2006

PhD and PsyD Graduates: More Alike Than Different

Elizabeth N. Wood

PhD and PsyD Graduates: More Alike Than Different

by

Elizabeth N. Wood

has been approved

at the

Graduate Department of Clinical Psychology

George Fox University

as a Dissertation for the PsyD degree

Signatures:

Clark Campbell, PhD, ABPP Chair

~~Vice President for Academic Affairs~~ -Provost

Members:

Date: Sept. 30, 2006

Kathleen Gathercoal, PhD

Wayne Adams, PhD, ABPP

Date: 9.29.06

PhD and PsyD Graduates: More Alike Than Different

Elizabeth N. Wood

The Graduate Department of Clinical Psychology at

George Fox University

Newberg, Oregon

Abstract

This study seeks to measure the attitudes and contributions of professional psychologists who have earned a PsyD degree. Initially developed as a degree to emphasize training in clinical practice over academia or research, the Doctor of Psychology degree follows the "Vail Model," also known as the "practitioner-scholar model." A random sample of practicing clinical psychologists was surveyed to determine if practicing clinical psychologists with a PsyD versus a PhD degree differ in attitude regarding serving diverse populations, public advocacy, and scholarship, and whether these attitudes are confirmed in practice. A questionnaire with practice-based questions was administered to 600 licensed and practicing members of the American Psychological Association (APA), awarded degrees between 1995 and 2000. Half had earned PhD degrees and half earned PsyD degrees. Results demonstrated no significant differences between respondents with a PhD and respondents with a PsyD regarding diversity and advocacy attitudes or practice. Scholarly activities did not differ significantly between the groups with respect to conference attendance, professional presentations, time spent in teaching and research activities, or in the reading of professional literature, but PhD respondents indicated more publications over their lifetime than PsyD respondents. The study demonstrates actual

practices of professional psychologists following graduation and licensure whereas previous comparisons of PsyD and PhD trainees were based on admission rates to graduate programs and scores on the Examination of Professional Practice for Psychology (EPPP).

Acknowledgements

Many have helped this project come together, and I owe them my thanks. My Research Vertical Team helped tremendously in the developmental stages to gather ideas and begin to shape them. Drs. Kurt Free and Joe Wood, Jr., helped me trim the excess and improve the clarity of the survey. I am extremely grateful to the Richter grant committee for supporting this project financially. Elizabeth Holme oversaw the printing and Sherrie Frost the bulk mailing, making it easier than it might have been to carry out the data collection phase from afar. Kim Harmon and Carol Jaquith have always been cheerfully helpful and integral in managing the details and logistics even when it went beyond their job descriptions. I cannot thank my internship training director, supervisors, and fellow interns enough for their support and encouragement along the way, so thank you, thank you to Drs. Kathlyn Dailey and Pam Moore at the Texas State Counseling Center, and to Anne Crowley and Melanie Noble. My family also has been a great support, listening to me talk through my frustrations and inspirations, so thank you to my parents, Joe and Diana Kupko, and to my husband, Joe Wood III. Most of all, I am grateful to my dissertation committee for their flexibility, their assistance, and their expertise.

Table of Contents

List of Tables

Chapter 1

Introduction

A tradition of dispute haunts the field of psychology. The relative importance of science and practice in psychology training has been a matter of hot debate through the 20th century and into the next. "Answers to the questions of *what* needs to be known (Spence, 1994), *who* needs to know it, and *how* it is to become known are different in the perceptions and preferences of practitioners and researchers" (Beutler, Williams, Wakefield, & Entwistle, 1995, p. 984). These questions have fueled debates on psychology training, and have resulted in different models of education. These models will be discussed with further elaboration on the specific educational model developed by the National Council of Schools and Programs of Professional Psychology (NCSPP). Specific critiques and challenges to the outcomes of this vision will then follow, along with the hypotheses for this study.

Training in Clinical Psychology

Following World War II, the need for counseling by veterans far exceeded the capacity for psychiatrists and psychoanalysts to provide it (Hergenhahn, 1997). Faced with individuals needing help in their return to civilian life, the Veteran's Administration began funding training programs for clinical psychologists. The training model up to that point had emphasized the scientific side of psychology and the American Psychological Association (APA) required individuals to have achieved multiple publications to qualify as a voting member until the year 1941 (Hergenhahn, 1997). However, with the demand for clinicians increasing, psychologists

were seeking further guidance on applied skills and therapeutic techniques. Thus, the question of how best to train clinical psychologists became a pressing matter.

