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President's Message

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What We Know About Excellence in Training
(CCPPP 30th Anniversary)

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The CCPPP celebrated their 30th anniversary at the CPA Conference in Ottawa in June 2007. We had a panel of presenters who collectively have a wealth of experience and knowledge about training both for academic and internship programs and the CCPPP. We are very happy to publish this Special Edition of the CCPPP Newsletter with the proceedings from the workshop. Participants heard about training excellence and the bumps along the way! from the collective experiences of the panel through their roles as directors of clinical training programs, accreditation site visitors, department heads, recipients of the CCPPP award for excellence in training, and authors of published articles on training.

This workshop reviewed the history and evolution of professional psychology training and the development of the CCPPP. The history and path of accreditation in Canada as well as future trends was also discussed. Current and past models of training (doctoral and internship programs) were reviewed. The workshop addressed present and future trends in training, including aging of the profession (including interns and graduate students!), gender differences within psychology, as well as issues of competency-based training and other trends occurring in professional psychology training.

We hope you will enjoy this Special Edition on the past, present and future of professional psychology training in Canada.

Professional Psychology's Path of Development

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Travel on a journey can be enriched by looking back on the path traveled. To gain such a perspective on our discipline, this commentary examines clinical psychology's earliest days, with special emphasis on the creation of the Boulder Model of training. Pieces of our history are reviewed to better understand current trends in training and practice.

<u>Our Humble Origins</u>
G. Stanley Hall laid the first brick in the psychology house when he called three dozen scholars to an organizational meeting

of the APA in 1892. This moment in our history had been preceded by Wilhelm Wundt's 1879 Leipzig lab and G. Stanley Hall's 1883 Johns Hopkins lab, both giving impetus to "a new domain of science" (Fancher, 1979,126). Clinical practice was soon to follow.

The birth of professional training can be dated by the opening of Lightner Witmer's University of Pennsylvania Child Guidance Clinic in 1876. Within a year, practicum students were admitted to his agency to learn parental guidance skills. Although an important first step, only a few community agencies emerged over the next decades; the time was not yet ripe for our profession to emerge. Perhaps we were awaiting advances in measurement technology that were just then arising in the work of Binet, Cattell and others. Indeed, it was not until the 1920s that clinics appeared in universities and gave our young profession a boost. In that decade, eight schools came on line to offer Ph.D. training in psychology (Routh, 2000). With special energy, Columbia had produced 25 Ph.D. graduates by 1930.

Concurrent with the emergence of the first clinics, professional psychology associations turned attention toward issues of practice. For example, in 1920 an APA committee was struck to consider certification of test examiners. Because only 25 members applied for that status by 1923, the certification plan was discontinued (Shakow, 1969). Not discouraged, the APA's Clinical Section then developed a special committee on Standards of Training for Clinical Psychologists, and by the mid-30s APA boldly set forth recommendations on how to train professional psychologists.

Late Adolescence

It was in the 1940s that clinical psychology burst into full bloom. Like adolescence, these years were active ones, with vigorous debates about identity issues. The major historian of these events was David Shakow who was the spokesperson for the all-important Boulder Model from a conference held in Boulder, Colorado. That model emerged from a two week-long toil of 73 participants and gave voice to the need for joint contributions of science and practitioner skills in all professional psychologists (Shakow, 1942).

A Brief Review of Features of the Boulder Model

A. *Non-controversial Early Views*:

- Boulder conference participants readily agreed on the need for a rigorous education, one that is every bit as academically rigorous as that required of non-clinical students. (However, one cannot help but recall the tongue-in-cheek definition that Raimy gave for defining the "rigor" of psychotherapy training, saying, psychotherapy is "…an undefined technique applied to unspecified problems with unpredictable outcome; for this technique we recommend rigorous training" [Raimy, 1950]).
- Our intellectual parents argued for integration of theory and practice, not only within a university, but between university and internship training programs.
- Students should have opportunities for client contact throughout all years of their graduate program.
- Students should develop a sense of social responsibility.
- Students should be made keenly aware of the research implications of their practice and acquire a life-long investment in scholarship.
- A steady dedication to core areas of psychology was emphasized.

B. Some Contentious Early Issues:

- Many argued against having overly detailed rules about programs. This was, and still is, a feisty concern. Academics get their feathers ruffled when they hear prescriptions that give exact stipulations for programs, despite concurrent instruction to set their own means and goals.
- There were arguments against courses on technique training, favouring instead broad education.
- In 1969 Shakow wrote that he didn't like the immodest quality of psychology – he felt we showed too much personal arrogance. He also thought there were too many psychologists in private practice, although only a paltry 15% at that time.
- Current critiques echo some of Shakow's concerns about ill-educated and unreflective students. For example, Paul Meehl in his classic 1973 paper entitled "Why I Don't Attend Case Conferences" was irate about students' lack of curiosity and their failure to appreciate statistical issues (e.g., base-rates in decisions and in making predictions). Other voices have echoed these concerns (Chapman & Chapman, 1969 and Dawes, 1994).
- There is a steady decline in assessment practice. Although public opinion polls regard psychologists to be "the test specialists" (Lerner, 1980), an early fondness for assessment (and the teaching of basic testing skills) has been much reduced in our academic programs; (Newman & Taylor, 1996). Moreover, professionals' choice of tests has seemingly petrified; year after year, polls find we endorse the same few "sacred" tests (Lubin, Larsen & Matarazzo, 1984).

