into the future.

Baker, R.R., & Pickren, W.E. (2007). *Psychology and the Department of Veterans Affairs: A Historical Analysis of Training, Research, Practice, and Advocacy.* Washington, DC: American Psychological Association.

Goldstein, G. (in press). *H*istory and Future Directions of Neuropsychology in the Department of Veterans Affairs. In S.S. Bush (Ed.), *Neuropsychological Practice with Veterans.* New York: Springer.

Roper, B.L. (2008). The Commitment to psychology training within the Department of Veterans Affairs: Remarkable developments. *APPIC e-Newsletter,* 1, 11-12.

Roper, B.L. & Caron, J.E. (in press). *Training and supervision in neuropsychology within the Department of Veterans Affairs.* In S.S. Bush (Ed.), *Neuropsychological Practice with Veterans. New York: Springer.*

Twamley, E.W., Jak, A., Thomas, K., & Delis, D. (2009). *Cognitive Symptom Management and Rehabilitation Therapy (CogSMART). Baltimore: VA National Mental Health Conference.*

Setting-related Issues

Tough Times Ahead - But Help is Available

By Robert H. Goldstein

For some of you, the training year may just be getting started, and for others it may be well under way.

In either case, it might seem a bit premature to be thinking about what comes next for your trainees. But these are not ordinary times (were they ever?) and drastic changes in the nation's economy are starting to have an ever greater impact on our profession.

The financial realities of the current scene are beginning to show up in very significant ways, and the general economic outlook for psychologists is becoming somewhat less rosy than it had been just a few years ago. At this point, no one really knows just what impact the recently enacted federal health care laws will have, or how they will influence psychological services. Some see this as a golden opportunity for psychology to get on the bandwagon and hitch onto things like "medical homes", "accountable care organizations" or some variant of interdisciplinary health care services. Others are more gloomy in their predictions and one hears questions being raised as to whether or not the practice of psychology will survive.

Certainly, some of the relatively newer specialty areas such as health psychology or forensic psychology are showing potential for continuing growth. But what about the "traditional" forms of clinical practice? What is the outlook for them? And how should trainees be starting to think about their futures.? Most crystal balls are rather cloudy these days and, as has been said, predicting, especially about the future, is not easy.

A quick glance at some aspects of the data on the psychology workforce does seem to be revealing. For one thing, most psychologists in the health care field turn out to be involved is some type of private practice. The

latest figures from the APA surveys on where psychologists who provide health care services are working indicates that a bit over 45% are in some form of private practice. This is by far the largest single area of employment and greatly exceeds the numbers for hospital work, academia or any other setting. Moreover, about one in three describe themselves as being in individual private practice. I guess that's good news, since it indicates that a substantial plurality of psychologists are making a living via a type of practice in which they are paid more or less directly for the services they provide.

Yet, it would appear that this is the area in which the most questions as to future prospects for psychologists are raised. One hears, and it seems to be more than idle rumors, that actual incomes for practicing psychologists are dropping. A number of factors are said to be contributing to this situation. Of course, there is the old nemesis, the managed health care system. We all should realize by now that this is a system designed not to provide care, but rather to manage costs, and that was the basis on which it was promoted to employers. Even that system is changing rapidly. In many areas, health care professionals had banded together in associations of various sorts (e.g. IPA's) and contracted with managed care entities. Under this model, there was an opportunity to negotiate and work out an equitable fee schedule. Increasingly, HMO's are rejecting this arrangement, canceling association contracts and. seeking to offer individual contracts on a take it or leave it basis.The most egregious example of this trend was recently reported in the Florida area, where a large health care insurer has announced that it was dropping the existing con-

CONTINUED ON NEXT PAGE

tracts with all mental health professionals, sub-contracting out mental health services to a "carve-out" mental health delivery system and then offering the mental health professionals an opportunity to sign up and rejoin this new system under another contract at 30% to 60% lower rates than they had been receiving. It would also appear also that a major insurer in a large Midwestern city has unilaterally decreased fees paid to psychologists by more than 25%

When one asks "How can they do this?", the general response has been "Because they can!" For one thing, there is increasing competition from folks with other than psychology degrees or who are trained at at a less than doctoral level. Insurers are in business to make money and if they can arrange for some sort of mental health services to be provided by those who will accept a lower fee, they will not hesitate to do so. And it rolls downhill from there.

Moreover, in many areas, if psychologists attempt to get together to organize resistance to these moves, they are said to be at risk of violating federal anti-trust laws. Of course, these laws were written by legislatures that had been heavily lobbied and contributed to by these very same insurance companies. I understand that there has been some outcry about this circumstance and issues are being raised as to whether or not this violates some of the recently enacted mental health parity laws. We'll see how this plays out, but it is not a favorable omen for mental health practice.

A second rather troubling development for private practitioners has been the progressively lowed rates paid for services covered by Medicare. Decreases of 5% for each of the past several years have brought compensation for these services back to the level of more than a decade ago. And congress is struggling with what to do with regulations that would require a more than 20.% cut in fees. Activity by APA and other voices has prevented these larger cuts from being put into effect for several years now, but no clear method for resolving this problem has shown up as of yet.

Even more concerning is the fact that many commercial insurers see the rates paid by Medicare as being the benchmark to which their rates should be pegged. As that begins to happen, changes in compensation are likely to follow a similar pattern.

I'd rather not go on with these tales of woe, since they are clearly not the whole story and there is no question but that there is a bright future and an economically sustainable one for the vast majority of those now in the training pipeline. But, I do raise these points to remind us that it's not to soon for trainees to begin thinking about how their careers can be effected by current economic conditions and to begin some early consideration or even planning regarding their short-term or even longer-term financial matters. And there is always the cloud of student loan-related debt to be dealt with.

And now for the pitch. No, I'm not selling anything, but I would warmly suggest that trainees begin to be advised to avail themselves of an enormous resource that can help them in their thinking and planning about their future. APA's Division 42, the Division of Independent Practice, is a never-ending source of information, ideas and guidance regarding both clinical and practical/financial issues that confront an early career practitioner. The Division has a discussion list on the web on which questions can be asked and answers provided by experienced psychologists regarding all types of practice-related matters. Lurking,or even participating on this list can be most informative. A mentoring arrangement for new practitioners can also be arranged. through this group and suggestions for readings (a number of members have written useful books about practical aspects of practice management) are abundantly available. So, I urge that this resource be brought to the attention of trainees at the first convenient opportunity. They should know that, while times are relatively tough, they needn't feel alone in coping with the complex and changing world of practice they'll be entering when they leave the relative protection of their training experience and move on to the world that's out there.

