APPIC e-newsletter
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From the Desk of the APPIC Executive Director

By Jeff Baker, Ph.D., ABPP

Oh What A Difference 5 Years Makes! The Psychology Internship Imbalance. More than five Years Ago, APAGS identified the Internship Imbalance as the "Internship Crisis". They were correct. More than 25% of psychology graduate students who went through the APPIC match were not placed during Phase I. It left a lot of graduate students wondering why. It left a lot of graduate students sad. It left a lot of psychology graduate students and faculty mad. As it should have. How can a system result in 25% of students who have completed all their requirements for a doctorate in psychology not be able to complete the final clinical step? How could their faculty, APPIC, anyone involved in psychology training and education do something so terrible? 2012 had the worst match statistics of all time and nobody was doing anything concretely to fix it. APPIC leadership previously expected that the match imbalance would correct itself given the supply-demand market. Simple economics, the market will correct itself. We all learned that in the economics 101 class (Samuelson ISBN: 9780073511290).

What undergraduate student would choose to get a graduate degree in psychology given the profession can't even provide enough training positions to complete the doctoral degree? The market correction was expected to happen every year between 2001 and 2010 but it never materialized. Instead a record number of psychology graduate students were entering the APPIC match and it just kept getting worse. How could this be? Why weren't internships keeping up with the demand for training slots?

I'm sure there are many theories but thought I would throw mine out there and see what sticks. I was on the APPIC board from 2000 until 2006. It was painful to see students go through

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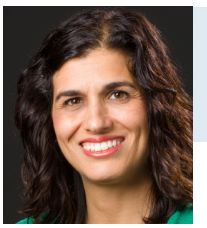

CHAIR'S COLUMN

By Allison N. Ponce, Ph.D.

Diversity, in its many forms, is at the very heart of psychology and psychology training and education. With renewed energy, the current APPIC Board is actively engaging to celebrate and support diversity and inclusion through multiple channels.

An important step in this direction was the establishment in 2016 of the first APPIC Diversity Committee thanks to Chair Dr. Jenny Cornish's vision and leadership. With Dr. Mary Mendoza-Newman as the APPIC Board Liaison, the committee consists of a stellar group chaired by Dr. Margaret Smith: Drs. Barbara Garcia Lavin, Aida Jimenez Torres, Angela Kuemmel, and Hsin-Tine "Tina" Liu-Tom.

One of the Diversity Committee's first orders of business was collaborating with the Board to produce a diversity statement. The preamble to this statement reads, "The Association of Postdoctoral and Psychology Internship Centers (APPIC) values diversity, inclusion, equity, and self-examination in all training environments. It is committed to promoting diversity in all aspects of training and ensuring that such issues remain in the consciousness of the organization." Please visit http://www.appic.org/Portals/0/downloads/APPIC_Diversity_Statement.pdf for the full statement.

With the spirit of the diversity statement in mind, the Board and Diversity Committee affirm our commitment to these important issues and I would like to take this opportunity to share some details with our members.

The Board is considering ideas including APPIC-sponsored grants to develop diversity enhancement projects in internship and postdoctoral training programs; a membership survey about diversity training needs; and bolstering the APPIC website by adding substantial and relevant materials pertinent to diversity-aware training and supervision.

A natural time for APPIC members to engage around diversity training issues is our 2018

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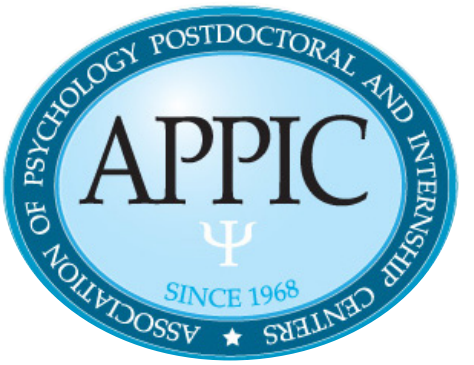
ASSOCIATION OF PSYCHOLOGY POSTDOCTORAL AND INTERNSHIP CENTERS (APPIC)



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the "rejection" of not getting matched and having to search and find something their doctoral program would count as an internship. A number of students did just that, a few continued work on their dissertation and re-entered the match, but it was really a small percentage, probably less than 10% a year were re-entering the match which only created more applicants, but far fewer than one would expect. Many doctoral programs scrambled to find a position for their students as they wanted to help as much as possible for them to complete the program. There were quality training positions out there and there were some that were not so high-quality, but I think a lot of people turned their heads and decided this was the path of least resistance and decided to go forward and hope for the best and placed them in settings that were not always holding a high regard for training. They got some great clinical experience but training was not always prioritized in many of these settings. Fortunately, most ended up in quality training positions, but many did not. What was happening? Where are all these students coming from and why haven't the internships expanded instead of held a steady number? APPIC was stunned. APA and CPA were stunned. APAGS was stunned. Fingers were pointed. Too many graduate students! Too many psychology training programs? Not enough internship programs! Not enough students were aware of what was ahead of them when they entered their doctoral training program! What could be done? There were discussions, there were journal articles, there were many speculative ideas that were diverse and meaningful but, we needed action. Steve McCutcheon was chair of APPIC at that time and became chair of CCTC (Council of Chairs of Training Councils). He, working with Cathi Grus, came up with the idea to begin a series of meetings titled "difficult dialogues" and "courageous conversations". People were asked to set aside their blame and asked to focus on solutions. There were meetings of key members of CCTC who had a vested interest in placing their students in quality training sites. APPIC took a leadership role as they were the direct beneficiaries of this supply demand imbalance. Programs were somewhat happy they had 200 applications for 3 positions and that 150 of those applications were of high quality. How could they choose wrong? That was an enviable position, but also one that brought insight. This was not right, this needed to be corrected. Graduate students needed to be placed in a quality training site and be guaranteed that the match would work correctly. If the system worked correctly there will always be those that don't match but mostly because of "fit" issues and not a fluke. The Courageous Conversations that took place requested everyone put everything on the table. Would they reduce their admissions to match their match rate? If a doctoral program had a 90% match rate would they reduce their admissions? If they had a 50% match rate, would they reduce their class size by 50%? No one did any of these options, but that doesn't mean they didn't make efforts. NCSPP took a leadership role and began developing training positions through APPIC membership and then accreditation. They added over 400 training slots, most if not all of them are still going strong today and are accredited. Many graduate programs during this time period (2008-2012) were pressured to increase their class size in order to bring in additional tuition revenue. Most psychology graduate programs appropriately did not do this, even when many other health service programs did just that (Medicine, Physical Therapy, Physician Assistants). Most graduate doctoral programs stood their ground and did not increase their enrollment. Internships did not see a problem (from their perspective). They had quality applications and their hardest decision was who not to invite for an interview. APA and BEA developed an idea to provide stimulus grant funds for current internship training programs to provide a financial incentive for them to seek accreditation. It worked. Over a 3 year period more than 200 slots were created and more are in the works.

APPIC developed an online membership review process (eMembership) that increased the speed in which programs were reviewed and approved. The APA CoA (Commission on Accreditation) decided there needed to be better access to outcome data (directed by the Department of Education). Applicants to doctoral programs needed to see outcome results of all accredited psychology training programs. C-20

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IR was born and then edited the next year to require it be "1-Click" away as many were buried. C-20 allowed everyone to see the match results along with other important factors such as the first year's tuition, student financial support, etc. They did their part and students, many undergraduates seeking a doctoral program now use this routinely and are advised to use this to compare programs.