The APA hosted a conference on clinical psychology training in Boulder, Colorado in 1949 to address the balance of science and practice in training. "The Boulder model upheld the tradition that clinicians obtain the Doctor of Philosophy (PhD) in psychology, which meant that they were trained in research methodology as any other psychologist was" (Hergenhahn, 1997, p. 548). This way, those performing psychological research would be the same people who put the knowledge they gained into clinical practice. This model of training came to be known as the "scientist-practitioner model." A second conference in 1990 at Gainesville, Florida, reconfirmed this model for use in PhD programs in clinical psychology (Buchanan, 2002).

A segment of psychologists, however, continued to feel the need for a shift toward practice-oriented education and training. With poetic flair, my advisor Clark Campbell articulated the stance of what these practitioners were noticing: "Psychologists were taught how to do statistical regression, but did not know how to handle regression in their clients" (personal communication, February 2005). Thus, many met in Vail, Colorado in 1973 to address the need for relevant clinical training (Buchanan, 2002). The conference attendees discussed the potential for developing a unique degree to meet the demand for clinically-based training. In regard to the balance of science and practice, the model of psychology training discussed would differ from the scientist-practitioner model developed in Boulder decades before. The "Vail Model" or "practitioner-scholar model" would be aimed at the portion of psychology students wishing to focus on clinical applications of psychology and not necessarily an academic or research-based career. Culminating in a Doctor of Psychology (PsyD) degree, these programs considered

research skills as one competency area among many (Peterson, Peterson, Abrams, & Stricker, 1997).

An organization devoted to clarifying the educational and training goals of professional schools, the National Council of Schools and Programs of Professional Psychology was formed in 1976 (Peterson et al., 1997).

> In the view put forward by NCSPP, practitioners engage the challenge of the human condition directly, starting with the needs of each client and bringing the best available theoretical conceptions, the most useful available research, along with individual and collective experience to bear in studying and improving the functional condition of the client. (Peterson et al., 1997, p. 376).

The NCSPP later also adopted the "local clinical scientist" model as articulated by Trierweiler and Stricker in 1992 (as cited in Peterson et al., 1997). The model of the *local clinical scientist* encourages psychologists to be concerned about local phenomena and needs within their communities, utilizing critical theories, scholarship, and scientific research, as well as their own investigative abilities and personal experience, to address the realities facing them. Peterson et al. (1997) suggest that the local clinical scientist must draw on knowledge beyond the individual to the broader community and to environmental concerns, making inquiries in how the local economy, resources available, and social attitudes might aid or hinder a client's recovery. Broadening the domain of educational goals, Peterson et al. (1997) and the NCSPP claim that professional psychology depends on multiple ways of knowing and "is characterized by scholarly, disciplined thought that is grounded in science, the humanities, and personal and professional experience and is enhanced by interdisciplinary perspectives" (p. 378).

The NCSPP Competencies

The NCSPP, over the course of several annual conferences, determined the core competency areas to be included in the curriculum of professional psychology schools and programs that would best match their vision of a *practitioner-scholar*. Choosing to emphasize a competency approach rather than focusing on specific content areas enabled programs to meet certain standards while responding to the unique interests of faculty and the needs of communities. "These professional core competencies areas [*sic*] represent key, related clusters of activities derived from and organized around an analysis of the social circumstances, needs, and demands of psychological practice – characteristics of what professional psychologists actually do" (Peterson et al., 1997, p. 380). Recognizing that they overlapped, Peterson et al. (1997) listed and summarized these core competencies: (a) relationship, (b) assessment, (c) intervention, (d) research and evaluation, (e) consultation and education, and (f) management and supervision.

Emphasizing the aspect of *relationship* related to creating a working therapeutic alliance between client and counselor, Peterson et al. (1997) claimed that this competency is the foundation of all other tasks of professional psychology. Integrating this relationship competency into curriculum design and implementation, skills such as conveying empathy, respect, and relational connection are taught. Additionally, the aims of this competency were to foster particular interpersonal attitudes including open-mindedness, belief in the capacity for change, appreciation for diversity, personal integrity, and self-awareness, among others. The clinical skill of relationship is taught as a function of courses as well as supervisory experiences, though it is often integrated as an element of importance throughout training.