NEW APPIC MEMBER PROGRAMS

Doctoral Internships

Minneapolis Internship Consortium
Minneapolis, MN

Applied Psychology Group of Texoma
Sherman, TX

St. John's Marian Center
Springfield, MO

Southern Idaho Internship Consortium
Pocatello, ID

Frontier Health, Nolachuckey Mental Health Services
Greenville, TN

Venture Psychology Internship Consortium
Battle Creek, MI

Chestnut Hill College Consortium
Philadelphia, PA

Vancouver Coastal/Fraser Child & Youth Community-Based Program
Port Moody, BC, Canada

Lone Star Psychology Residency Consortium
Edinburg, TX

University of Washington CARE Clinic at Haring Health Point
Seattle, WA

Illinois Psychological Association Internship Consortium
Chicago, IL

Range Mental Health Center
Hibbing, MN

Postdoctoral Residencies

G. V. (Sonny) Montgomery VA Medical Center
Jackson, MS

Hunter Holmes McGuire VA Medical Center
Richmond, VA

VA Eastern Colorado Health Care System
Denver, CO

2. Degree Sought

Ph.D.	1479	54 %
Psy.D.	1239	45 %
Ed.D.	1	0 %
Other	7	0 %

NOTE: Four of the Seven who designated "other" reported that they were respecializing.

3. Is your doctoral program APA- or CPA-accredited?

Yes	2558	94 %
No	160	6 %

4. Location of your doctoral Program

United States	2566	95%
Canada	123	5%
Other, please specify	24	1%

5. Is your program housed within a religiously-affiliated institution?

Yes	372	14 %
No	2340	86 %

6. Please select the training model of your DOCTORAL program (as you specified on your AAPI):

Scientist-Practitioner	1199	44%
Practitioner-Scholar or Scholar-Practitioner	1149	42%
Practitioner	23	1%
Clinical Scientist	131	5%
Local Clinical Scientist	61	2%
Practitioner-Scientist	98	4%
Practitioner Informed By Science	33	1%
Other, please specify	30	1%

7. Including the current (2010-2011) academic year, how many years have you been enrolled in your CURRENT doctoral program (excluding any time spent in other doctoral or masters programs):

This is my 2nd year	29	1%
This is my 3rd year	324	12%
This is my 4th year	1244	46%
This is my 5th year	750	28%
This is my 6th year	261	10%
This is my 7th year	76	3%
This is my 8th year	21	1%
This is my 9th year	7	0%
This is my 10th year	4	0%
This is my 11th (or later) year	4	0%

8. Please check the item that best describes your status PRIOR to entering your CURRENT doctoral program:

I had NO prior graduate-level training	1530	56%
I had a Master's degree in psychology	672	25%
I had a Master's degree in a mental health field other than psychology (e.g., counseling, social work, marriage and family)	269	10%
I had a Master's degree in an unrelated field	75	3%
I had been enrolled in a Master's program in psychology but did not receive a degree	75	3%
I had been enrolled in a Master's program in a mental health field other than psychology (e.g., counseling, social work, marriage and family) but did not receive a degree	21	1%
I had been enrolled in a Master's program in an unrelated field but did not receive a degree	11	0%
Other, please specify	73	3%

9. Including yourself, how many students began your current doctoral program in the same academic year in which you were admitted? Please estimate if you don't know the exact number.

Mean = 24.1 Median = 13
SD = 24.1 Mode = 8

1-10	1137	42%
11-20	474	18%
21-30	395	15%
31-40	193	7%
41-50	118	4%
51-60	109	4%
61-70	93	3%
71-80	53	2%
81-90	38	1%
91-100	75	3%
101 or more	22	1%

10. Including yourself, how many students from your current doctoral program applied for internship this year? Please include all students who initially applied, regardless of whether or not they stayed in the process or were successful in locating an internship position. Please estimate if you don't know the exact number.

CONTINUED ON NEXT PAGE

Mean = 19.4 SD = 20.7	Median = 13 Mode = 8	
1-10	1304	48%
11-20	557	21%
21-30	292	11%
31-40	178	7%
41-50	133	5%
51-60	56	2%
61-70	43	2%
71-80	50	2%
81-90	44	2%
91-100	25	1%
101 or more	11	0%

11. Please estimate the total amount of DEBT that you have accrued to date as a consequence of attending GRADUATE SCHOOL IN PSYCHOLOGY, including tuition, fees, living expenses, books, etc. Please include all forms of debt such as student loans, credit cards, personal loans, etc. Please do NOT include undergraduate debt or debt that is unrelated to your graduate training.

Mean = $85,545 SD = $73,572	Median = $80,000	
$0	456	17%
$10,000	173	6%
$20,000	140	5%
$30,000	111	4%
$40,000	114	4%
$50,000	111	4%
$60,000	124	5%
$70,000	93	3%
$80,000	119	4%
$90,000	83	3%
$100,000 - $140,000	587	22%
$150,000 - $190,000	328	12%
$200,000 - $240,000	185	7%
$250,000 - $290,000	48	2%
$300,000 - $340,000	24	1%
$350,000 - $400,000	2	0%
$400,000 or higher	7	0%

NOTE: Compared to last year's applicants, the average debt load increased by $7,628 (9.8%). Virtually all applicants will remain in training for at least 18 months (including the internship year) after the completion of this survey and may incur additional debt during that period.

12. Which of the following internship programs would be considered acceptable to your doctoral program? Please check all that apply.

An accredited internship program	2672	98%
An APPIC-member internship program that is NOT accredited	1514	56%
An internship program that is NOT accredited and NOT an APPIC member	676	25%
An unpaid internship program	724	27%

13. Please check the item that applies to you (please respond even if you withdrew from the Match or did not submit a Rank Order List):

This is my FIRST time participating in the Match	2460	90%
This is my SECOND time participating in the Match	234	9%
This is my THIRD time participating in the Match	18	1%
This is my FOURTH time participating in the Match	5	0%
Other	3	0%

14. Were you matched to an internship program by the APPIC Match? (i.e., did your official notification from National Matching Services [NMS] indicate that you were successfully matched to an internship program?)