C. Continuing Issues:

Although current training emphases tend in large part to agree with opinions generated in the 1940's, a number of issues linger.

- A perennial bugaboo, the clinician - experimental rift, is still with us. During the '40s when academic clinicians were not terribly abundant - - perhaps working in remote corners of the university - - there was no threat to the status of hard-nosed psychology. Then came World War II, with many veteran casualties requiring our service. The rapid development of the U.S. VA Hospitals and Public Health Services brought in money and clinical trainees in abundance. These developments tended to redistribute the power balance in academic departments. With this shift came "territorial" clinical-experimental skirmishes. Considerable tension ensued. The term "Damn Clinicians" replaced "Damn Yankees" in departmental vocabularies, reflecting a religiosity about the distinctions. The following table gives some of the pejorative terms used for each wing of our enterprise.

Author	Experimental	Clinician
Meehl (quoting Russell vs Whitehead	Simple-minded	Muddle-headed
D. Shakow	Virgins	Prostitutes
G. Albee	Anal-retentive	Oral-dependent

<u>Turning the Corner in our Adulthood Year: the 1950s and 1960s</u>

Clinical graduate students in the 1950s (my era) were emotionally buoyed by the idea of the scientist-practitioner model. However, mainstream faculty themselves had variable amounts of "practitioner" training. Consequently, students received different messages from the methods-bent academics who worked on their "left-brains" and the practitioners who looked after the "right hemispheres". Although the blend of the two traditions was expected to produce well-hyphenated "scientist-practitioners", the

early '50s curriculum primarily featured large doses of hard-nosed psychology.

The Academic Curriculum. In accord with the Bouler model, my experience at the University of Illinois in the late 1950s found clinical students well-educated in topics common to the education of non-clinical students. The curriculum then was rich in "general-experimental" psychology topics, lots of statistics, a two-language proficiency, and experience with laboratory apparatus (t-scopes, rat runways etc.).

With respect to clinical skill development, a bit of abnormal, developmental and personality theory was injected into the curriculum, but we listened with frustration to uncritical accounts of Freudian dogma and debates about the number of basic factors (16, 3 or many) in the structure of normal personality. Clinical skill training was scanty then. Although precise scoring practices were taught to summarize projective test protocols, personality constructs were fuzzy and diagnostic categories stretched credibility. It was evident too that clinical faculty were often located outside the main corridors of academic departments, although those people were much appreciated by clinical students.

The Emotional Climate of Meetings in the 60s. As an antidote to the frustration arising from a graduate school curriculum that sought to meld two diverse world views, and taught by professors who were engrained in one tradition, major convention addresses at that time generated excitement about promising advances. As noted in Steffy (2003), a few memorable moments included:

- Harlow speaking of maternal attachment (complete with the chicken wire, terry cloth covered, and nipple-laden forgery of monkey mothers). In addition to Harlow's compelling data and theorizing, his Sunday morning scientific award address was made vivid by the use of slide after slide of monkey copulatory activity and a boldly blasphemic caption of "A Sermon on the Mount" (Harlow, 1958).
- Paul Meehl's (1962) presidential address entitled "Schizotaxia, Schizotypy and Schizophrenia". This paper toppled the psychodynamic doctrine about bad parenting practices as the root of schizophrenia – destroying the "schizophrenogenic mother" concept.

Although there was excitement in the presentations of field leaders, the bulk of 15 minute long convention papers in those years were deadly dull, with little attention to ideas and to argument. Could it be that the tedium of these talks inspired the high levels of alcohol use that was a regular part of students' convention activity?

Training In the 60s. A fresh force appeared in our field in the 1950s and 60s, and its presence energized us all. Operating virtually as a callosal pathway between academic faculty's "left" and our clinical faculty's "right" brain interests, new academic perspectives were emerging to integrate hard and soft psychology, thus fulfilling the Boulder Model dream. Contributing influences came from Dollard and Miller's (1950) blend of Hull's and Freud's theories, the social learning theories of Rotter (1954) and of Bandura and Walters (1963). Bruner and Postman (1947) awoke us to the "new look" in perception. Early efforts to introduce cognition into our view of human motivation (e.g., George Kelley's [1955] Construct Theory) were welcome. Reitan's use of neuropsychological tests to chart brain damage, and to do so with remarkably good levels of accuracy, became a darling of the curriculum (Reitan & Wolfson, 1993).

By the mid-60s, a major revolution in clinical practice was emerging, for example, Wolpe's (1963) classic work on anxiety treatment and the publication of the first behavioural therapy journal (Behaviour Research and Therapy appearing in 1963). Skinnerian operant-based learning theory paradigms – as championed by Allyon & Michael's (1959) work in developing "token economies" – showed that psychotic behaviours are under operant control and can be ameliorated by behaviour modification strategies. One of my friends got his Ph.D by training schizophrenics to reduce "sick talk" utterances (Meichenbaum, 1966). Another's dissertation compared psychodynamic and behavioural therapy strategies in treating anxious individuals (Paul, 1967).

These advances were in the air at the time I reached vocational puberty. It was an exciting era. Even though my training had not yet embraced the new behavioural technologies, who could resist their use? After graduation, my first personal efforts pursued aversive conditioning strategies with incarcerated pedophiles, and also attempted a "token economy" project to serve highly regressed and aggressive patients who had been locked on back wards for many years. Aspects of the latter worked well; the former was not as effective.