The *assessment* competency draws on multiple methods and theories in the process of conceptualizing a client and making predictions. Psychologists may draw information from various sources pertaining to a particular client from clinical history, formal tests and measurements, the sociocultural context, and client functioning in multiple settings to formulate an assessment of the client's overall functioning, strengths, and limitations. Thus, to be competent in the area of assessment, psychologists must be able to formulate relevant questions about the client, select methods of gathering information, interpret the findings, make conclusions based on the appraisal, and communicate them accurately to the relevant parties (Peterson et al., 1997). Coursework and supervised experience provide psychology trainees with the skills of assessment as well as the ethical, sociocultural, legal, and administrative demands that accompany psychological assessment.

A common area of focus in psychology, *intervention* was the third core competency area. "Conceptualized as activities that promote, restore, sustain, and/or enhance positive functioning and a sense of well-being in clients through preventive, developmental, and/or remedial services, (R.L. Peterson, D.R. Peterson, Abrams, & Stricker, in press)" (as cited in Peterson et al., 1997, p. 380), intervention should consider diversity in its application. Although coursework often covers intervention according to particular theoretical frameworks, it is in the supervised experience and practical training that psychologists often learn to carry out interventions.

The fourth core competency area articulated by the NCSPP was *research and evaluation.* Since the the role of research was covered earlier, it will not be repeated here except to say that it is given a less prominent role in the *practitioner-scholar* model. The word "scholar" emphasizes that clinical psychologists may more often be consumers and utilizers of the research than

conductors of research. The competency also suggests, however, that any psychologist ought to have the capacity to evaluate programs and outcomes in order to maintain standards of practice.

Consultation and education made up the fifth area of competency in the NCSPP model. Defined thoroughly by Peterson et al. (1997), consultation refers to the collaborative interaction of psychologists with other professionals or clients to address particular needs and problems. In this process, psychologists are not directly implementing changes, but rather offering their professional advice and giving suggestions on principles and procedures. Education, by contrast, involves disseminating information to facilitate growth and learning in the areas of knowledge, skills, and attitudes. Peterson et al. recommended that these skills be taught in classes, practicum, and internships to facilitate learning and experience among psychology trainees.

The sixth and final core competency area outlined by Peterson et al. (1997) for the NCSPP is *management and supervision*. Management includes the organizing tasks of the practice of psychology, including its business, legal, and administrative aspects. Supervision involves a relationally-based teaching role meant to enhance the abilities and competence of trainees. Convinced that these important activities ought to be explicitly taught, Peterson et al. promote their inclusion in the core curriculum. "Going further, professional psychology programs should support advanced preparation for leadership, advocacy, and public and social policy planning roles" (Peterson et al., 1997, p. 381). In this way, psychologists would utilize their professional knowledge in the broader community and government to effect change on a wider scale.

Beyond the core competencies, the NCSPP has discussed additional competencies to be integrated into the core. The 1990 midwinter conference and the volume that resulted from it advocated expanding "traditional content to include material relevant to the self of the

professional psychologist, to experience, to women, and to ethnic diversity" (Edwall, 1992, p. 129). Singer, Peterson, and Magidson (1992) summarize the importance of the self of the professional psychologist by supporting the lifelong education of self-awareness in practitioners to know what the profession's roles, activities, and clients evoke for them on a personal level. This information may then inform their choices about the tasks they perform and the populations they serve in order to be more responsive and caring (rather than counterproductive or destructive) with fuller awareness of the consequences of their work. Edwall and Newton (1992) and Davis-Russell, Forbes, Bascuas, and Duran (1992) discuss ways to incorporate the perspectives of women and diverse ethnic groups, respectively, to the extent that it may result in a paradigm shift in the field. This re-emphasizes the recognition of "multiple ways of knowing" that professional psychology recognizes.

Diversity was adopted as a separate core competency area during the August, 2002 business meeting of the NCSPP. The NCSPP (n.d., paragraph 2) defined diversity as follows:

> Diversity refers to an affirmation of the richness of human differences, ideas, and beliefs. An inclusive definition of diversity includes but is not limited to age, color, disability and health, ethnicity, gender, language, national origin, race, religion / spirituality, sexual orientation, and social economic status, as well as the intersection of these multiple identities and multiple statuses. Exploration of power differentials, power dynamics, and privilege is at the core of understanding diversity issues and their impact on social structures and institutionalized forms of discrimination.