Yes	2175	80%
No	477	17%
Withdrew / No rankings submitted	77	3%

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

Mean = 16.0 SD = 6.5	Median = 16 Mode = 15

NOTE: The AAPI Online service provided a financial disincentive for applicants to submit more than 15 applications. For comparison purposes, the mean numbers of submitted applications in previous years were:

2010 Match	15.1 applications
2009 Match	14.7 applications
2008 Match	13.9 applications
2007 Match	13.4 applications
2006 Match	12.9 applications
2005 Match	12.4 applications
2004 Match	12.4 applications
2003 Match	12.1 applications
2002 Match	13.1 applications
1999 Match	13.8 applications

CONTINUED ON NEXT PAGE

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

Mean = 1.5	Median = 0
SD = 3.5	Mode = 0

NOTE: A total of 57.0% of applicants reported being properly notified of their interview status by all sites to which they applied.

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

Mean = 6.4	Median = 6
SD = 3.9	Mode = 5

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

Mean = 7.1	Median = 6
SD = 4.9	Mode = 3

NOTE: Use caution when comparing these numbers with the results from questions 15-17, since some sites used multiple program code numbers.

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

Yes	26	1 %
No	2690	99 %

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

APPLICATION COSTS involve preparing and submitting applications to sites, and may include such items as the fee for the AAPI Online service, obtaining official copies of transcripts, printing, copying, regular and overnight mailing, etc.

TRAVEL COSTS may include such items as air or train fare, car rental, taxi, gasoline, hotel, etc.

OTHER COSTS may include such items as your Match registration fee ($130 or $160), clothing costs, phone calls, etc. Please enter your BEST ESTIMATE of the dollar amount spent, digits only, in each of the following areas (e.g., one hundred dollars would be entered as simply 100):

TOTAL COSTS:	Mean = $1812 Median = $1425	SD = 1483
APPLICATION COSTS:	Mean = $ 275 Median = $ 250	SD = 172 Mode = 200
TRAVEL COSTS:	Mean = $1382 Median = $1000	SD = 1326 Mode = 2000
OTHER COSTS:	Mean = $ 297 Median = $ 200	SD = 311 Mode = 200

NOTE: After remaining essentially unchanged from 2008 to 2010, the mean total cost increased by 6.3% as compared to 2010. Application costs increased 6.2% as compared to 2010, travel costs increased 4.2%, and other costs increased 2.4%.

INFORMATION ABOUT YOUR INTERNSHIP

NOTE: Items 21-28 were asked only of applicants who reported having matched to an internship site.

21. Location of the internship program to which you were matched:

United States	2044	95%
Canada	88	4%
Other	9	0%

NOTE: All nine who designated "other" reported being matched to an internship in Puerto Rico.

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

Yes	1690	79 %
No	448	21 %

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

Yes	146	7 %
No	1952	93 %

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

Yes	2086	98 %
No	50	2 %

25. Is your new internship position:

A one-year, full-time internship experience	2117	99%
A two-year, half-time internship experience	15	1%
Other	10	0%

CONTINUED ON NEXT PAGE

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

Mean = $24,218	Median = $23,798
SD = $ 8,973	Mode = $24,000

The mean salary represents a 2.2% increase as compared to 2010.

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

Armed Forces Medical Center	55	3%
Child/Adolescent Psychiatric/Pediatrics	324	15%
Community Mental Health Center	360	17%
Consortium	202	9%
Medical School	294	14%
Prison/Other Correctional Facility	118	6%
Private General Hospital	127	6%
Private Outpatient Clinic	109	5%
Private Psychiatric Hospital	65	3%
Psychology Department	38	2%
School District	82	4%
State/County/Other Public Hospital	229	11%
University Counseling Center	319	15%
Veterans Affairs Medical Center	386	18%
Other (please specify)	68	3%

28. What was the rank of the program to which you were matched?
(Please see the 2011 APPIC Match Statistics for this information)

FEEDBACK ABOUT THE AAPI ONLINE SERVICE

In this section, please rate ONLY your experiences with the AAPI Online service and the application submission process. Please do NOT consider your experiences with the APPIC Match or any other aspect of the process.

Please answer the items below using the following scale:

29a. The AAPI Online was user-friendly and easy to navigate.

Strongly Agree	875	33 %
Agree	1423	54 %
Neutral	231	9 %
Disagree	106	4 %
Strongly Disagree	19	1 %

29b. The AAPI Online instructions were helpful and clearly written.

Strongly Agree	828	31 %
Agree	1392	53 %
Neutral	301	11 %
Disagree	111	4 %
Strongly Disagree	19	1 %

29c. The AAPI Online support team was effective in addressing my
questions and concerns.

Strongly Agree	820	48 %
Agree	587	34 %
Neutral	180	11 %
Disagree	77	5 %
Strongly Disagree	41	2 %

29d. The AAPI Online support team responded to my inquiries in a timely manner.

Strongly Agree	775	50 %
Agree	501	32 %
Neutral	157	10 %
Disagree	71	5 %
Strongly Disagree	48	3 %

29e. Overall, I believe that the AAPI Online saved me TIME in the application process.

Strongly Agree	1692	65 %
Agree	684	26 %
Neutral	163	6 %
Disagree	43	2 %
Strongly Disagree	27	1 %

29f. Overall, I believe that the AAPI Online saved me MONEY in the application process.

Strongly Agree	1154	45 %
Agree	657	25 %
Neutral	499	19 %
Disagree	176	7 %
Strongly Disagree	104	4 %

29g. The AAPI Online is an improvement as compared to the previous paper-based application submission process.

Strongly Agree	1606	75 %
Agree	413	19 %
Neutral	111	5 %
Disagree	11	1 %
Strongly Disagree	12	1 %

CONTINUED ON NEXT PAGE

29h. Overall, I am satisfied with the AAPI Online service.

Strongly Agree	1163	44 %
Agree	1263	48 %
Neutral	157	6 %
Disagree	40	2 %
Strongly Disagree	25	1 %

FEEDBACK ABOUT THE APPIC MATCH

In this section, please rate ONLY your experiences with the APPIC Match. Please do NOT consider your experiences with the AAPI Online service.

30a. The materials and instructions provided by National Matching Services (NMS) were clear and comprehensive.

Strongly Agree	977	37 %
Agree	1303	49 %
Neutral	232	9 %
Disagree	105	4 %
Strongly Disagree	18	1 %

30b. The registration process with NMS went smoothly.