Beginning in 2013 there was a slowing of applicants and a small increase in program training slots. In 2016 there were many less applicants compared to the previous five years and many more training slots. In 2017 there were actually only 23 more applicants than training slots. This compares with 2012 when there were more than 1200 applicants than there were training slots. This is a turnaround. Given that in previous years about 200 applicants withdraw before match day; it is likely there will be more training slots during Phase I than applicants (this article was written before match day). What a difference five years makes!

Is it time to open the floodgates and increase the class size in a doctoral program? No. There is one other issue that needs to be addressed. There is still a shortage of accredited training slots both in the U.S. and in Canada. We need about 600 more accredited training slots for every graduate to be placed in an accredited training program. APA and CPA accreditation is the gold standard in psychology training. The Department of Education recognizes APA and has rigorous standards for APA to meet. Similar structure in Canada where they have to respond to the Education Ministry. Every graduate student who successfully completes an accredited doctoral training program should also complete an accredited internship. This is possible. We are closer than we have ever been. This can happen in the next 5 years if the profession does not lose momentum. APA has been in a difficult budget situation for a couple of years yet the Board of Directors provided some additional funds in 2017 to continue the internship stimulus grant program. APA should be congratulated for their efforts. They put their money where their mouth is. APPIC has also put some money in this effort. The Accreditation Readiness Project (ARP) with efforts led by Dr. Allison Ponce, APPIC Chair, has put over $150,000 into this effort and has already added 30 programs to the accredited side of the equation. They are in the process of placing another 30 programs to be added within the next one year. Why are other APPIC member programs not taking advantage of either of these two grants? Now is the time. Now is the place. APPIC and APA will likely continue these programs for maybe another year or so. After that, programs may be left to their own financial resources or be left out in the cold. Or will they let market forces decide. Unfortunately, APPIC has seen more than a dozen programs close this year due to not having trainees or even applicants to their program. APPIC now requires that only students from accredited programs be allowed in the APPIC match. This was requested in 2013 by CUDCP (Council of University Directors of Clinical Psychology), CCPTP (Council of Counseling Psychology Training Programs) and APAGS (American Psychological Association Graduate Students). Does APPIC want to live in a double standard? Should they really only require doctoral programs to meet this requirement? I don't think this will be true for much longer. I believe that APPIC will, in the very near future, begin requiring all APPIC member internship programs to be accredited. No more double standard. It is not the right time yet to make this requirement, but soon, maybe 2020 or maybe 2025? It is now time for your psychology internship program to seek accreditation either from APA or CPA. Discussions need to begin now as this takes years of planning, considerable effort by the training director and financial and administrative support to make this happen. Now is the time. Do it. If you don't start now, you are late.

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Membership Conference, and in the current sociopolitical climate, this takes on particular urgency. Along these lines, the Board is actively discussing the fact that the May 2018 conference is scheduled to take place in San Antonio, TX. As this newsletter goes to press, the Texas state legislature is debating anti-trans bathroom bills (HB 2899 and SB 6) leading to great concern among the Board members. We are actively considering our options should such discriminatory legislation be passed. We have a heavy (non-refundable) financial investment in the conference contract, yet are distressed at the idea of asking hundreds of APPIC member training directors and staff to go to Texas under such circumstances. We continue to discuss options and will certainly be in communication with our members as the situation becomes clearer.

While we cannot control the North American sociopolitical climate, we can be introspective about our personal commitments to diversity and the composition of the Board of Directors. With enthusiasm, the Board changed its usual Board member nominations process this year in several ways. Most notably, we have added explicit language to our call for nominations to make clear that we are keen on welcoming people who represent diverse backgrounds, and have asked nominees to make note in their statements of interest in what ways they are committed to diversity. While these may seem like simple changes, they are the result of our sincere wish for the APPIC Board to be representative of all of our constituents and to bring different voices to the important business of psychology training and education.

Speaking of voices, we would like to hear yours. Do you have ideas for how to support diversity in training? Have you considered ways that APPIC could use its resources to support social justice and inclusion? Please let us know. The Diversity Committee is working on a survey for distribution, and I can be reached at allison.ponce@yale.edu and would be happy to hear from you.

Remarks from the e-Editor
The Residue of Design

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

In past columns, I summarized an emerging consensus of APA units (CoA, CRSPPP) and other groups (e.g. ABPP) with respect to the identification of health service psychology specialty practice areas and the progression of trainee careers within those areas. As this consensus emerges, however, the number of self-identified practice interest groups proliferates, each typically associated with its own set of core and specialized competencies. At some point, this universe will cease to expand and need to undergo considerable contraction through consolidation and hierarchicization. Training program planning will be crucial for adapting to this evolving professional environment.

With respect to future planning for the Louis Stokes Cleveland DVAMC training programs I administered, I always adopted the principle set forth by Branch Rickey, late owner of the Brooklyn Dodgers, that "luck is the residue of design." That is, good outcomes result from anticipation of future developments and preparation for change. For example, as our APA Accredited Clinical Psychology residency grew from 2 to 11 residents, I anticipated applying for separate residencies in Clinical Health and Rehabilitation Psychology – which had become new categories of APA residency accreditation since our initial Clinical accreditation - as well as seeking re-accreditation in Clinical. Accordingly, I delegated program management in these areas to three separate Program Directors and tasked them to develop seminar(s) and other resident learning activities particular to each specialty. Thus having already restructured one residency into three, we were prepared for an omnibus residency accreditation Site Visit which eventuated in our becoming accredited in all three specialties. In fact, one Site Visitor commented that ours was the best postdoctoral clinical health psychology residency he had ever visited.

In the spirit of Branch Rickey, therefore, I will look beyond the current emerging consensus, and speculate on what the structure of health service psychology might be in 2025. In my opinion, some new specialties will be recognized and implemented while others will be subsumed as formal subspecialties rather than continue as independent specialties. Some subspecialties will be included under more than one specialty. [For brevity, I am omitting consideration of more discrete proficiencies, in this schema. E.g. proficiencies of EMDR and Motivational Interviewing might be included under the specialty of Evidence-Based Intervention (see below). A proficiency such as Competency Evaluation might be common to several specialties, such as Clinical Neuropsychology, Forensic Psychology, Geropsychology, Clinical Health Psychology, et al.]