The NCSPP suggests that diversity ought to be integrated throughout training in addition to being taught explicitly in courses and through required experiences.

Furthermore, the NCSPP adopted *advocacy* as a "professional value and attitude" at the business meeting in January, 2004. They suggest that psychologists ought to aspire to going beyond the direct service needs of clients, promoting public policy and raising public awareness to improve service, research, training, and funding at the levels of individual clients, systems of care, public health and welfare, and professional psychology itself (NCSPP, 2004). The NCSPP (2004) advises that the promotion of advocacy need not be required in coursework, but rather is expressed through encouraging the development of "active citizen psychologists" by a "multitude of mechanisms" (final paragraph). "From grassroots activism to local, national and international lobbying, the informed, effective advocate provides expertise on challenging human welfare issues while strengthening the voice of psychology in public policy decisions" (paragraph 2).

Critiques and Challenges

Although the long-term nature of the science and practice debate causes periodic ebbs and flows in its discourse, a recent refueling of concerns was prompted by D. R. Peterson's (2003) *American Psychologist* article entitled "Unintended Consequences: Ventures and Misadventures in the Education of Professional Psychologists." One of the authors in the NCSPP's educational model, Peterson raised concerns that the lofty ideals for the PsyD degree were not being met well enough in reality.

EPPP scores and admissions rates. Before presenting evidence, Peterson (2003) provided the following caveat: "From the outset, let us agree that demonstrably valid methods for the appraisal of professional competence and educational effectiveness in professional psychology have yet to be devised" (p. 794). He goes on to present comparisons between PhD and PsyD programs in which the programs are ranked according to the mean scores of their

graduates on the Examination for Professional Practice in Psychology (EPPP), demonstrating a greater representation by PhD programs in the top rankings and by PsyD programs in the bottom. Secondly, he discussed the acceptance rates in each type of program, with PhD programs showing an average acceptance rate of 11% and PsyD programs showing an average rate of 41%. He further divided the PsyD programs into university-affiliated and free-standing schools, with free-standing schools accepting an average of 50% of applicants.

In response to Peterson's article, Kenkel, DeLeon, Albino, and Porter (2003) pointed out the minimum requirements that must be met to be considered as applicants, which serves a self-selecting purpose. Kenkel et al. felt that Peterson's alarm was not merited in the comparison between PhD and PsyD programs since the failure rate of graduates on the licensing exam was not exceptionally high and because minimum required Graduate Record Examination (GRE) scores and undergraduate grade point averages (GPA) were comparable. "If 80% (or even 50%) of graduates were failing the licensing exam, or if the data showed students with low scores entering programs, then we might agree that quality measures were missing" (p. 803). Furthermore, Kenkel et al. suggested that the goal of ensuring quality training resides with the APA Committee on Accreditation, where such concerns are self-evident.

Templer and Arikawa (2004) reply to Kenkel et al. (2003) by suggesting that the mean EPPP scores are close to the pass rate, thus influencing who is getting licensed. Making an inferential jump from the mean scores and standard deviations between traditional programs (PhD) and professional schools (PsyD), Templer and Arikawa (2004) conclude that "...the pass rates for traditional programs were obviously much higher than for professional schools" (p. 646). Because Peterson (2003) and Kenkel et al. (2003) had both discussed the EPPP as being a limited or weak measure of professional competence, Templer and Arikawa raised a challenge.

"If the EPPP is as ineffective in appraising knowledge required for responsible practice as Kenkel et al. suggested, it would seem unethical and possibly illegal for the United States and Canadian provinces to continue using it to qualify and disqualify practitioners for licensure" (p. 646). Templer and Arikawa also took issue with Kenkel et al.'s presentation of the minimum required GRE scores as being comparable between educational degrees, stating that "...the mean or median of students actually accepted would appear to be a better indicator of student quality. In the Pate report the traditional student medians were appreciably higher for both Verbal (575 vs. 538) and Quantitative (625 vs. 575) scores" (p. 647).