Strongly Agree	1394	53 %
Agree	1111	42 %
Neutral	97	4 %
Disagree	27	1 %
Strongly Disagree	12	0 %

30c. The submission of my Rank Order List to NMS went smoothly.

Strongly Agree	1546	60 %
Agree	924	36 %
Neutral	84	3 %
Disagree	23	1 %
Strongly Disagree	16	0 %

30d. NMS was responsive to my questions and concerns (choose "N/A" if you never contacted NMS).

Strongly Agree	215	43 %
Agree	190	38 %
Neutral	62	12 %
Disagree	21	4 %
Strongly Disagree	17	3 %

30e. I am satisfied with the Match result that I received from the Matching Program.

Strongly Agree	1453	57 %
Agree	483	19 %
Neutral	146	6 %
Disagree	132	5 %
Strongly Disagree	352	14 %

30f. Overall, I am satisfied with the APPIC Matching Program.

Strongly Agree	1075	41 %
Agree	901	34 %
Neutral	277	11 %
Disagree	195	7 %
Strongly Disagree	172	7 %

31a. In your judgment, did you experience any violation(s) of APPIC Match Policies by any site?

Yes	232	9 %
No	2201	83 %
Unsure	213	8 %

NOTE: Results to this question from previous years:

	YES	NO	UNSURE
2010	8%	84%	9%
2009	8%	83%	9%
2008	8%	83%	9%
2007	8%	84%	8%
2006	9%	83%	9%
2005	8%	85%	7%
2004	8%	86%	7%
2003	11%	77%	12%
2002	11%	78%	12%
2001	10%	76%	14%
2000	15%	74%	12%
1999	12%	77%	11%

It should be noted that Match Policy changes over the years may have influenced responses to this item.

31b. Did you reveal any ranking information (e.g., "You are my first choice") to any site?

Yes	20	1%
No	2613	99 %
Unsure	15	1 %

31c. Did you experience inappropriate pressure from any site to reveal your rankings?

Yes	56	2 %
No	2546	96 %
Unsure	42	2 %

31d. Did any site reveal ranking information to you (e.g., "You are our first choice")?

Yes	46	2 %
No	2541	96 %
Unsure	61	2 %

CONTINUED ON NEXT PAGE

32a. In general, my doctoral program faculty provided a high level of support for my internship application and interview experience.

Strongly Agree	928	35 %
Agree	869	33 %
Neutral	398	15 %
Disagree	320	12 %
Strongly Disagree	142	5 %
Not Applicable	1	0 %

32b. I worked closely with other students in my program throughout the process (e.g., sharing information, giving and receiving support).

Strongly Agree	890	34 %
Agree	888	33 %
Neutral	369	14 %
Disagree	349	13 %
Strongly Disagree	149	6 %
Not Applicable	11	0 %

32c. I took the selection process very seriously (i.e., I worked hard on my application, invested much time and energy, etc.).

Strongly Agree	2214	83 %
Agree	390	15 %
Neutral	42	2 %
Disagree	3	0 %
Strongly Disagree	3	0 %
Not Applicable	3	0 %

32d. I attended local or national workshops that focused on the internship selection process.

Strongly Agree	280	11 %
Agree	458	17 %
Neutral	144	5 %
Disagree	533	20 %
Strongly Disagree	860	32 %
Not Applicable	377	14 %

32e. I used reference materials (e.g., the APAGS workbook, other books) to educate myself about the internship selection process.

Strongly Agree	948	36 %
Agree	829	31 %
Neutral	206	8 %
Disagree	275	10 %
Strongly Disagree	296	11 %
Not Applicable	103	4 %

DEMOGRAPHIC INFORMATION

33. What is your age?

Mean = 30.1	Median = 29
SD = 5.5	Mode = 27
Range = 23 to 64	N = 2609

34. How many dependent children are currently living with you?

None	2226	85%
1	234	9%
2	99	4%
3	37	1%
4	9	0%
5	3	0%
6	1	0%

35. How many adult dependents are currently living with you, or for whom you are responsible? (DO include other relatives or individuals, i.e., mother, father, grandparent, ward. DO NOT include an able-bodied spouse/partner).

None	2482	96%
1	94	4%
2	13	1%
3	3	0%

36. What is your current marital or relationship status?

Married/Partnered	1372	53 %
Not Married or Partnered	1229	47 %

37. In which country(ies) do you hold citizenship? Individuals with dual citizenship should designate all countries in which citizenship is held.

U.S.	2367	91 %
Canada	157	6 %
Other	161	6 %

NOTE: Responses total greater than 100% due to dual citizenship.

38. What is your gender?

Male	541	21 %
Female	2051	79 %
Other (e.g., trans, intersex)	5	0 %

39. What is your racial/ethnic identification? (Check all that apply)

African-American/Black	169	6 %
American Indian/Alaskan Native	25	1 %
Asian/Pacific Islander	190	7 %
Hispanic/Latino	206	8 %
White (Non-Hispanic)	1959	75 %
Bi-racial/Multi-racial	101	4 %
Other	89	3 %

CONTINUED ON NEXT PAGE

40. What is your sexual orientation?

Heterosexual	2363	92%
Gay Male	59	2%
Lesbian	57	2%
Bisexual	85	3%
Other	18	1%

41. What types of disability(ies) do you have? Check all that apply. (If none, please check "None")

None	2345	93%
Blind/Visually Impaired	11	0 %
Deaf /Hard of Hearing	9	0 %
Physical/Orthopedic Disability	15	1 %
Learning Disability/Cognitive	44	2 %
Cognitive Disability	3	0 %
Chronic Health Condition	81	3 %
Mental Illness	33	1 %
Other	18	1 %

42. (Open-Ended Question)

43. Did you have any geographic restrictions on your internship search that EITHER (a) reduced the number of sites to which you applied, OR (b) kept you from applying to sites in which you were interested?

Yes	1061	41 %
No	1538	59 %

NOTE: In 2009 and 2010, 51% and 45% (respectively) responded "Yes" to this item.