Afterthoughts criticizing the Boulder Model

Not everybody was delighted with the Boulder Model development. Some cautioned against it's practicality and it's suitability. Many students rose up in indignation about the lack of personal relevance of dissertation work, in light of their personal intentions to provide service and not conduct research (Wright and Cummings, 2001). Particularly strong objections were voiced by George Albee.

George Albee's Admonition. Had graduate students not been much excited by the thought of a science-practice rapprochement, APA Ex-President George Albee's (1970) concerns might have extinguished all enthusiasm. Albee thought the Boulder Model was doomed to be a failure. He said we had no right to expect that scientist and practitioner roles could be contained in any one Ph.D's brain. He noted that the mentality of the clinical guild (featuring secrecy of technology, intuitive reasoning and idiographic strategies) openly clashes with scientific method (featuring rigorous hypothetical-deductive strategies, nomothetic analyses, and free sharing of information), and he felt that these contrary mindsets are impediments to harmony in professionals' brains.

Onwards and Upwards

Since the time of these early developments (during the '40s, '50s and '60s), professional psychology's efforts have burgeoned. We have witnessed, and continue to see, exciting advances into understanding the nature of psychological disorders. We also see a variety of new treatments propelled by a desire to develop "evidence-based practice". The reader is recommended to Hunsley's (2007) thoughtful discussion of this development. As well, prevention efforts to assist the population's physical health have been making strides (Arnett, 2006). With these new developments in mind, it is clear that the energies unleashed in psychology in the 1940s are still building muscle and recognizing creative advances.

Commentary

This brief historical account ends without attention to recent professional developments, e.g., Psy. D programs, the influence of HMO sources of funding, continuing debates over how a curriculum can best ensure professional competencies

(Benjamin, 2001), specialty designations, etc., etc.. Although professional psychology seems to be blossoming, this paper has suggested that one should revisit the past to better grasp directions for the future.

The 1950 Boulder Model arguments had emphatically affirmed recognition of our scholarly roots. That history should caution our education efforts about practitioner skill training that fails to value the core discipline. I notice, for example, that the abundance of clinical practice workshops advertised every week in my mailbox stands in stark contrast to scanty advertisements alerting to research developments. Is it time for another Boulder Model Conference that re-invigorates curiosity about the utility of our core areas? My wish list would include exposure of students to the sciences of emotional regulation, sub-cortical brain circuitry, behavioural genetics, neuropharmacology, psycho-immunology, decision processes and other domains that have implication for life development. Everywhere I look promises connections for improved understanding of the human condition, but I doubt that many others are looking intently. And the history of our profession suggests that the entry of new (and more complex) core content will take acts of courage for our already quite busy professional training programs. Reviewing the past prompts one to ensure that the scholarly aspect in our hyphenated model is not neglected.

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A Brief History of Professional Psychology Accreditation in Canada: The Journey to the "Grand Day" of National Accreditation and Implications for the Future

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In 1984 Mary Wright expressed the hope that "someday Canadian psychologists may agree on a set of national standards for both the training and credentialing of professional psychologists – in spite of our cultural diversities", and exclaimed that our success in attaining these goals would be a "grand day" (Wright, 1984, pp. 194-195). Although

we are now accustomed to national standards for the accreditation of doctoral and internship training programs in professional psychology, this was a novel and for some a threatening prospect – "grand" may not have been an adjective they would have readily adopted 23 years ago!

So what is this article about? First, I briefly review events that lead to the development of Canadian professional psychology training and accreditation, followed by a description of the role the Canadian Council of Professional Psychology Programs (CCPPP) played in this debate. Having a basic template of the history of Canadian professional training is essential to understanding of how we got to the point where national accreditation standards are well accepted *a mari usque ad mare.* I end by offering some thoughts about what we may need to do to make Canadian training in professional psychology even better than it is today.

A Brief Historical Survey of Canadian Professional Psychology Training and Accreditation

Although clinical training in Canada was in "full swing long before World War II" (Wright, 1984, p. 192), the war served as an impetus for the further growth of professional psychology after it had established its utility in the area of the selection, training and rehabilitation of military personnel (Conway, 1984). Education, health, government and industry began to demand psychological services, and in 1949 the National Research Council and Health and Welfare Canada granted some funds to support graduate students.

Despite these promising beginnings, clinical training in Canada faced a number of obstacles. Psychologists employed in applied settings were afforded little professional status, their roles were restricted, remuneration was less than generous and there were no accepted standards or procedures for professional licensure (Conway, 1984). Moreover, by the early 1950s there was what Conway labeled a "backlash" against professional psychology (Conway, 1984, p. 178). Academic psychology departments in Canada were struggling to gain the respect of "hard" scientists in their universities and consequently emphasized basic research areas in the discipline. Macleod's report (MacLeod, 1955) on the state of Canadian psychology exemplified the notion that professional psychology and clinical training were "premature" and that the emphasis should be placed instead on rigorous basic psychological science.

In the early 1960s CPA began to examine the problems confronting professional psychology and in 1965 sponsored the Couchiching Conference to develop a definition of professional psychology. This was a significant event in the development of clinical training. Participants reached a consensus regarding the basic components of training. They endorsed a scientist-practitioner model leading to the Ph.D. within departments of psychology, supported solid training in general psychology and in theories and principles underlying clinical skills, as well as broad-based training and continued practice in assessment and treatment domains. In a recommendation that presaged by several decades CPA's current accreditation standards, conference participants recognized that professional training must prepare students to teach and supervise individuals with less training.