CONTINUING SPECIALTIES	ASSOCIATED SUBSPECIALTIES
CLINICAL PSYCHOLOGY	Counseling, Couple & Family, Group, Substance Use, Trauma Psychology, Integrated Primary Care, Seriously Mentally Ill
CHILD & ADOLESCENT	School, Couple & Family, Pediatric Health
CLINICAL HEALTH	Pain, Integrated Primary Care, Sleep, Psychoeducation, Pediatric Health, Group
CLINICAL NEUROPSYCHOLOGY	Pediatric Neuropsychology, Geroneuropsychology, Cognitive Rehabilitation
FORENSIC	Police & Public Safety Psychology, Correctional Psychology Geroneuropsychology, Couple & Family
ORGANIZATIONAL AND BUSINESS CONSULTING	Group, Vocational Aptitude & Ability
REHABILITATION	Cognitive Rehabilitation, Pain, Couple & Family, Substance Abuse Proposed Specialties Associated Subspecialties

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PROPOSED SPECIALTIES	ASSOCIATED SUBSPECIALTIES
ASSESSMENT & TESTING	Response-Restricted Questionnaires, Projective Techniques, Vocational Aptitude & Ability
EVIDENCE-BASED INTERVENTION	Cognitive & Behavioral Therapy, Psychoanalysis, Couple & Family
PHARMACOLOGICAL PSYCHOLOGY	Psychopharmacology, Psychoeducation
SUBSUMED/ELIMINATED SPECIALTIES	COGNITIVE & BEHAVIORAL, COUPLE & FAMILY, COUNSELING, GROUP, POLICE& PUBLIC SAFETY, PSYCHOANALYSIS, SCHOOL

My rationale includes the following. Under Clinical, I have subsumed Counseling Psychology (since activities of clinical and counseling psychologists appear identical), as well as Couple & Family and Group which have relatively few practitioners self-identified as such. I have added special populations, including the Seriously Mentally Ill, Trauma Psychology, and Substance Use Disorders as subspecialty areas. I have subsumed School Psychology under the Child and Adolescent specialty since activities of school psychologists are now those of the general child clinician, including therapy, but conducted in schools rather than clinics. I have split off Assessment & Testing, since many clinicians primarily practice assessment while others identify themselves almost exclusively as psychotherapists. I have established Pharmacological Psychology since it will require an additional master's degree and needs to be identified as an area of psychology, not merely the writing of prescriptions. I have established Evidence-Based Intervention to include advanced techniques beyond 'common factors' therapies, such as Cognitive & Behavioral and Psychoanalysis. With respect to new or emerging subspecialties, in particular I have designated Pain Psychology and Substance Use Disorders since, in my opinion, these are important constituent areas of expertise for several specialties.

The 21st century knowledge explosion in health service psychology is most strongly seen in the rapid development of postdoctoral specialty residency programs. APPIC's new Universal Psychology Postdoctoral Directory lists 888 programs for this year contrasted with 72 programs in 1980, the first year that postdoctoral programs were included in the APIC Directory. For decades, however, internship programs have reflected the differentiated interests of trainees and practice developments by typically offering tracks or rotations reflecting prespecialization or "specialty" tracks. As postdoctoral programs 'catch up' with the field, these tracks now prepare interns for further specialty residency training more often than serving as the capstone of competency attainment. Following these practice trends, many graduate programs have also expanded education through advanced courses, concentrations, or mini-curricula, even granting preinternship 'certificates' in these specialty areas. The websites of many programs, particularly those with small faculty numbers, now clearly indicate prespecialization curricular emphases, e.g. defining themselves as child clinical programs or programs emphasizing health psychology. At least for the present, however, APA continues to accredit doctoral programs as generic Clinical Psychology programs. The degree to which even internships expect applicants to have prior specialized experience can be illustrated in a comment by an ABPP-certified clinical neuropsychologist who decried the fact that a third year graduate student had not as yet observed brain-cutting in a neurology department!

As it has in medicine, the era of the general practitioner psychologist is fast disappearing. Job opportunities will increasingly require specialized residency training and evidence of advanced competencies acknowledged, for example, by attainment of hospital clinical privileges. In my opinion, a current university DOT or TD of an internship or residency would be well-advised to prepare and expand curricula and training to position his/her program for anticipated developments such as new requirements for trainee competency attainment and program accreditation in a reorganized and modified definitional field. Hopefully, by pursuing that strategy, a program's future luck will indeed be the residue of design.

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Note: The concepts and opinions expressed here are solely those of the e-Editor and do not reflect policies or opinions of APPIC, ABPP, or of any other organization with which he is now or previously has been affiliated.

2017 APPIC Match Statistics Combined Results: Phase I and Phase II

Compiled by Greg Keilin, Ph.D., APPIC Match Coordinator

This report provides statistics and information about the combined results for both phases of the 2017 APPIC Match.

Here is a summary of the numbers of applicants and positions in 2016 as compared to the last four APPIC Matches, combining both Phase I and Phase II:

COMBINED PHASE I / PHASE II

	2012 MATCH	2013 MATCH	2014 MATCH	2015 MATCH	2016 MATCH	2017 MATCH
Applicants:Registered for the Match	**4,435**	**4,481**	**4,335**	**4,247**	**3,999**	**3,921**
Withdrew or did not submit ranks	**368**	**367**	**294**	**242**	**185**	**192**
Matched	**3,152**	**3,326**	**3,458**	**3,569**	**3,595**	**3,560**
Unmatched	**915**	**788**	**583**	**436**	**219**	**169**

APPLICANTS

PARTICIPATION - COMBINED PHASE I/II

Applicants Registered in the Match	3,921
Applicants Who Withdrew or	
Did Not Submit Ranks	192
Applicants Participating in the Match	3,729

MATCH RESULTS - COMBINED PHASE I/II

Applicants Matched	3,560	(95%)
Participating Applicants Not Matched	169	(5%)

INTERNSHIP PROGRAMS

PARTICIPATION: COMBINED PHASE 1/11

Training sites Participating in the Match	785
Programs Participating in the Match	1,462
Positions offered in the Match	3,881

Note: A training site can offer more than one "program" in the Match. Each "program"was identified in the Match by a separate 6-digit code number.

MATCH RESULTS -

PROGRAMS COMBINED PHASE I/II

Filled in either Phase i or Phase II	1,280	(89%)
Remaining unfilled in Phase II	161	{11%)

NOTE: 65 of the programs that remained unfilled submitted either no ranks or fewer ranks than the number of positions available in Phase II.

MATCH RESULTS

POSITIONS - COMBINED PHASE I AND II

Filled in either Phase I or Phase II	3,560	(93%)
Remaining unfilled in Phase II	284	(7%)

NOTE: No ranks were submitted for 99 of the positions that remained unfilled in Phase II.

Tips for Trainers: Due Process

By Allison C. Aosved, PhD, APPIC Board

In the context of psychology training, due process is a requirement that the entity with more power (in this case trainers and training programs) respect all the rights of the person with less power (psychology trainees – graduate students, interns, and postdoctoral residents/fellows). Due process provides important protections and represents best practice in education, training, and employment. Given this, due process and grievance procedures are a requirement for APPIC membership (http://appic.org/Joining-APPIC/Members/Internship-Membership-Criteria and http://appic.org/About-APPIC/APPIC-Policies/Postdoc) as well as for accreditation by the Commission on Accreditation (http://www.apa.org/ed/accreditation/). The APPIC board recommends you address following domains in your policies and procedures: due process, appeal, and grievances.

DUE PROCESS. This should be utilized when a health service psychology trainee's behavior is problematic. Problem behaviors can take many forms (e.g., lacking sufficient academic preparation, lack of appropriate clinical experiences, personal difficulties that impact professional performance, significantly underdeveloped competencies, etc.). One question to answer related to this is: Do trainees have legitimate reasons to deviate from standard training practice (e.g., ADA accommodations)? Next, consider how you would give notice to a trainee exhibiting problem behaviors (that do not warrant a deviation from standard training practice in your program). Questions to answer related to notice include:

1. What is first level of notice to the trainee that the program has a concern?
2. How long it will it take to give notice?
3. How is notice given (written, informal, etc.)?
4. How is a remediation plan determined?
5. As part of your remediation plan, how do you determine what additional supports will be implemented to assist the trainee in resolving the problem behaviors?
6. Once a remediation plan is implemented, how often do you review it?
7. Once a remediation plan is implemented, how do you know if it is working?
8. Once a remediation plan is implemented, how do complete or exit the plan?
9. What would be the next step if a remediation plan is not working?
10. Do you include a probation option?
11. How is probation determined, reviewed, completed, documented?
12. What is the next step if probation is not working?
13. Is termination an option?
14. How is termination determined, reviewed, completed, documented?
15. Is Human Resources involved? If so, when and how?
16. What is the specified timeline for your due process element(s)?