Norcross, Castle, Sayette, and Mayne (2004) surveyed APA-accredited programs regarding admissions rates, comparing PsyD programs, practice-based PhD programs, and research-based PhD programs. They found the three types of clinical psychology programs received similar numbers of applications each year—ranging from 135 to 170—and enroll a similar percentage of accepted students—59% to 63%. However, 41% of PsyD applicants are accepted compared to 17% at practice-oriented PhD programs and 11% at research-oriented PhD programs. He further compared freestanding PsyD programs to university-based PsyD programs, finding that one half of all applicants were accepted in freestanding institutions. "Rising acceptance rates and shorter training periods will probably translate into less qualified students (at least on conventional academic criteria)..." (Norcross et al., 2004, p. 418).

In summary, while there is argument as to how to interpret the measured differences in EPPP scores and admissions rates, the numbers do show discrepancy between PhD and PsyD programs and further discrepancy between university-based PsyD programs and freestanding PsyD schools. Some choose to interpret this discrepancy as an urgent matter of crisis in the training of professional psychologists and the quality of practitioners in the field, while others

indicate that the numbers keep us from seeing the bigger picture as to the contributions professional psychologists are making and the roles they are fulfilling.

Unique roles and challenges. Jaffe (2004, pp. 647-648) suggests that professional psychology schools and academic/research departments have different and complementary roles, and were originally envisioned to fulfill different roles, therefore should have different standards and means of evaluating candidates for the programs.

> The academic department is looking for intelligence, research capability, and a high level of competence as a scholar....A professional school has a commitment to provide people available for service, and therefore its selection should focus on finding applicants who will have that capability and dedication to be good professionals....[They need to consider] looking at broader skills that involve social commitments and working background as well as intelligence and grades.

Because of the nature of the roles of research and academic psychologists as compared to professional psychologists, it seems that direct service contact demands different skills and capabilities than conducting research and scholarship.

Crossman, Horowitz, and Morrison (2004) name some intended consequences of the NCSPP and its affiliated schools and programs: "pioneering and continuing contributions to the development of competency-based training, ongoing work to define and support new roles for psychologists, and holding diversity central in how we train, who we are, and who we train" (p. 645). The authors suggest that the way to assess the success or failure of professional psychology schools and programs (rather than focusing on test scores and admission rates) should be by examining the *relevance* of training and practice to the communities in which

programs and practitioners reside, demonstrating that training and practice accounts for *diverse and marginalized populations*, and showing *evidence of quality* practice in the field.

Summarizing recommendations of the Pew Health Professions Commission, Kenkel et al. (2003) reiterate the following points:

1. Professional training should mirror the demands of the new health care system.
2. The workforce should reflect diversity.
3. Health professionals should have interdisciplinary competence.
4. Education should move to ambulatory practice.
5. Public service should be encouraged.

Much of these recommendations reflect Crossman, Horowitz, and Morrison's three goals of relevance, diversity, and evidence of quality practice, while adding specificity of the relevance criteria in terms of the health care system, interdisciplinary collaboration, providing clinical experiences beyond merely hospital settings, and offering public service beyond the standard practice.

Among many recommendations for how to address discrepancies in exam performance, Peterson (2003) recommended evaluating practitioners in the field. "Useful definition of professional expertise requires, of all things, more systematic research on the performance of practitioners in their many workplaces" (p. 797). Thus, it seems there is a paucity of information about actual practice in the field according to the unique contributions of professional psychologists. How well has the competency-based training envisioned by the NCSPP translated to actual contributions by professional psychologists, and what unique roles and services are PsyD graduates fulfilling?

Purpose of the Study

The PsyD degree was originally created to fulfill a practice-based training role meant to complement the academic and research-focused PhD training programs. The NCSPP developed specific aims of the degree in the form of competencies, articulating a core curriculum as well as additional values to be explicitly upheld in training and practice (see Edwall, 1992; Peterson et al., 1997). While some raise concerns about the discrepancies between the programs in terms of quality outcomes and lowered standards (see Norcross et al., 2004; Peterson, 2003; Templer & Arikawa, 2004), others suggest that using test scores and admissions rates misses the point of the PsyD degree which is to provide valuable and needed services (Crossman et al., 2004; Jaffe, 2004; Kenkel et al., 2003). With Peterson's (2003) recommendation to determine the actual performance of professional psychologists in the workforce, this study seeks to go directly to practitioners to uncover their actual attitudes and practices, especially regarding particular competencies of scholarship, serving diverse groups, being responsive and relevant to community needs, giving public service, and practicing interdisciplinary competence.