Many academic psychologists were not committed to the Couchiching model but the substantial growth of Canadian psychology faculty in the 1960s, especially those

teaching popular undergraduate courses in abnormal, personality and clinical, lead to the development of graduate programs. In most university departments clinical programs grew to become the largest graduate program, thereby solidifying their status, and the development of practicum and internship programs in the 1970s enhanced the academic components of clinical training. Training in professional psychology had become securely established.

The Development of Canadian Accreditation Standards and Procedures

Serious consideration to accreditation of clinical psychology training programs emerged in the 1960s. The Couchiching Conference had recommended that CPA establish a Board of Education and Training that would accredit doctoral programs in applied psychology. The CPA Committee on Professional Affairs (1966, 1967) called for provincial psychology associations and CPA to jointly establish a set of accreditation standards and procedures via their participation in a National Council of Training Boards in Psychology. However, the CPA Board did not implement these recommendations, maintaining that education and training were the exclusive responsibility of the provinces and viewing itself as primarily a scientific society. Furthermore, the provinces were not interested or sufficiently united to effect the recommendations (Conway, 1984).

Conway (1984) laid some of the blame for the failure in the 1980s to develop national accreditation standards and procedures on CPA:

> CPA, for its part, has historically not provided national leadership in the development of clinical training…For years CPA maintained that it could neither say nor do anything about professional training programmes; the autonomy of universities was sacred, and the provinces had sole jurisdiction over educational and professional matters anyway. (pp. 186-187)

Wright (1984) provided a different perspective, arguing that it was not CPA but the BNA Act that slowed the development of professional psychology in Canada by giving the provinces the funds for training professionals and the power to accredit and control them.

At this point in the chronology the situation looked pretty bleak but the early 1980s saw a massive shift in CPA's apparent lack of leadership that coincided with efforts undertaken by CCPPP or, as it was known at the time, the Canadian Council of Clinical Psychology Programme Directors (CCCPPD), to develop accreditation criteria (CPA, 2002; Minnes, 2005). CCCPPD first raised the possibility of exploring accreditation at its 1980 meeting and established a working group to draft accreditation criteria. The CPA Board of Directors, via the CPA Standing Committee on Professional Affairs, supported this initiative and draft accreditation criteria were first circulated at the 1981 CCCPPD annual meeting. Ken Craig, a key player in the development of the criteria, noted that although the APA criteria served as an initial model, … these were substantially altered to reflect the Canadian context prior to the circulation of early drafts to directors of graduate programmes and internships in clinical psychology. Crucial differences between Canada and the United States in linguistic mix, ethnocultural make-up, regional dispositions, patterns of professional practice and health, education, and political systems dictate diversity. (Craig, 1984, p. 230).

Compared to the 1980 CCCPPD meeting that John Schallow (1984) estimated was attended by eight individuals, the prior circulation of the first draft of the accreditation criteria drew a large crowd to the 1981 and generated "heated debate" about the relative merits of OPA and draft CPA criteria (Craig, 1984, p. 230). Subsequent meetings in 1982 and 1983 were also well-attended and included lively discussions regarding the draft criteria. There was close cooperation between CCCPPD and CPA and in 1983 the revised *Accreditation Criteria for Clinical Psychology Programmes and Internships* was strongly endorsed by CCCPPD and adopted by the CPA Board (Minnes, 2005). The first meeting of the CPA Accreditation Panel was held in 1984.

While CCCPPD's active involvement in the accreditation debate undoubtedly moved the process forward, it also had a beneficial effect upon the development and growth of our organization. According to Schallow (1984), CCCPPD in the late 1970s and early 1980s was a very different entity:

The main thing that CCCPPD did for the longest time, as far as I could tell, was to have rather casual meetings for about two hours at the CPA annual convention. Having attended most of the meetings, I do not feel I am being unfair in characterizing them as usually ill-attended and primarily involving almost gossipy exchanges of information that we thought might be of mutual interest. (p. 229)

But after the 1981 CCCPPD meeting where the draft accreditation criteria were first debated, "CCCPPD became more organized and formalized, and begun to have a life beyond the meetings at the CPA annual meeting" (Schallow, 1984, p. 229). Consistent with a greater emphasis on the formal aspects of the organization, the CCCPPD executive began writing by-laws and collecting dues between 1982 and 1985. Both CCCPPD and CPA accreditation gained national stature in the 1980s via a mutually beneficial and reciprocal process, lots of hard work and close collaboration and cooperation – truly a "grand day" for both bodies!

Despite the happy ending, it was not accomplished without considerable acrimony and, as Ken Craig put it so diplomatically, "heated debate." The draft accreditation standards generated an array of reactions that ranged from outright pessimism about the chances of attaining a national consensus to strong support for better defined and higher quality training. Although the responses offer us a snapshot at the time of the perspectives on professional psychology training by many of the major players, they also serve to remind us just how far Canadian professional psychology training has come since the accreditation criteria were adopted in 1984.

What follows is a summary of some of the major issues raised in response to Conway's 1984 article and a review of how our current accreditation standards have addressed these concerns (All of the following quotes can be found in: Responses to Conway, *Canadian Psychology, 25*, 192-233).