APPEAL. This is the mechanism for the trainee to disagree with a solution/step in the due process as well as a mechanism to disagree with the outcome of a grievance (see below for further discussion of grievances). Questions to consider when evaluating or updating your appeal process:

1. Do your policies explicitly state that a trainee can appeal any decision in the due process?
2. What is the time frame for appeal?
3. Must it be made in writing?
4. To whom must appeal be made?
5. What is time frame for a decision on the appeal?
6. Are there steps beyond the initial appeal? If so, to whom is that appeal made and what is the time frame?
7. Who is the final decision maker? What is the time frame in which the final decision is made? How is trainee informed of final decision?
8. Do you include alternatives to appeal if there is a conflict of interest (ie, the person of concern is the Training Director)?
9. Is Human Resources involved? If so, when and how?
10. What is the specified timeline for your appeal element(s)?

GRIEVANCE. This is the mechanism for a trainee to make a complaint. Complaints may or may not be related to the due process and appeal process. Questions to consider when evaluating or updating your grievance process:

1. What can a trainee make a complaint about?
2. Do you encourage an informal step first?
3. Who is the complaint made to? How is it made? (written, verbal)
4. Is there a length of time in which a trainee can place a grievance?
5. What is the time frame in which a decision is made and how is the trainee informed?
6. What is the next step if the trainee does not agree with the decision?
7. Who is the final decision maker? What is the time frame in which the final decision is made?
8. Do you have an alternative to the standard grievance process if there is a conflict of interest (ie, the person of concern is the Training Director)?
9. Is Human Resources involved? If so, when and how?
10. What is the specified timeline for your grievance element(s)?

We often learn how good (or bad) our due process policies are when we have to use them. Take the time now to review and update your due process, appeal, and grievance policies and procedures so they will be strong, reasonable, and appropriately flexible when you need to use them.

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News from the APA Education Directorate

By Catherine Grus, PhD

In this column I address a topic that is not always well understood but could have had (and hopefully will not) a big impact on internship placements, state authorization. States and territories regulate higher education within their borders, with varying requirements for out-of-state institutions that want to do business in the state. Why would this matter to internships (and the doctoral program that has a student going on internship)? Educational experiences that are regulated by the state can include field placements such as internship. Field placements fall under a broader category of distance education, according to the Department of Education, but little attention and oversight was in force until 2010. Then the Department of Education published a regulation proposed to offer greater oversight of interstate education programs (e.g., distance learning). The distance education regulation was litigated in the U.S. District Court for the District of Columbia. The regulation was struck down; in 2012, the appellate court upheld the decision. These events have been related to a surge of interest at the state level of increased regulation of distance education programs that were based out of one state but offering education activities in another state (or other states) and prior to the 2016 Presidential election, a continued federal focus as well.

APPIC and APA became aware of attempts to apply distance education regulations to internship placements when a doctoral program who had a student match to an internship was told that their university would need to apply to the state where the internship was located for approval to send the student for an educational experience in that state. While the application process varies from state to state, it is time consuming and in some cases quite costly. Fortunately, in this and another situation that we have been made aware of, advocacy efforts were successful in getting interns exempted but that is clearly not the best long term plan.

What is being done? A non-profit entity, the National Council for State Authorization Reciprocity Agreements (NC-SARA, www.nc-sara.org) was established in 2013 to create a compact or agreement among states, districts, and territories that establishes comparable national standards for interstate offerings of postsecondary distance education and programs. Educational institutions based in a state that is a member of the compact register with their state and then can send their students to complete training in other compact states without needing specific authorization from that state. Becoming a member of the compact is a voluntary process. To date, all but Massachusetts, California and Florida have joined the compact. NC-SARA is overseen by a national council and administered by four regional compacts (Midwestern Higher Education Compact, New England Board of Higher Education, Southern Regional Education Board, and the Western Interstate Commission for Higher Education). Field experience placements are covered by the provisions of NC-SARA that govern interstate distance education activity; whether the placement is part of a distance-education program or one that is campus-based.

While NC-SARA has lessened concerns related to state-based regulation of internship placements this remains an issue that will be carefully tracked by the Education Directorate. A primary reason is that the U.S. Department of Education has issued a new rule related to distance education that is scheduled to go into effect on July 1, 2018. Existing reciprocity agreements, like those established through NC-SARA, are expected to be recognized under the final rule issued by the Department of Education in December of 2016. Because the state authorization regulations were released during the final days of the Obama Administration, just after the election of President Trump, there is uncertainty as to their future. It is an open question whether these regulations will remain or be reviewed or repealed by the republican controlled 115th Congress and a new Administration that is less favorable towards this type of federal regulation and oversight.

News from the ASPPB

By Tomas Granados, PsyD and Carol Webb, PhD

ASPPB is committed to providing regular updates to the education and training community on our progress in developing the EPPP Step 2. The EPPP Step 2 is a computer-based examination that is designed to assess the practice skills needed for independent licensure as a psychologist. It will augment and complement the EPPP, which measures the foundational knowledge required for the independent practice of psychology. With a test to assess skills in addition to the current examination to assess knowledge, licensing boards will have available to them an examination series that will offer a standardized, reliable and valid method of assessing competence. It is intended for the EPPP Step 2 to be taken after graduation, after the EPPP has been passed, and at the conclusion of all supervised experience requirements for licensure.

COMPETENCIES

The foundation of the EPPP Step 2 is the 2017 ASPPB model of competencies, entitled "Competencies Expected at the Point of Licensure". As with other health care professions, these competencies are empirically derived from periodic practice analyses or job task analyses. These analyses of the knowledge and skills needed for the independent practice of psychology are accomplished through surveys of practicing psychologists. The results of the most recent job task analysis provide the blueprint for the EPPP Step 2.

The EPPP Step 2 will consist of test items in the competency clusters listed below. The percentages of questions from each cluster that will be on the exam are as follows:

- Scientific Orientation 6%
- Assessment and Intervention 33%
- Relational Competence 16%
- Professionalism 11%
- Ethical Practice 17%
- Collaboration, Consultation and Supervision 17%

One of the reasons that ASPPB decided to move forward with the development of the EPPP Step 2 at this point is that there is now essential agreement within the profession of the competencies needed for independent practice. Table 1 highlights the substantial similarities between the ASPPB model, and the Mutual Recognition Agreement (Canada) model and the APA's Commission on Accreditation's model (US).

ASSESSMENT

The EPPP Step 2 will be a computer-based exam and as such has advantages and limitations as to the kinds of skills it will assess. ASPPB believes that most skills can be effectively assessed by a computer-based, written examination. However, there will be some skills, especially those in the relational competency cluster that require assessment through direct observation, either with an Objective Structured Clinical Examination (OSCE) or similar type of assessment tool, or by enhanced supervisor assessments. The assessment of these skills will not be included in the EPPP Step 2.