44. IF YOU ANSWERED "YES" TO QUESTION 43: Which of the following best describes the reason for your geographic restriction:

I could only apply in a particular geographic area because of significant family, financial, and/or health considerations	465	41%
I chose to restrict my search to particular geographic area(s) due to personal preference (e.g.,preferred place to live, to benear family or friends)	594	52%
Other	81	7%

45. IF YOU ANSWERED "YES" TO QUESTION 43: Which of the following best describes your geographic restriction?

A single city or town, or within a 100-mile radius of a city/town	313	29%
State / Province	175	16 %
Region of the Country	445	41%
Other	158	14 %

QUESTIONS ABOUT YOUR AAPI

46. We would like to know the TOTAL NUMBER OF PRACTICUM HOURS that you reported on your AAPI, including doctoral hours and terminal masters hours. (This information is located in the "Summary of Doctoral Training" section of the AAPI online, about halfway down the page under "Practicum Hours Information." Please enter all six numbers from this section below.)

a. Doctoral Intervention:	Median = 573	n = 1992
b. Doctoral Assessment:	Median = 148	n = 1959
c. Doctoral Supervision:	Median = 303	n = 1961
d. Masters Intervention:	Median = 295	n = 430
e. Masters Assessment:	Median = 38	n = 235
f. Masters Supervision:	Median = 100	n = 422

APPIC advises applicants to interpret these numbers cautiously.

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

47. For each of the following populations, what was the total number of supervised integrated psychological reports that you reported on your AAPI? (This information can be found in the "Psychological Assessment Experience" section of the AAPI Online, under "Integrated Reports.")

a. Adults	Median = 7	n = 1938
b. Children/Adolescents	Median = 5	n = 1872

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

48. Please check ALL settings below in which you completed PROGRAM- SANCTIONED clinical experiences/practica prior to November 1, 2010. Please exclude any clinical experiences that were not program-sanctioned, such as work experience.

CONTINUED ON NEXT PAGE

Child Guidance Clinic	136	6%
Community Mental Health Center	1184	54%
Department Clinic (psychology clinic run by a department or school)	1094	50%
Forensic/Justice Setting	432	20%
Medical Clinic / Hospital	940	43%
Inpatient Psychiatric Hospital	641	29%
Outpatient Psychiatric Hospital	446	20%
University Counseling Center/Student Mental Health Center	704	32%
Schools	586	27%
VA Medical Center	340	16%
Other	575	26%

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

Not applicable	79	4%
Prior to submitting internship applications	2047	91%
Prior to attending internship interviews	27	1%
Prior to the ranking deadline for the Match	14	1%
Prior to the beginning of internship	49	2%
During the internship year	13	1%
After the completion of internship	10	0%

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

Not applicable	20	1%
Prior to submitting internship applications	1741	78%
Prior to attending internship interviews	80	4%
Prior to the ranking deadline for the Match	43	2%
Prior to the beginning of internship	316	14%
During the internship year	40	2%
After the completion of internship	1	0%

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

Not applicable	70	3%
Prior to submitting internship applications	83	4%
Prior to attending internship interviews	37	2%
Prior to the ranking deadline for the Match	18	1%
Prior to the beginning of internship	1016	45%
During the internship year	930	41%
After the completion of internship	88	4%

52. On your AAPI, how many articles did you indicate having published in refereed journals? (Please estimate if you don't know the exact number) (This information is located in the "Certifications / Publications / Presentations" section of the AAPI Online, under "Publications.")

Mean = 1.3 Median = 0 N = 2228
SD = 2.3 Mode = 0

None	1272	57 %
1	365	16 %
2	203	9 %
3	126	6 %
4	86	4 %
5 to 9	147	7 %
10 to 14	16	1 %
15 to 19	8	0 %
20 or more	5	0 %

53. On your AAPI, how many books or book chapters did you specify?
(Please estimate if you don't know the exact number) (This information is located in the "Certifications / Publications / Presentations" section of the AAPI Online, under "Publications.")

Mean = 0.4 Median = 0 N = 2214
SD = 0.9 Mode = 0

None	1771	80 %
1	266	12 %
2	94	4 %
3	45	2 %
4	17	1 %
5 to 9	21	1 %
10 to 14	0	0 %
15 to 19	0	0 %
20 or more	0	0 %

53. On your AAPI, how many professional presentations did you indicate at regional, state, national, or international meetings/conferences? (Please estimate if you don't know the exact number) (This information is located in the "Certifications / Publications / Presentations" section of the AAPI Online, under "Presentations.")

Mean = 5.4 Median = 3 N = 2218
SD = 6.4 Mode = 0

None	553	25 %
1	245	11 %
2	203	9 %
3	151	7 %
4	119	5 %
5 to 9	484	22 %
10 to 14	256	12 %
15 to 19	108	5 %
20 or more	99	4 %

project:

Prior to submitting internship applications	Ph.D. = 81%	Psy.D. = 76%
Later	Ph.D. = 19%	Psy.D. = 24%

CONTINUED ON NEXT PAGE

PART 2: SUMMARY OF APPLICANT PLACEMENT BY APPLICANT AND PROGRAM CHARACTERISTICS

This report is the second of three parts of the results from the survey of applicants who were registered for the 2011 APPIC Match, and provides match rates across a variety of applicant and program characteristics.

Please note that most applicants completed the survey prior to the completion of Phase II of the Match, and thus these results primarily reflect matching that occurred only in Phase I. Important interpretation notes:

1. Many of these characteristics are likely to be correlated (e.g., having children, being older, geographic restrictions). One should not assume cause-and-effect relationships based on this data.
2. No significance testing has been performed on this data.Thus, one should not assume that differences are significant.
3. Some results with small n's have not had the match rate calculated.
4. Applicants who withdrew from the Match or did not submit a Rank Order List were counted as "unmatched."
5. Match rates are calculated based on the information provided by respondents to the APPIC survey.

All 4,199 applicants who registered for the APPIC Match were sent an e-mail message (along with two reminder e-mails) about the availability of the survey at a specific internet address. A total of 2,731 internship applicants (65%) completed some or all of the survey.