1. Fear of sub-standard training in external settings

Payne (1984) claimed that the clinical training offered to doctoral students by external settings was highly variable, including situations where "the overworked staff of mental hospitals merely set the psychology interns the task of administering hundreds of Wechsler intelligence tasks to keep them out of the way…" (p. 202). Another variant of this theme was the concern that service demands in practicum

placements and internships would compromise training goals. The current *Accreditation Standards and Procedures for Doctoral Programmes and Internships in Professional Psychology* (2002) explicitly address this issue: "… interns' primary roles are as trainees. Training needs can be accommodated through service demands and service demands do not erode training goals. Interns do not spend more than two-thirds of their time commitment to the agency providing direct service to clients" (p. 73).

2. Concern about accreditation's exclusive focus on clinical psychology

In his response to Conway, Evans (1984) stated that "CPA should develop a set of criteria for applied rather than clinical programmes" (p. 214). CPA has indeed expanded the scope of accreditation beyond clinical psychology: counseling psychology (1989); clinical neuropsychology (1991); and school psychology (2004) programs can apply for CPA accreditation.

3. Cost to programs

Steffy (1984) summed up this concern that has dogged anyone who has been responsible for a doctoral program or internship, written a self study or gone to administration with cap-in-hand requesting extra money for the site visit: "Individual programmes will always find the demands of paperwork, arrangements for the visit, and other such details to be both a nuisance and a threat… One perennial difficulty that must be faced squarely is the financial cost of the accreditation visits and other machinery" (p. 222).

As someone who has done his fair share of grumbling and grousing about this issue during his 9 year tenure as the director of a CPA-accredited internship, I know that this is a reality of accreditation – we have to pay dues to support the accreditation process and infrastructure and spend lots of time completing annual reports and self studies. But I think all of us who have held such positions would agree that the benefits of accreditation far outweigh the financial costs and time commitments. Also, the recent development where APA will no longer accredit Canadian programs who apply for joint CPA/APA accreditation will reduce some of the costs.

4. Concern that the APA-based standards do not reflect Canada's values and heritage

In a commentary that predicted the future debate about this issue, Hart (1984) offered the following warning:

We well know and respect the accomplishments of clinical psychologists in the USA and in good conscience could simply adopt their standards and procedures. The consequences could well be to lose forever the distinctive perspectives and values that should be the cherished products of our different history. (p. 218)

Other Canadian psychologists later amplified this theme, arguing that holding a program in one country accountable to the standards of an accrediting body from another country may not respect or represent the political, educational, cultural or demographic context in which the program operates (Bowman, 2000; Cohen, 1999). It has served as one of the major arguments for those who have advocated that Canadian professional psychology training programs should jettison APA accreditation.

5. Pessimism about the possibility of attaining national standards

In the early 1980s there was a lingering concern that Canadian psychologists would be unable to put aside their differences to achieve a nation-wide consensus about

accreditation standards and procedures. Ferguson (1984) clearly articulated this sentiment:

I don't think that there has been a discernible *continuing* "national" dimension in applied training in psychology until quite recently. And it is my prediction that even the recent interest in the subject taken by CPA, which has been fanning the flames of a national training entity, will not succeed. (p. 223).

There are now 53 CPA-accredited doctoral programs and internships in professional psychology, thereby attesting to the fact that accreditation standards have been adopted nation-wide.

6. Do APA-based standards respect the diversity of Canadian training in professional psychology?

This issue reflects the tension between prescriptive and outcome-based accreditation models. Prior to 1996, the CPA accreditation criteria were very similar to the APA criteria; both were based on a prescriptive model that clearly defined the criteria and prerequisites for doctoral and internship programs. Catano (1984) raised questions about the applicability of a purely prescriptive model to Canadian training programs:

As Conway states, the process of accreditation will allow training programmes to benefit from an examination of their goals, activities, and achievements and from peer review and evaluation. However, these benefits will be derived at the expense of programme originality and regional identity. With national accreditation criteria, the homogenization of clinical training in Canada is inevitable. (p. 208).

In 1996-1997, the CPA Accreditation Panel undertook its fourth revision of the accreditation criteria and surveyed respondents' preference for a prescriptive or outcome-based model, the latter being sanctioned by APA in 1996 (CPA, 2002). Respondents were equally divided in their preferences, and the current criteria reflect an amalgam of the two approaches, a typically Canadian compromise.

Despite these concerns, other respondents were supportive of national accreditation. For example: "I strongly concur regarding the benefits Conway feels will accrue to Canadian clinical psychology from CPA accreditation, and I am not too terribly concerned about the caveats he enters about accreditation" (Schallow, 1984, p. 229).

What Do We Need To Do To Make Training in Canadian Professional Psychology Even Better?

I would like to end this paper by offering some thoughts about future directions that we may want to pursue to make training in professional psychology even better. Professional psychology training has attained some major accomplishments. Accreditation is alive and well in Canada and has undergone numerous changes in response to developments in professional psychology over the last 20 years. We now have well-established criteria that constitute a workable compromise between the prescriptive and outcome-based models that reflect our national traditions and heritage and are widely accepted across the country.