The current EPPP uses a multiple-choice examination format, but there are many other item type options for computer-based examinations. Such innovative item types include expanding the multiple-choice format to include a larger number of distractors or multiple correct responses, including sequencing questions (e.g., the best next steps to be taken in a series of actions). Other possibilities include questions about test protocols, or questions requiring the candidate to circle or highlight the most important information presented in a table, figure, or paragraph. Graphics and images (audio or video) and stimuli including short video vignettes (either with actors or avatars) with multiple serial questions may also be used.

ASPPB is currently in the process of creating the item templates (the particular kind of innovative and traditional items types) that will be used on the EPPP Step 2. We have received over 120 volunteer applications to help with item writing of which just over 50% are early career psychologists. Item writers will attend training workshops to learn how to write traditional multiple choice questions and innovative or technology enhanced questions for the EPPP Step 2. Once trained, item writers will develop items in an identified competency cluster. These items will be reviewed by the EPPP Step 2 Item Development Committee (IDC), a group of subject matter experts in each cluster. The items will be reviewed and revised by the item writer and the IDC member and then sent to the EPPP Step 2 Examination Committee for another level of review. Once the EPPP Step 2 Examination Committee decides to use an item, it will be pretested on an EPPP Step 2 examination to evaluate its performance. If an item achieves acceptable statistics in the pretesting phase, it will be incorporated into an upcoming EPPP Step 2 exam. Item writing will begin this year (2017) and will be an ongoing effort to develop and maintain a robust item bank.

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TIMELINE

The timeline for the development of the EPPP Step 2 is presented in Table 2. We have accomplished a number of the necessary tasks to date and are on schedule to launch the EPPP Step 2 no earlier than January 2019. In 2018 we will conduct beta testing for the exam, essentially pretesting items that have been developed. Beta testing will require volunteers who have recently passed the EPPP.

FEES

ASPPB has not set an exact fee at this time as it is too early in the development phase to estimate the total expenses to develop this exam. However, we are sensitive to the issue of cost for the candidate and initially have set the fee at no more than $600 (not including any applicable site fees).

CONTACT

ASPPB has posted a number of informational documents about the EPPP Step 2 on our website. We hope that you will access these documents and share them as appropriate. The full report of the job task analysis as well as the "Competencies Expected at the Point of Licensure" including the actual competencies and the behavioral exemplars are now available. Additionally, videos discussing the development of the competencies and discussing the assessment of the competencies are included on the ASPPB website. There is also a volunteer form for those who wish to volunteer in the development of the EPPP 2.

If these online resources do not answer questions you may have about the EPPP Step 2, please feel free to contact the Chair of the EPPP Step 2 Implementation Task Force, Dr. Emil Rodolfa, or ASPPB's Chief Operating Officer, Dr. Carol Webb.

ASPPB web site: www.asppb.net/epppstep2

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University Counseling Centers

By Rhandi Clow, PhD

Over the course of the internship imbalance, many applicants have gone unplaced and in search of opportunities to help them to further their careers. During those years of placement difficulties, trainers at university counseling centers (UCC) internships held no shortage of concern about the experiences of hard-working, competent graduate students whose career paths were interrupted by the shortage of internships in general, and accredited internships in particular. A colleague of mine in the Association of Counseling Center Training Agencies (ACCTA) spoke recently of the position of privilege that internships have had over the past 20 years due to the match imbalance that began to develop roughly 50 years ago (APA, 2007).

UCC internships have traditionally been kind of a niche market in the psychology internship system. This speaks to something of a double privilege for UCC internships in that not only was it a "seller's market" during those 20 years but for counseling centers there was a ready-made group of applicants that we're looking to be placed particularly in counseling centers. These applicants typically had been "raised" in a Counseling Center atmosphere through early UCC practica, and were coming somewhat prepared to step into an internship in a UCC. Through ACCTA and APPIC, UCC Training Directors (TDs) have been fortunate to have shared resources and support in our efforts to provide a somewhat homogeneous set of offerings. UCC internships are not cookie-cutter, mind you, but a UCC is pretty typically a UCC across the board. You have a schema, an image of what to expect in a UCC internship.

To quote Allison N. Ponce, Ph.D., in a recent e-mail, the last few years have seen a dramatic correction of the internship imbalance, and this year there [were] more internship positions available in Phase II than ever before. This good news led me to consider what possible impact the rebalance might have not only on applicants but now on Counseling Center internships as well. Now we have an opportunity to consider what may be important considerations in filling our internship positions where perhaps this had not been a critical issue in the past era of internship privilege.

It is worth pondering what the overall impact of the market correction, so to speak, might be if the trend continues for a while. Responses to a recent survey of the ACCTA membership exploring their experiences of the 2017 APPIC match may give us a glimpse at how things might be changing in our experience.

Of Counseling Center training directors who responded to the survey 61% said they filled all of the positions they had offered in the match. Of those responding, 18 % entered Match II with one unfilled position, my own program among them, and 20% of the 44 responding training directors said that in fact they had gone to Match II with two or more positions unfilled. The TDs whose programs had unfilled positions going in to Match II were asked if they were concerned in any way about the outcome of the 2017 Match. Only one brave soul among them said they were not concerned while 18% said they were a little concerned about the outcome and 76% of them shared that "Yes" they are concerned about that outcome. TDs in Match II were also asked, "as a result of your participation in Match II, have you questioned your program's ability to attract high-quality candidates in the climate of the new balance?" I was somewhat surprised to find out that 80% of the training directors who went to Match II with unfilled positions do question their program's ability to attract high-quality candidates in the future. Likewise, 87% question their program's ability to fill positions in Match I in the future. I question whether this has been a great concern in the past years of program privilege.

The rebalance and the predictions of its potential impact on Internships winding up in Match II is a mildly bittersweet, but easily understandable outcome for those of us at the forefront of the match system. For others, counseling center staff directors and university administrators who have perhaps grown accustomed to our imbalance privilege over the years it may not be as readily understandable. Of those training directors of Counseling Center internships who experienced unfilled positions in Match I this year, 60% felt pressured to explain those unfilled positions. One can assume that in response to the pressure they felt, 53% reported that they had prepared an explanation to be given to their director, 60% had prepared an explanation for their staff, and 27% for administrators.

Responding mainly to my own internal reactions to being in Match II, I was keen to ask UCC TDs if they would seek to make changes not related to compliance to the new Standards of Accreditation before next year's application process. Of the respondents, 55% said "Yes", they will change something assumedly to increase their attraction to qualified applicants. Among the possible changes were changes to the site's webpage (55%), changes to advertising their positions (14%), changes to program offerings (7%), and changes to their APPIC online directory page (3%).

One TD communicated that her program had been in Match II the past 2 years consecutively. "As a result" she stated, "this year we increased the number of applicants we interviewed by almost 1/3... and also had a much needed increase in intern salary that happened just prior to ranking deadline, so that likely also influenced rankings." Her program matched all their positions in Match I.

I think this is an exciting time in training and especially for applicants as the balance of match privilege rolls to their side of the equation. I further look forward with optimism to the collaboration and comradery that UCC TDs have long enjoyed. I believe the net effect of the rebalance will be stronger, more refined, and well integrated internship programs that will bolster the field of Health Service Psychology and ultimately prophet those we serve.