1. Placement of Matched Applicants by Type of Doctoral Program

	Clin PhD	Clin PsyD	Couns	School
Armed Forces Med Ctr	1.5%	3.2%	5.1%	0.0%
Child/Adol Psych/Pediatric	18.3%	12.2%	7.9%	29.5%
Comm Mental Health Center	11.6%	25.5%	7.5%	12.6%
Consortium	13.8%	5.9%	4.8%	20.0%
Medical School	24.7%	6.5%	6.5%	9.5%
Prison/Other Correctional	3.9%	7.9%	2.1%	1.1%
Private General Hospital	9.0%	5.1%	1.4%	4.2%
Private Outpatient Clinic	3.9%	7.7%	1.7%	3.2%
Private Psych Hospital	3.0%	4.0%	0.3%	2.1%
Psychology Dept	2.9%	1.1%	0.0%	5.3%
School District	0.4%	2.3%	0.7%	54.7%
State/County/Oth Pub Hosp	13.1%	10.8%	3.8%	4.2%
University Counseling Ctr	4.2%	15.2%	48.3%	3.2%
VA Medical Center	27.6%	11.0%	20.2%	0.0%
Other	2.3%	4.1%	1.4%	2.1%
n =	825	844	292	95

NOTE: Respondents were permitted to provide multiple responses in defining the setting of their placement; thus, columns add to more than 100%. Combined programs omitted due to small n.

2. Type of Doctoral Program

Clinical	Match rate = 79%	n = 2161
Counseling	Match rate = 86%	n = 343
School	Match rate = 79%	n = 123
Combined	Match rate = 84%	n = 80

3. Degree sought:

Ph.D.	Match rate = 84%	n = 1479
Psy.D.	Match rate = 75%	n = 1239

4. Accreditation (APA or CPA) status of doctoral program:

Accredited	Match rate = 81%	n = 2558
Not Accredited	Match rate = 61%	n = 160

5. Location of doctoral program:

United States	Match rate = 80%	n = 2566
Canada	Match rate = 78%	n = 123
Other	Match rate = 63%	n = 24

6. Doctoral program housed within a religiously-affiliated institution?

Yes	Match rate = 83%	n = 372
No	Match rate = 79%	n = 2340

7. Model of doctoral program:

Scientist-Practitioner	Match rate = 86%	n = 1199
Practitioner-Scholar or Scholar-Practitioner	Match rate = 75%	n = 1149
Practitioner	Match rate = 65%	n = 23
Clinical Scientist	Match rate = 89%	n = 131
Local Clinical Scientist	Match rate = 57%	n = 61
Practitioner-Scientist	Match rate = 67%	n = 98
Practitioner Informed by Science	Match rate = 91%	n = 33
Other	Match rate = 80%	n = 30

CONTINUED ON NEXT PAGE

8. Years enrolled in current doctoral program (includes the current academic year; excludes other graduate programs; does not include year of internship):

2nd Year	Match rate = 79%	n = 29
3rd Year	Match rate = 74%	n = 324
4th Year	Match rate = 80%	n = 1243
5th Year	Match rate = 82%	n = 750
6th Year	Match rate = 81%	n = 261
7th Year	Match rate = 74%	n = 76
8th Year or greater	Match rate = 72%	n = 36

9. Status prior to entering current doctoral program:

No prior graduate training	Match rate = 81%	n = 1530
Master's degree in psychology	Match rate = 77%	n = 672
Master's degree in mental health field other than psychology	Match rate = 80%	n = 269
Master's degree in unrelated field	Match rate = 76%	n = 75
Enrolled in Master's program in psychology but did not receive a degree	Match rate = 83%	n = 75
Enrolled in Master's programin MH field other than psychology but did not receive a degree	Match rate = 62%	n = 21
Enrolled in Master's program in an unrelated field but did not receive a degree	Not Reported	n = 11
Other	Match rate = 82%	n = 73

10. Size of doctoral class (i.e., number of students who began doctoral program in the same year as respondent)

1 - 10 students	Match rate = 85%	n = 1136
11 - 20 students	Match rate = 82%	n = 474
21 - 30 students	Match rate = 75%	n = 395
31 - 40 students	Match rate = 72%	n = 193
41 - 50 students	Match rate = 73%	n = 118
51 - 60 students	Match rate = 69%	n = 109
61 - 70 students	Match rate = 82%	n = 93
71 - 80 students	Match rate = 70%	n = 53
81 - 90 students	Match rate = 79%	n = 38
91 - 100 students	Match rate = 72%	n = 75
101 and greater	Match rate = 59%	n = 22

11. Number of times participating in Match:

First time in Match	Match rate = 81%	n = 2460
Second time in Match	Match rate = 69%	n = 234
Third time in Match	Match rate = 61%	n = 18
Fourth time in Match	Not Reported	n = 5

12. Number of applications submitted:

1 to 5 applications	Match rate = 62%	n = 143
6 to 10 applications	Match rate = 72%	n = 258
11 to 15 applications	Match rate = 83%	n = 946
16 to 20 applications	Match rate = 81%	n = 912
21 to 25 applications	Match rate = 84%	n = 321
26 or more applications	Match rate = 74%	n = 132

13. Number of interview offers received:

1 to 2 interviews	Match rate = 52%	n = 385
3 to 4 interviews	Match rate = 69%	n = 516
5 to 6 interviews	Match rate = 85%	n = 538
7 to 8 interviews	Match rate = 92%	n = 433
9 to 10 interviews	Match rate = 95%	n = 355
11 or more interviews	Match rate = 99%	n = 417

14. Response to the following item: "My doctoral program faculty provided a high level of support for my internship application and interview experience."

Strongly Agree	Match rate = 87%	n = 928
Agree	Match rate = 80%	n = 867
Neutral	Match rate = 77%	n = 398
Disagree	Match rate = 70%	n = 320
Strongly Disagree	Match rate = 63%	n = 143

15. Response to the following item: "I worked closely with other students in my program throughout this process (e.g., sharing information, giving and receiving support)."

Strongly Agree	Match rate = 85%	n = 889
Agree	Match rate = 77%	n = 887
Neutral	Match rate = 79%	n = 369
Disagree	Match rate = 76%	n = 349
Strongly Disagree	Match rate = 75%	n = 149

16. Age of applicant:

Ages 23-25	Match rate = 75%	n = 211
Ages 26-30	Match rate = 84%	n = 1611
Ages 31-35	Match rate = 81%	n = 506
Ages 36-40	Match rate = 65%	n = 125
Ages 41-45	Match rate = 68%	n = 71
Ages 46-50	Match rate = 63%	n = 40
Ages 51-55	Match rate = 50%	n = 28
Ages 56+	Match rate = 40%	n = 15

NOTE: These results should be interpreted cautiously. There are many variables that may be correlated with age (e.g., geographic restrictions, having children, number of sites to which one applied). Thus, the differences observed above, if significant, may be due to factors other than (or in addition to) age.