What else can we do to further refine and improve training for our students? I believe a central challenge is how to train students to become the supervisors and educators of the future. Supervision is a primary means by which students develop competencies in traditional areas such as assessment and intervention but now it is also regarded as a distinctive professional competency and as such should be developed through

systematic graduate education and clinical training (Falender, Cornish, Goodyear, Hatcher, Kaslow, Leventhal, et al., 2004). The importance of supervision as a core competency is reflected in the Mutual Recognition Agreement wherein Quebec and Newfoundland and Labrador require that one of the demonstrated competencies is supervision. The 2002 *CPA Accreditation Standards* also identify training in supervision as a requirement. This is an admirable goal but it raises a number of questions that we must address:

1. What is the most effective way of training students to become competent supervisors? What is the empirical base, if any, for psychology training? Do we have empirically-supported practices for education and training in supervision?

2. The first question suggests an even more basic question: What is the desired outcome of training? Should we be examining improved client outcome, supervisee satisfaction or supervisees' attainment of specific skills? This is a perplexing issue with no clear answers. Green and Dye (2003) summarized the challenges of utilizing treatment outcome as a dependent variable:

It has proved very difficult to trace the effect of differences in supervisory style through to improved treatment outcomes: the acid test of a clinical supervisor's effectiveness (Holloway & Neufeldt, 1995). There are so many intervening variables between the beginning and end of the causal chain (for example, supervisee characteristics, clients' presenting problems, psychotherapeutic approach used) that unambiguous research findings are inherently improbable (Holloway, 1984). (Green & Dye, 2003, p. 108).

3. What is the level of support (institutional, financial) for research in supervision, especially process and outcome issues?

4. Is there sufficient institutional support for training in supervision? Do graduate programs, internships and postdoctoral programs have sufficient time, resources and expertise to offer such training?

5. Should we train and supervise students in other areas of professional practice? How do we train students to become competent supervisors in domains such as research, consultation and administration?

The significant diversification of professional psychology is the proverbial double-edged sword. It has opened up exciting areas of practice for professional psychologists who can utilize their academic, research and clinical skills to promote public welfare and well-being but we will have to modify and refine professional psychology training programs to accommodate these developments. Can we do this? I am optimistic, given the challenges that Canadian psychology successfully confronted in developing national accreditation criteria and procedures. There may be an even grander day in the future for Canadian professional psychology training.

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Psychology: present state, future trends: A view from the West Coast

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This paper looks at four interrelated demographic trends and their impact on internship training.

I Age of interns and graduate students.
According to Church (Psynopsis 2007), the average age of psychology graduate students completing their programs was 34. She also

indicated that there are a significant minority of psychology students who are in their doctoral programs for 8-10 years, although the average is 6 years.

These numbers are consistent with our own experience. For example, the average age of our pre-doctoral interns at the start for their internship, for the last 5 years was 31.5, (range 27 -37 years). The results reported in the 2007 APPIC Match Survey of Internship Applicants, indicated a mean age of 30.4 with a range of 22 to 61. We can estimate that it takes another year for dissertation completion and defense. Also, some provinces (e.g. Ontario) now require a post doctoral residency year. At least in B.C., it then takes up to, an additional year to complete registration with the College of Psychologists.

It does not seem unrealistic, then to estimate that a psychology student would be 35 years old by the time she had completed the degree and registration process and was ready to begin practicing as a psychologist.

II Aging of the Profession.

Information from a number of different sources is confirming that the average age of practicing psychologists is increasing quite significantly. For example, 35% of Psychology Faculty are over 55 years of age (Canadian Association of University Teachers 2006). The College of Psychologists of BC data shows that 49% of registrants are age 55 or over, and the average age of registrants is 53 (2004 data). APA (2002) also confirms that the average age of members in 2001 was 52.2 years.

These numbers are particularly concerning because the demand for psychology services both in academic and applied centres is increasing at the same time. For example, AUCC (Association of Universities and Colleges of Canada) is projecting a **20%** increase in enrolment. On a local level, our hospital has created 5 new psychology positions (more than 3 full time equivalents) in the last year. It is very unclear where the new psychologists are going to come from to meet these increasing demands.

Retirement

There is a trend with psychologists, particularly in clinical practice to retire earlier than 65 years. The reasons cited are "burn out" and the heavy emotional toll of working with populations of difficult and needy individuals or groups and where the rewards are not always concrete and obvious. This is reflected in some therapists' guilt about being "emotionally unavailable" to their own families and in a desire to do something with concrete rewards – the proverbial flower shop!

The profession of psychology is a regulated profession which puts continuing demands on all of us and these demands often make it seem onerous to maintain ones status within the profession. For example, there are continuing education requirements, the fear of ethical complaints, potential death and suicide of patients, and the continuous stream of new tests to master. In addition, the length of time it takes for training prior to starting work (see section above), makes some psychologists feel that they have been working flat out since high school and hence the desire to do something completely different in their fifties and sixties.

III. Feminization of Psychology – Where did the men go?

Most large universities now have slightly more female than male students registered. However, the trend in graduate clinical psychology is much more dramatic. For example at C&W we average 50 to 60 intern applicants per year. In the last 5 years, the

number of males applying per year has ranged from zero to 3 (which works out to a maximum of 6% male applicants per year). We have only selected 1 male intern in 5 years. This is consistent with the trends at the 3 provincial universities, University of British Columbia (UBC), Simon Fraser University (SFU), and University of Victoria (U Vic) that have accredited clinical programs as **Table 1** indicates. The 2007 APPIC Match survey reported 78% of students applying for internship were female.