A Model Social Learning Program

By Edward E. Hunter, Ph.D., ABPP

I am particularly delighted to write a column this season. This is because I am very proud of one of our former psychology interns who recently came back to The University of Kansas Medical Center to present to our current interns. I have written about her before. Her name is Brandy Baczwaski, Ph.D., and she has had a longstanding commitment to working with Severely Mentally Ill patients. Dr. Baczwaski went on from our program to do a postdoctoral fellowship at Fulton State Hospital in Fulton, MO. Subsequently, she accepted a staff psychologist position at that institution. This article is especially about the program with which she is involved at Fulton State Hospital. It is the best program for patients with Psychosis of which I am familiar.

Dr. Baczwaski's work is with the Social Learning Program, which is one of four different programs for patients with particular characteristics (e.g. substance abuse program, sex offender program). The Social Learning Program is for persons with Psychotic Disorders, and focuses on these individuals who have lost or never learned basic social and coping skills. The program was originally developed in consultation with the authors of the seminal work of Paul and Lenz (1977) on social learning in psychotic patients. The general goals of the program are to increase quality of life, independent functioning and decision-making, and to reduce unusual behaviors, as well as any aggressive behaviors. The fundamental assumptions are that skills are need for successful community living, that all people can and do learn, and that all interactions have therapeutic potential.

One of the great strengths of the program is that it is based on a solid, empirically-grounded psychological framework. This is learning theory, including operant conditioning. The program applies learning theory principles to a very practical clinical situation. The application includes differential reinforcement of verbal and nonverbal behaviors that are desirable, shaping and modeling, and skills training. As an example, skills training involves individualized planning and depends on the level of functioning of the patient. Shaping, in a very dysfunctional patient, might include putting away a single article of clothing along the way toward a goal of keeping their room clean and neat. The skills training also utilizes role play, repetition and homework.

The social learning program takes place within a token economy. This follows operant theory with tokens leading to backup reinforcers, which include goods and privileges. A fading approach is taken with gradual removal of program administered reinforcers replaced with naturally occurring reinforcers. These can include desirable alterations in schedules such as free time within a levels system. Groups for patients include self-care training, job skills, anger management, fitness, substance abuse, illness management, and many others, depending on the individualized need of the patient. However, importantly, the group leader is separate from a change agent in each group, who specifically monitors for desirable behaviors or undesirable behaviors in the group, in order to provide reinforcement.

Eliminating undesirable behaviors is achieved via the same operant theory, with application of extinction and response costs such as fines, time out, and natural consequence. For example, fines for infractions depending on severity, are imposed which reduce the payoff of tokens earned, with individuals able to restore their value of tokens by being free of infractions for set numbers of days. Difficult client interactions are studied from a behavioral standpoint, looking for cues, reinforcers, etc, which can identify high risk situations, for instance, including denials of privileges, overwhelming activity demands, feelings of hopelessness, etc. Plans are then modified to suit the problem.

The controlled environment of the hospital setting, where patients may stay form many months or years, facilitates considerable progress for the patient.

The staff are a highly multidisciplinary group, with an egalitarian planning approach. The structure involves a team, which includes a psychologist, social worker, recreational specialist, educational specialist, pharmacist, substance abuse counselor, dietitian, nurse, psychiatrist, nurse manager and program director. There is a team leader who can be of any discipline. The psychologist's role includes psychological therapies, case management, data collection and reports, and supervision of interns, postdoctoral fellows and students. A team of individuals, completely separate from the clinical team, continually monitors the behavior of the staff for therapeutic fidelity, and provides regular feedback to all staff on performance. This method, rarely a part of psychological interventions, is, in my opinion, one of the most powerful aspects of the program.

The program is not all work, with play and fun activities such as games, gym, art, music, gardening, holiday parties, etc. part of the experience. In my opinion, a program like this could not be run effectively without the environment being supportive and welcoming, with staff who are positive and motivated. In fact, this is a part of the program's guiding principles. Dr. Baczwaski convinced us that these features are a reality at Fulton State Hospital.

I let Dr. Baczwaski know that I would promote her program, because I was truly extremely impressed by the effort put into designing the program, and the rigorous implementation of psychological principles involved. It struck me as a fantastic place for training and work for psychologist, including training at the internship level and postdoctoral level. Obviously, the appropriate candidate at any level must be a person with a high interest in a severely mentally ill population. There is much to be learned at Fulton State Hospital. Check it out!

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Link to presentation of the Social Learning Program at Fulton State Hospital:

https://prezi.com/ljdsmxucfe3d/a-social-learning-approach-to-psychiatric-rehabilitation/?utm_campaign=share&utm_medium=copy

Supervising Trainees with Disabilities in Psychological Assessment

By Erin Andrews, Psy.D., ABPP

Training directors and supervisors often have questions about how to teach and supervise psychology trainees with disabilities in the area of psychological assessment. Even though some licensed psychologists do not conduct assessment in their practice, all psychology trainees require assessment training in order to complete mandatory graduate coursework, secure clinical training positions, pass licensure examinations, and become gainfully employed as a psychologist (APA, 2011). Further, even psychologists who do not perform assessments need an adequate knowledge base to utilize assessment results completed by other psychologists (Krishnamurthy et al, 2004).

Psychological assessment is an integral function of psychology. Rather than a simple process of test administration, psychological assessment is a complex, integrative and conceptual activity (Krishnamurthy et al, 2004). The APA competency benchmarks for the practice of professional psychology includes psychological assessment as a functional competency, described by behavioral anchors for various trainee developmental levels (Fouad et al., 2009). Under the assessment domain, the following skill proficiencies are included: measurement and psychometrics, evaluation methods, application of methods, and diagnosis (Fouad et al., 2009). This highlights the fact that there are many facets to the assessment process.

Psychology training programs must offer training that is consistent with that received by other trainees in the program, as per the Section 7.01 (Design of Education and Training Programs) of the APA Ethics Code (APA, 2002):

"Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program."

Supervisors and training programs should decide what type of knowledge is crucial for a trainee to have about a particular assessment procedure. Declarative knowledge indicates understanding of an instrument, whereas operational knowledge involves demonstration of the use of an assessment tool (APA, 2011). This may be best conceptualized as a continuum from exposure to experience to expertise and from declarative to operational knowledge (APA, 2011). There are several aspects of the operational knowledge of assessment beyond administration, including planning and test selection, scoring and interpretation, integration, diagnosis, and recommendations. Training programs should decide which of these are essential for trainee acquisition (APA, 2011).

Often, instructors are concerned that because of disability, a trainee may face limitations in completing assessment course requirements. However, there is no reason why trainees with disabilities should be excluded from assessment courses, even if it is anticipated that the trainee may never independently conduct psychological assessments. Psychological assessment requires both implicit and explicit skills (APA, 2011). Some implicit skills become explicit when the assessor has a disability. For example, psychomotor skills are required to handle testing materials and visual acuity is needed to observe an examinee's physical responses. In order to determine whether a trainee with a disability has the necessary skills, each skill must be explicitly identified. If the skills are not present, is may be possible for the trainee to acquire those skills by training or by adaptation to the assessment process. Time spent individually with a trainee to problem-solve difficulties and strategize solutions can be helpful. There are psychologists with significant disabilities who have learned, by training and practice, to seamlessly administer complex instruments. There are also psychologists who do not have and do not need a particular skill; a Deaf psychologist does not have the ability to hear an examinee's verbal response, but this is irrelevant when both the examiner and the examinee are fluent in and communicate using American Sign Language (ASL).