CONTINUED ON NEXT PAGE

17. Number of dependent children living with applicant:

None	Match rate = 82%	n = 2224
One or more	Match rate = 71%	n = 383

18. Number of adult dependents living with applicant:

None	Match rate = 80%	n = 2480
One or more	Match rate = 74%	n = 110

19. Current marital or relationship status:

Married/partnered	Match rate = 81%	n = 1371
Not married/partnered	Match rate = 79%	n = 1228

20. Country(ies) of citizenship:

United States	Match rate = 80%	n = 2365
Canada	Match rate = 78%	n = 157
Other	Match rate = 81%	n = 161

21. Gender:

Male	Match rate = 79%	n = 540
Female	Match rate = 80%	n = 2050
Other	Not Reported	n = 5

22. Racial/Ethnic identification:

African-American/Black	Match rate = 83%	n = 169
American Indian/Alaskan Native	Match rate = 84%	n = 25
Asian/Pacific Islander	Match rate = 84%	n = 190
Hispanic/Latino	Match rate = 72%	n = 206
White (non-hispanic)	Match rate = 80%	n = 1957
Bi-racial/Multi-racial	Match rate = 84%	n = 85
Other	Match rate = 87%	n = 77

NOTE: The last time this analysis was conducted, in 2008, the Hispanic/Latino group had the highest Match Rate of any group listed. See the "Match Statistics" page at www.appic.org and click on the 2008 applicant survey results, part 2.

23. Sexual Orientation:

Heterosexual	Match rate = 80%	n = 2361
Gay Male	Match rate = 81%	n = 59
Lesbian	Match rate = 83%	n = 57
Bisexual	Match rate = 74%	n = 85

24. Disability:

None	Match rate = 80%	n= 2343
Blind/Visually Impaired	Match rate = 73%	n = 11
Deaf/Hard of Hearing	Match rate = 89%	n = 9
Physical/Orthopedic	Match rate = 67%	n = 15
Learning Disability	Match rate = 75%	n = 44
Cognitive Disability	Not Reported	n = 3
Chronic Health Cond.	Match rate = 86%	n = 81
Mental Illness	Match rate = 70%	n = 33
Other	Match rate = 72%	n = 18

NOTE: These results should be interpreted cautiously due to low or very low sample sizes.

25. Geographic restriction on internship search:

None	Match rate = 81%	n = 1537
Due to significant family, financial, and/or health considerations	Match rate = 71%	n = 465
Due to personal preference	Match rate = 85%	n = 594

26. Scope of geographic restriction:

Single city or town, or within 100-mile radius of a city/town	Match rate = 72%	n = 313
State/Province	Match rate = 78%	n = 175
Region of the country	Match rate = 83%	n = 444

7. Completion of comprehensive / qualifying / preliminary exams:

Prior to submitting internship applications	Match rate = 83%	n = 2045
Later	Match rate = 66%	n = 113

28. Completion of proposal for dissertation or research-project:

Prior to submitting internship applications	Match rate = 84%	n = 1741
Later	Match rate = 71%	n = 478

29. Number of articles published in refereed journals:

Zero	Match rate = 78%	n = 1271
One or more	Match rate = 86%	n = 955

30. Number of professional presentations at regional, state, national,
or international meetings/conferences:

Zero	Match rate = 75%	n = 553
One	Match rate = 76%	n = 244
Two	Match rate = 75%	n = 203
Three	Match rate = 81%	n = 151
Four	Match rate = 82%	n = 119
Five	Match rate = 86%	n = 141
Six or more	Match rate = 89%	n = 805

CONTINUED ON NEXT PAGE

PART 3: COMPARISON OF APPLICANTS BASED ON DEGREE TYPE

This report is the third of three parts of the results from the survey of applicants who were registered for the 2011 APPIC Match, and provides a comparison of applicants based on type of doctoral degree sought (Ph.D.and Psy.D.). Please note that most applicants completed the survey prior to the completion of Phase II of the Match, and thus these results primarily reflect matching that occurred only in Phase I.

Important interpretation notes:

1. Many of these characteristics are likely to be correlated (e.g., having children, being older, geographic restrictions). One should not assume cause-and-effect relationships based on this data.
2. No significance testing has been performed on this data. Thus, one should not assume that differences are significant.
3. Some results with small n's have not had the match rate calculated.
4. Applicants who withdrew from the Match or did not submit a Rank Order List were counted as "unmatched."
5. Match rates are calculated based on the information provided by respondents to the APPIC survey.

All 4,199 applicants who registered for the APPIC Match were sent an e-mail message (along with two reminder e-mails) about the availability of the survey at a specific internet address. A total of 2,731 internship applicants (65%) completed some or all of the survey.

1. Training model of doctoral program:

	Ph.D.	Psy.D.
Scientist-Practitioner	77%	5%
Practitioner-Scholar or Scholar-Practitioner	10%	80%
Practitioner	0%	2%
Clinical Scientist	8%	1%
Local Clinical Scientist	0%	4%
Practitioner-Scientist	2%	5%
Practitioner Informed by Science	0%	3%
Other	2%	1%

2. Years enrolled in current doctoral program (includes the current academic year; excludes other graduate programs; does not include year of internship):

	Ph.D.	Psy.D.
2nd year	1%	2%
3rd year	9%	16%
4th year	34%	59%
5th year	37%	17%
6th year	14%	5%
7th or later	6%	2%

3. Status prior to entering current doctoral program:

	Ph.D.	Psy.D.
No prior graduate training	56%	57%
Master's degree in psychology	25%	24%
Master's degree in mental health field other than psychology	11%	9%
Master's degree in unrelated field	2%	3%
Enrolled in Master's program in psychology but did not receive a degree	2%	3%
Enrolled in Master's program in MH field other than psychology but did not receive a degree	1%	1%
Enrolled in Master's program in an unrelated field but did not receive a degree	0%	1%
Other	3%	2%

4. Size of doctoral class (i.e., number of students who began doctoral program in the same year as respondent)

	Ph.D.	Psy.D.
1 - 10 students	74%	8%
11 - 20 students	17%	21%
21 - 30 students	4%	26%
31 - 40 students	2%	10%
41 - 50 students	2%	9%
51 or more	2%	26%

5. Debt accrued to date as a consequence of attending GRADUATE SCHOOL IN PSYCHOLOGY, including tuition, fees, living expenses, books, etc. Includes all forms of debt; does not include undergraduate debt or debt that is unrelated to graduate training.