Table 1
Ratio of Male to Female Clinical Graduate Students, BC 2002-2006

University	UBC **All** Psychology Grad. Students	UBC **Clinical** Grad Students	SFU **Clinical**	U Vic **Clinical**
Total # of Students	124	23	30	16
Total # Males	34	2	5	4
Total # Females	90	21	25	12
Percent Males	27.42	8.70	16.67	25
# of Total Female Cohorts (out of 5)	0	3	2	2

These same trends are reflected in the psychologists working in local hospital settings. For example, at C&W 11.86% of psychologists are males. St Paul's hospital has 25 male psychologists and Vancouver Coastal Hospital, which across both sites has 35%, has the largest male representation.

APA is also reporting similar trends. According to Amy Cynkar (Monitor June , 2007), in 1970 women made up 20% of PhD recipients in psychology but by 2005 women made up 72 % of recipients. Women also made up 75% of psychology graduate students. She also makes the point that although there is a trend of increasing female graduates in most professions; psychology is outstripping other professional fields in female graduates. Both female law school entrants and female medical school graduates have leveled off at just below 50%.

In BC, as these numbers reflect, males represent less than 20% of our internship and clinical graduate students working in hospital settings. We are already approaching the point of approximately 80% female practitioners and the student trend confirms that this will only continue or get worse.

What are the implications of this trend? One recent example is reflected in the controversy stemming from an article in "The Clinical Practitioner" (Feb. 2007). Jerry Morris negatively links the feminization of psychology with a change in culture at state associations: "*…their tenor is likely to change with regard to valuing relationships and nurturance, positive emoting, socialization and to eschew more aggressive, guild oriented and battleground engagement activities more characteristic of male dominated and guild oriented*

associations". (p 7). The failure to develop and support sufficient numbers of aggressive and action oriented leaders…would render future state psychological associations to the future of a "book club", "social hour specialty group" or a haven for academics…(p 8).

While as you would expect, this article provoked a storm of controversy and buzz on various list serves and women in psychology groups, it does serve 2 functions. It is a strong indication of the level of anxiety this trend is having in some circles and it raises the issue of what will be the impact, if any, of this development. For example, it will likely have both systems and financial implications (e.g. number of part time workers) which we haven't yet considered as a profession.

IV Families and Psychology.

Consider the following information on woman combining academic and family responsibilities. In 2003-2004, 37.3% of doctoral students had dependents (Church 2007)**.** While **49.6**% of women professors in psychology, aged 35-39 did NOT have children (compared to 32.9% in physics and 42.3%in law). Only a third of women who were childless when they started their 1st tenure track position ever became mothers (Mann & Goulden, 2004). However, a full 70% of male professors had children while working. Of those psychology graduate students applying for their internship year, fully 83% (APPIC, 2007) had **NO** dependent children. In other words, psychology graduate students are less likely to have children while they are in graduate school and also female graduates are more likely to remain childless if they choose an academic career.

However, once the student's graduate, if they begin working in an applied setting, the trend is dramatically reversed. A large number of new graduates almost immediately become pregnant. For example, in our department, since January 2007, we have had 4 babies born to members of the department and 3 more announce their pregnancies. Given the year long maternity/paternity leave, this is no small matter. This is particularly true when you factor in the increased likelihood that the new parent will choose to return to work part time rather than full time, at least for a few years.

If we combine the information from the demographic trends that we have been discussing, there is an alarming picture that emerges. If we assume that it takes until age 35 years to complete training and become registered as a psychologist and then factor in the converging biological clock where research is now saying that pregnancy should not be delayed past age 40, we have the reason for the sudden new grad baby boom. If we consider that the new grad will have two children within 5 years of beginning practice, two of these years will be completely away from psychology (the year maternity leaves) and more than likely the other three will be in part time work. The conclusion:

The majority of female psychologists will not be available to focus full time on their careers until AGE 40. If they retire at age 60 as is the present trend, they have only **20 years** to provide psychological work full time. This will not be sufficient to meet either clinical or academic demands.

Furthermore, will we be able to continue to attract female graduate students when they realize what their career path looks like? This is particularly true if you consider the issue of preparation time versus eventual compensation. For example, while it may take equally long to get trained and qualified

as a physician, when the physician is licensed, she will earn a substantial salary/fee for service, which quickly compensates for the time invested in training. This is not true for many psychology positions, particularly in applied settings. This is part of the reason that many psychologists develop at least a part time private practice. But this makes recruiting and retaining psychologists for applied settings even more difficult and increases the likelihood that we will not be able to meet the demand for psychologists in many different settings.

What can we do about this?

The following are some concrete suggestions to help deal with this situation.

1. Provide flexibility and support for children and maternity leave from the beginning of graduate school.
2. This includes financial support during maternity leave.
3. Stop extending the training requirements, like the additional post degree year before qualification.
4. Tighten up course requirements so that there is less overlap between university and internship, e.g. decide who is responsible for supervision or multicultural courses.
5. Provide mentors both academically and in clinical practice of people who have managed both a profession and a family.
6. Be realistic about the trade offs the joint family/career requires-Don't set false expectations that no one can achieve and only serve to stress the students.
7. Don't just give lip service, show by example that children are welcome, e.g. child friendly department events.
8. Give students permission and flexibility to acknowledge and take part in family events, e.g. family milestones, sports day.
9. Abandon the old, "I had to work 20 hours a day so they have to too." Remember the example of medical interns who were expected to be on call 24 hours a day for days on end. This practice wasn't abandoned until statistics showed that there was an increase in medical errors and deaths associated with the long hours.
10. CPA must be more clear on what steps should be involved in dealing with a pregnant intern and acknowledging in writing that offering flexible internship arrangements will not jeopardize the accreditation of the internship.
    - Give explicit permission or a mechanism for approving arrangements in advance for being more flexible and creative in accommodating part time students.
11. A pregnant intern (APPIC Newsletter, L.Padgett, July 2002), gives the following advice to Internship directors. They should:
    - *Be the initiator* – open the discussions with the student and monitor stress level
    - *Be flexible* - restructure rotations and hours of work
    - *Be an advocate* - for the student in helping to make things work with other supervisors and program faculty.
12. We need to find out why we are not attracting more male candidates. Are we loosing male students to the more lucrative high tech fields? The skewed undergraduate sex ratio does not seem to be an adequate explanation since, as noted earlier, the feminization trend is much