When aspects of a test serve as barriers to independently conducting an assessment, accommodations may be needed. There is a wide range of accommodations that may be appropriate, and each situation will be specific to the needs of the disabled examiner. Examples may include extended time to administer instruments, use of electronic versions of specific tests, an assistant to facilitate the placement or movement of testing stimuli, use of a psychometrician, breaking testing into several shorter sessions, or a modified testing surface. Supervisors should give careful consideration to the degree to which any adaptations could affect the validity of the assessment. Most standardized assessments measured require precise procedures for administering and scoring. Decisions to modify the protocol require thoughtful consideration and information gathering.

However, modifications of test procedures do not necessarily compromise the validity of the administration. Although we have some research to inform variations for

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disabled examinees, there is very little empirical information about the alteration of test procedures and materials to accommodate the examiner (APA, 2011). As many psychologists, especially rehabilitation and neuropsychologists, know, the purpose of any evaluation is to assess the patient's "best performance" (Caplan, 1995; Geisinger, 1998; Vanderploeg, 2000). As a result, sometimes modification of standardized test procedures for persons with disabilities is warranted. For example, an administration may be adapted for limit-testing when assessing persons with severe impairments (Caplan, 1995; Geisinger, 1998; Vanderploeg, 2000). As with adaptions made for examinees, case-by-case and subtest-by-subtest level decisions may be required with disabled examiners. Ethically, psychologists have duty to note the use of any accommodation in assessment reports, along with any interpretative cautions (APA, 2002, 2011).

Training directors or supervisors may feel uncomfortable broaching these issues with trainees with disabilities, especially those who are inexperienced in working with disabled trainees (Andrews et al, 2015). Frequently, the trainee will have some of the same concerns and may worry about how he or she will become competent in psychological assessment. It is best to take an objective and transparent approach, and be willing to consider creative and nontraditional solutions (Andrews et al, 2015). Solicit the trainee's input throughout the process, in order to enhance his or her professional identity and sense of competence (APA, 2011). Be willing to spend the time and exert the effort to facilitate the trainee's knowledge and proficiency in assessment. Available data suggest that psychology trainees with disabilities face considerable barriers to training, including graduate admissions and securing training placements. For example, disabled trainees are less likely to successfully match for internship than their non-disabled peers (Andrews & Lund, 2015). As a result, disability is severely underrepresented in a field that prides itself on diversity and promotes cultural competence. Training directors and assessment supervisors have the unique opportunity to foster the development of future psychologists with disabilities.

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Diversity issues

Election Based/Race-Based Traumatic Stress

By Lynette Sparkman-Barnes, Psy.D., University of Missouri-Kansas City

Since the Presidential Election in November 2016, something troublesome and phenomenal has been happening on our campus (and I wonder if on campuses across our nation). I don't think most of us were surprised at the shock, fear and disbelief our students conveyed after the election overall; however, I was surprised at how our Counseling Center was flooded with tearful students, faculty and staff members who felt so afraid and so disarmed by what occurred. We experienced an influx of students who exhibited clear signs of distress specifically associated with the election results. Most were white, most were female, most were tearful, fearful and worried about being sexually assaulted and worried about the repercussions regarding reproductive rights. And this did not only occur in our office, it was manifested in the number of campus wide processing sessions we were asked to lead, providing an avenue for many more students, staff and faculty members to process a sense of shock, fear and disjointedness. For months our staff has been engaged in being the backbone support, the needed undergirding to a wonderfully diverse population that was thrown into a panic and an unveiled feeling of disconnection from a reality that seemed (far too) comfortable.

Here is the phenomenal part:

Out of this processing and out of this pain, many who had been voiceless finally found their voice. Students, staff and faculty who had been silent for months and years found a safe place to speak honestly about their feelings and frustrations, either in the therapy room or in a moderate sized processing group experience. Through this post-election altered reality, we have seen new student leaders thrust into the forefront marching with righteous defiance and leading protests on campus and in the greater Kansas City community. Through this we've helped strengthen clients and colleagues to begin to define what is most meaningful for them, to reach beyond themselves and connect with others, and to form new relationships based upon the principles that fuel them right now, even if it means restructuring close and familial relationships based upon those same principles. In a sense, we seem to be witnessing a "growing up" of a generation and of a community overall.

But here are the troublesome parts:

PART I

As expected with such a tremendous feeling of upheaval and injustice, it has been answered with a sense of white fragility, an anger and fatigue associated with not wanting to hear or comprehend another's narrative of oppression, bias and discrimination (DiAngelo 2011). An ugliness has been uncovered as those who continue to sit in privilege work to negate the feelings and experience of the oppressed through their own protests, marches, and angry confrontations in the classroom, on the streets and even in some of the processing sessions.

PART II

What does being the sometimes catalyst and all times supporter of this level of processing do for those of us who are charged with leading these experiences? How does it impact us, as Psychologists, Licensed Counselors, Licensed Social Workers and trainees? We, too, are part of this population that is grappling with the meaning of this particular election.

PART III

Even more troubling, as a person and as a mental health professional of color, how is one supposed to feel about this level of distress in our white clients and colleagues? I am reminded of Carter's work regarding race-based traumatic stress reactions (2009, 2013, 2015), and am pondering not only my reaction to the election, but my reaction to having to take on the role of helper/care-taker to a segment of the population that only just now appears to be gaining a seminal understanding of oppression and the fear, trauma and frustration associated with it.

I am fortunate to work in an environment where I can be honest about my frustrations at colleagues who now want to be allies in the fight for human rights, but who were not as enthusiastic or present when the fight for human rights focused on race, sexual orientation or disability status. I work in an environment that can withstand my overtly spoken desire to not take care of the white woman feeling scared that she might be sexually assaulted because of an exposed culture of rape and misogyny, and where I can speak up and say I come from a group that has had to fear not only rape culture, but also the other "isms" that we've been fighting against for years. But I realize that not everyone can speak so freely in their work environment.

So, I wonder, as a person of color experiencing race based stress, who is now having to help those who have been privileged by not having to recognize or do anything about that stress - but are now experiencing significant levels of distress associated with the unmasking of their vulnerabilities within their gender identity….Is it re-traumatizing for members of historically and presently oppressed groups to be the holder of these spaces, to be the care provider in such circumstances?

I'm not sure of the answer, nor am I trying to persuade anyone of anything. I only want to ask the oft overlooked question. We are in a pivotal point in history, a point where overt "isms" cannot be denied and a point, reminiscent of the Civil Rights era, in which we truly understand that we are all needed in the fight for social justice and human rights. There is no room for "pecking orders" or hierarchies of oppression, because as Fannie Lou Hamer put it, "Nobody's free until everybody's free."

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What do you do when informants disagree on rating scales?

By Beth Jerskey, Ph.D.