Ph.D.	Median =	$ 40,000
	Mean =	$ 53,160
	S.D. =	$ 58,932
Psy.D.	Median =	$ 120,000
	Mean =	$ 123,787
	S.D. =	$ 70,013

NOTE: Mean debt load for Ph.D. students has increased by $2,043 (4.0%) since 2008, while Psy.D. students have experienced an increase in debt of $14,253 (13.0%) in the same time period.

Percent of applicants with:

No debt	Ph.D. = 24%	Psy.D. = 8%
Debt <= $50,000	Ph.D. = 62%	Psy.D. = 16%
Debt >= $100,000	Ph.D. = 21%	Psy.D. = 70%
Debt >= $150,000	Ph.D. = 8%	Psy.D. = 38%
Debt >= $200,000	Ph.D. = 3%	Psy.D. = 17%

CONTINUED ON NEXT PAGE

Virtually all applicants will remain in training for at least 18 months (including the internship year) after the completion of this survey and may incur additional debt during that period.

6. Types of internship programs that would be considered acceptable by applicant's doctoral program.

Accredited internship	Ph.D.=99%	Psy.D. = 97%
APPIC-member, not accredited	Ph.D.= 35%	Psy.D = 80%
Not accredited, non-APPIC	Ph.D. = 18%	Psy.D.= 33%
Unpaid internship	Ph.D. = 18%	Psy.D.= 37%

7. Match Rate

	Ph.D.	Psy.D.
Matched	84%	75%
Not Matched	14%	22%
Withdrew or did not submit rankings	2%	3%

8. Times participating in the APPIC Match:

	Ph.D.	Psy.D.
First time	91%	90%
Second time	9%	9%
Third time	0%	1%
Fourth time	0%	0%

9. Percentage of matched applicants that were placed at an APA- or CPA-accredited program:

Ph.D. = 94%
Psy.D. = 64%

10. Doctoral practicum hours reported on the AAPI:

	Ph.D.	Psy.D.
Doctoral Intervention Hours		
Median	602	540
Mean	650	576
St. Dev.	348	293
Doctoral Assessment Hours		
Median	167	122
Mean	225	163
St. Dev.	202	162
Doctoral Supervision Hours		
Median	347	262
Mean	377	284
St. Dev.	186	149

11. Integrated testing reports reported on the AAPI:

Adult Testing Reports		
Median	7	7
Child/Adolescent Testing Reports		
Median	5	4

12. Number of applications submitted:

	Ph.D.	Psy.D.
Median	15	17
Mode	15	15
Mean	14.9	17.1
SD	5.5	7.1

13. Number of interviews offered:

	Ph.D.	Psy.D.
Median	7	5
Mode	5	3
Mean	7.0	5.7
SD	3.9	3.9

14. For matched applicants - setting to which they were matched (respondents were instructed to check all that applied):

	Ph.D.	Psy.D.
Armed Forces Medical Center	2%	3%
Child/Adol. Psychiatric/Pediatrics	17%	13%
Community Mental Health	11%	25%
Consortium	12%	6%
Medical School	19%	6%
Prison / Other Correctional	3%	9%
Private General Hospital	7%	5%
Private Outpatient Clinic	3%	8%
Private Psychiatric Hospital	2%	4%
Psychology Department	2%	1%
School District	5%	3%
State / County / Other Public Hosp.	10%	11%
University Counseling Center	14%	16%
VA Medical Center	24%	10%
Other	2%	4%

15. Rank of program to which applicant was matched:

	Ph.D.	Psy.D.
#1 choice	50%	48%
#2 choice	23%	23%
#3 choice	11%	11%
#4 choice	7%	7%
#5 choice	4%	4%

16. Age of applicant:

	Ph.D.	Psy.D.
Median	29	28
Mode	28	27
Mean	30.2	30.0
SD	5.1	5.9

Percent of applicants who were:

Age 25 or less	Ph.D. = 5%	Psy.D. = 12%
Age 40 or older	Ph.D. = 6%	Psy.D. = 8%
Age 50 or older	Ph.D. = 2%	Psy.D. = 2%

CONTINUED ON NEXT PAGE

17. Gender

Female	Ph.D. = 79%	Psy.D. = 79%
Male	Ph.D. = 21%	Psy.D. = 20%

18. Racial / Ethnic identification:

African-American/Black	Ph.D. = 7%	Psy.D. = 6%
American Indian/Alaskan Native	Ph.D. = 1%	Psy.D. = 1%
Asian/Pacific Islander	Ph.D. = 8%	Psy.D. = 6%
Hispanic/Latino	Ph.D. = 6%	Psy.D. = 10%
White (non-hispanic)	Ph.D. = 75%	Psy.D. = 75%
Bi-racial/Multi-racial	Ph.D. = 5%	Psy.D. = 3%
Other	Ph.D. = 3%	Psy.D. = 4%

19. Sexual Orientation:

Heterosexual	Ph.D. = 92%	Psy.D. = 91%
Gay Male	Ph.D. = 2%	Psy.D. = 2%
Lesbian	Ph.D. = 2%	Psy.D. = 2%
Bisexual	Ph.D. = 3%	Psy.D. = 3%
Other	Ph.D. = 1%	Psy.D. = 1%

20. Disability:

None	Ph.D. = 94%	Psy.D. = 91%

21. Geographic restriction on internship search:

None	Ph.D. = 41%	Psy.D. = 40%

22. Of those who reported a geographic restriction, the reason for the restriction:

Due to significant family, financial, and/or health considerations	Ph.D. = 35%	Psy.D. = 48%
Due to personal preference	Ph.D. = 58%	Psy.D. = 45%

23. Scope of geographic restriction

Single city or town, or within 100-mile radius of a city/town	Ph.D. = 22%	Psy.D. = 37%
State/Province	Ph.D. = 14%	Psy.D. = 19%
Region of the country	Ph.D. = 49%	Psy.D. = 30%
Other	Ph.D. = 15%	Psy.D. = 14%

24. Completion of comprehensive / qualifying / preliminary exams:

Prior to submitting internship applications	Ph.D. = 96%	Psy.D. = 93%
Later	Ph.D. = 4%	Psy.D. = 7%

25. Completion of proposal for dissertation or research

Prior to submitting internship applications	Ph.D. = 81%	Psy.D. = 76%
Later	Ph.D. = 19%	Psy.D. = 24%