stronger in the psychology than in other professions

13. Are we in danger of creating a "pink ghetto"? Historically once a profession becomes predominantly female, the wages tend to drop or at least not keep up with the wage increases in other predominantly male professions.

    The issue of men in clinical psychology, both in terms of present numbers nationally, and how to recruit more men, seems to be an ideal study or survey topic for CCPPP.
14. We must articulate clear and realistic expectations for both male and females in graduate school and internship so that students can adequately plan their lives around them. This must include a "reality check" on our part about what truly is a reasonable amount of work and time to do it in.

Curriculum and other broader base issues.

In addition to the specific suggestions listed above, there are also two areas of training that may help our students be better prepared and able to cope with the supply and demand issues that they are likely to face. Are we training clinical students appropriately for the work and working environment that they will be exposed to once they graduate?

The training model that most clinical psychology programs follow is competitive, that is, the training focus seems to have an emphasis on competitive individual achievement within a mental health context. But does this make sense? Most applied settings work on a team model and within the psychology departments, support and a chance to debrief difficult clinical situations is necessary. Consequently, the most appropriate training model would be a cooperative, supportive approach. This type of approach would also fit more appropriately with the goal of a more family/child friendly atmosphere in graduate school. Many students are afraid if they take a leave or work only part time that some one else will get the grant or their place in the lab.

The strongly mental health focus of most graduate programs is also limiting for the opportunities available for psychologists. To take the example that is most familiar to me: health psychology is hugely under represented in graduate curricula but is a large and growing area of opportunity for psychologists. For example on the front page of the Vancouver Sun, May 1, 2007, there is a story describing applicants for grants in cancer research in "thrivership" the new term for post cancer lives and needs. They quote the Chair of NCIC (National Cancer Institute of Canada), Michael Wosnick: "We are absolutely open for business" referring to the fact that research-granting agencies are inviting scientists to pay more attention to the psychosocial and medical concerns of cancer survivors. In our hospital, the role of psychology is constantly expanding with an ever expanding list of medical clinics requesting psychology services (e.g. rheumatology, gastrointestinal, renal, degenerative muscle diseases, and so on).

One way to ensure the broadening of psychology training and to help deal with impending shortages in many professional areas is to expose students early and often to the interprofessional model of training and support. *"Interprofessional Education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care"*

(Center for the Advancement of Inter Professional Education 2002). Over the past few years, governments at both the provincial and federal levels and universities have invested heavily in this model of training and service delivery. Its goal is to maximize the contribution of each discipline to the well being or recovery of individual clients or patients. It makes the assumption that if various professional can speak a common language and truly understand the potential contribution of other disciplines that the over all treatment outcomes will be dramatically enhanced. However, psychology's present emphasis on individual achievement and success, are out of synch with this change in training and work approach. This could prove a serious impediment to our development in the future.

Both Drs. John Arnett and John Service have recently also reinforced this notion of broader and more cooperative training. Dr. Arnett in his 2005 CPA presidential address highlighted the need for interdisciplinary collaboration and asked if we were preparing and training students and researchers adequately.

"*The graduate curriculum should better balance depth and breadth in order to facilitate students' ability to work in a variety of settings and to enhance interdisciplinary collaboration. Disciplinary insularity that impedes change and a strong and dominant culture in research universities too often precludes the involvement of nonacademic "practitioners". This needs to change." (p. 30)*

Dr. Service noted at the conclusion of a federal project on which he chaired the steering committee, called Enhancing interdisciplinary Collaboration in Primary Health Care (EICP: www.eicp.ca), that because of our focus on research and practice, our concentration on building individual practitioner skills, and emphasis on Mental Health training, we weren't always a good fit with the rest of the group. In other words, we were the least equipped to work on interdisciplinary teams, and were under represented on existing IPE programs. We need to take advantage of the opportunities presenting themselves both in terms of new university faculties (e.g. Faculty of Health Sciences at Simon Fraser University and the College of Health Disciplines at University of British Columbia) and in opportunities at applied health settings.

With psychologists' abilities to design research projects and clinical skills in group dynamics and systems work, we are uniquely placed to become leaders in this field. Moreover, interprofessional education and work is one way to deal with anticipated shortages at both the teaching and clinical work level.

I believe that CCPPP could play a very significant and central role in confirming on a national level, the demographic trends I have discussed from a BC perspective, and in suggesting creative, but concrete solutions to the demographic issues identified. CCPPP could also reinforce, encourage and facilitate the development of interdisciplinary training and applications by working with both the universities and applied settings in training and implementing interdisciplinary skills and applications.

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