Trainees often ask about how to reconcile differences reported in rating scales of behaviors. In neuropsychology, the use of multi-method, multi-informant for assessment is not only good practice, it is oftentimes a necessary part in making a diagnosis. Rating scales are an efficient way to capture the presence and severity of specific symptoms and are often given to teachers and caretakers as well as the individuals being assessed. In many cases there are discrepancies in how informants report symptoms and decades of research have demonstrated that this is more than simple measurement error across the scales (see De Los Reyes et al., (2013) for review). To gauge the accuracy of reports is difficult and there may be value in the inconsistency between informants. In their seminal article on the subject, Achenbach and colleagues (1987) conducted a meta-analysis and reported several main findings as to the reasons for rater dissimilarities and they found: reports from different informants resulted in low to moderate levels of correspondence, reports from informants playing similar roles were higher than reports from informants in different roles in different settings, reports of school-aged children corresponded more than that of adolescents, and reports of externalizing behaviors (e.g., hostility, distractibility, bullying) corresponded more than reports of internalizing behaviors (e.g., withdrawn, depressed, apathetic). There were also no significant differences between mothers versus fathers, ratings for boys versus girls, or clinical versus non-clinical samples.

Discrepancies can be seen as either an artifact of perceptual differences between raters or a true difference across contexts and both can be informative. If we take the approach that discrepancies are simply due to a perceptual difference, and less likely an actual behavioral change across environments, the use of semi-structured interviews may yield a better indicator of the severity of symptoms (e.g., teachers may have different base rates in which they are measuring a child compared to parents, elevated stress in the home environment may inflate parent ratings). There may be cases in which the over- or under-endorsement of a behavior by one rater is inconsistent with clinical history or presentation (e.g., a parent may report that a child "never" makes eye contact, however, during the evaluation there are multiple instances of appropriate eye contact between the examiner and examinee). However, be cautious when determining the extent to which an informant is endorsing behaviors. Some rating scales have embedded validity indicators of negativity and inconsistency, however, before ruling these scales as invalid it is important to again consider the rater within the context (e.g., are behaviors being viewed as overly negative or could the behaviors actually be the severity in which they are reported?)

What is often the reason for informant differences is that behavior is actually different depending on the environment in which it is being measured. This would be consistent with Achenbach et al. and would yield more fine grained recommendations that are specific to different environments. Not only is providing tailored recommendations clinically in the best interests of the individual being assessed, discrepancies in and of themselves have also been shown to serve as a prognostic indicator for response to subsequent treatment (e.g., Panichelli-Mindel et al., 2005). Since there are some behaviors that are more consistently reported than others between informants, it is always recommended that trainees have an appreciation for symptoms they most likely will encounter in their practice (e.g., activities of daily living in geriatric assessments, executive dysfunction in ADHD) and an understanding to the extent to which differences in informant report are informative.

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Setting-related issues
Politico-psycho-diagnosis revisited

By Robert H. Goldstein, PhD

To return to a topic previously discussed in this column could, perhaps, constitute an activity that would fall under the purview of the Department of Redundancy Department. Nevertheless, the subject of the above-titled matter, while explored previously in an admittedly somewhat jocular manner, has now become a topic of serious dispute.

In my last column, I had suggested that it would be good policy to teach our trainees to avoid expressing diagnostic judgments about political candidates. While, as I noted, our APA has no explicit ethical guidelines on this, our sister (brother?) mental health organization (the ApA) has promulgated the "Goldwater Rule" which asserts that it would be unethical for a diagnostic judgment to be made by a psychiatrist about any public figure absent a personal evaluation of that individual. And most mental health professionals have accepted that principle and behaved accordingly.

There have, of course, been historical exceptions to this principle. After World War II, psychological profiles of some of the German leaders, most notably Adolf Hitler, were written to much public acclaim. And it is probably not well known that Sigmund Freud had co-authored a book-length psychological study of U.S. President Woodrow Wilson, without ever having met him, but with the collaboration of an American diplomat, William Bullitt, who knew Wilson and had had extensive contact with many who had been close to him.

During the recently concluded presidential campaign, however, and particularly since the inauguration of the current president, circumstances seem to have changed markedly. The self-imposed limitations on psychological analyses of political figures appear to be no longer in effect. So, should our advice to trainees also be modified?

The press and other media have been filled with the controversy surrounding opinions which have been expressed by a variety of mental health professionals regarding the current president's mental health or otherwise. Most likely, many of your trainees have seen this eruption of conflicting views and may approach you for clarification of what is the proper role of a psychologist in this arena, and what is not.

We have now already had an opportunity to observe a sufficiently substantial sample of presidential behavior that it would be difficult to escape the conclusion that his behavior is different from what we have seen in his predecessors. The data are pretty clear in this regard and it is no longer a matter of making huge inferential leaps about what traits or characteristics can be understood to be operating in the behavior patterns that are in evidence. The more complex questions relate to how these should be interpreted, what conclusions, if any, can be drawn from this and what actions, if any, should follow from such conclusions.

One group of clinicians has asserted quite explicitly that we are seeing definitive indications of serious character pathology, and the term "narcissism" has typically been included in the opinions being expressed. Almost any even reasonably objective observer would have to agree that that term has some considerable relevance in describing what we are seeing on a daily basis. Whether this is a matter of "style" or character or personal pathology is where opinions clash, not to mention whether or not it is even proper to speculate about the diagnostic judgments that can flow from these observations. Very few people who run for the office of president are deficient with regard to narcissistic qualities. But how far from the norm is acceptable in such a powerful office?

A well-regarded medical school-affiliated psychologist has opined publicly that what we are seeing is undoubtedly an indication of "malignant" character pathology. An eminent psychiatrist, himself the author of the DSM-5 criteria for Narcissistic Personality Disorder, has argued that a diagnosis of Personality Disorder requires evidence of some type of personal distress or impairment of functioning before the label is justified, and that indications of those have not been apparent. A petition circulated within the mental health community has called for serious steps to be taken by way of evaluating the president's mental fitness for the office he holds. Others have already begun to call for impeachment proceedings to be initiated on the grounds of inability to fulfill the responsibilities of the office.

The argument has been advanced that, despite the commendable ethical intentions underlying the "Goldwater Rule" of not leaping to diagnostic judgments, the ethical obligation of a "duty to warn" overrides that rule. That is, not an individual, but rather a whole society is in danger of being harmed as a result of possible ill-considered, impulsive or simply uninformed and precipitous actions by someone whose character predisposes him to taking such actions. A conflicting argument has raised concerns about the entire mental health profession being viewed negatively and losing creditability as a consequence of injecting itself into partisan political battles. And yet another position that has

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been expressed is that using diagnostic labels to characterize unpleasant behavior runs the risk of unnecessarily stigmatizing atypical human behavior.. ("So he's just a jerk, but so what. That doesn't make him sick".)

Well, then, what do we tell our students? I would suggest that we urge them not to reach firm conclusions about degrees of pathology that can be inferred from the behavior they observe in the political arena. If pathology is present, it will likely become more apparent as the stress of the presidential office settles onto the occupant, as that stress invariably does.

Perhaps we might want to seize the present circumstances as an excellent opportunity to observe quite directly what the trait of narcissism looks like. A small task to consider might be an exercise that involves listing the criteria for Narcissistic Personality and then observing the news and media for examples of the behavior included in that list. I understand that some may want to march in the streets with signs disparaging or supporting the president and while this might release some tension, what does one really learn from that experience? Our role might more properly be to find what can be learned about the human condition from the chaos through which our nation is passing.