Because of the unique training of PsyD practitioners with the competencies delineated above, I hypothesize that PsyD practitioners may serve diverse populations more widely and more often act as public advocates. Because of the focus on scholarship in the PhD degree, I expect PhD practitioners to be more widely published and to read more journal articles in addition to spending more time in research and teaching.

Chapter 2

Method

Participants

Utilizing a random sample of currently-practicing, licensed members of the American Psychological Association as evidenced by payment of practice dues, 300 clinical psychologists with a PhD and 300 clinical psychologists with a PsyD were surveyed concerning their attitudes and practices. The sample was limited to those practitioners who completed their doctorate between 1995 and 2000 to encompass graduates of recently-developed programs, and subjects were randomized across groups on gender, race/ethnicity, and geography.

Instruments

Research questionnaire. A research questionnaire (see Appendix A) was developed to gather demographic information as well as to correspond with certain competency areas to measure the actual attitudes and practices of clinical psychologists. The questionnaire covered five areas: (a) demographics: including age, gender, ethnicity, and geographic designation, degree, and graduate institution type; (b) public service, including advocacy for the field and pro bono work; (c) diversity in populations served; (d) scholarship; (e) and service capacities. The survey is primarily quantitative in nature to measure hours spent or percentage of clients served in various activities, with a few brief qualitative responses to determine the nature of public services offered. Two Likert-rated responses seek to probe attitudes about service values.

During the development of the questionnaire, two private practitioners offered feedback on the wording of items and the content of the questionnaire.

Procedures

A request was made to the APA research office for a randomly-selected sample of 300 PhD and 300 PsyD currently-practicing, licensed psychologists who received their doctorates between 1995 and 2000 from among the APA members who paid the practice surcharge in 2005. These subjects were then mailed the informed consent letter (see Appendix B) and the research questionnaire (see Appendix A), along with a self-addressed, stamped response envelope. To maintain the anonymity of the respondents, a follow-up reminder postcard was sent approximately two weeks later to all subjects (see Appendix C). The cover letter and postcard contained a humorous appeal as a method of generating interest in participating.

Chapter 3

Results

Demographics

Out of the 600 surveys that were distributed, five survey packets were undeliverable and 206 completed surveys were returned to be analyzed, yielding a 34.6% response rate. Due to the low response rate, an analysis was performed to determine whether characteristics of the sample and sampling frame were comparable. The proportion of PhD (N=300) and PsyD (N=300) degree recipients was equal in the sampling frame. The proportion of PhD (n = 114) and PsyD (n = 91) practitioners in the sample was not significantly different from the proportion represented in the sampling frame, $z = 1.54$, $p = 0.12$. Comparably, an analysis of proportions indicated no difference between the sample and sampling frame regarding gender and all categories of ethnicity (i.e., Asian/Pacific Islander, Hispanic, African American, and Native American) for both PhD and PsyD practitioners besides Caucasian. White PhD and PsyD practitioners were overrepresented in the sample as compared to the sampling frame (White PhD: $N = 215$ out of 300, $n = 101$ out of 114; White PsyD: $N = 209$ out of 300, $n = 85$ out of 91). A one sample t-test comparing the mean age of PhD practitioners in the sample ($m = 42.33$, $sd = 6.72$) to the sampling frame ($M = 43.0$, $SD = 7.4$) showed no significant difference t (113) = -1.06, $p = .29$ (two-tailed). Similarly, PsyD practitioners did not differ significantly in age between sample (m

= 45.10, *sd* = 8.11) and sampling frame (*M* = 44.4; *SD* = 8.6) on a one sample t-test: *t* (90) = .82, *p* = .41 (two-tailed).

Descriptive statistics for the study sample appear in Table 1. Pearson chi square tests revealed that respondents with PhD degrees were significantly more likely to be female than those with a PsyD degree, $\chi 2$ (2, *N* = 205) = 6.67, *p* = .04; no significant differences were found between groups on ethnicity, $\chi 2$ (8, *N* = 204) = 1.81, *p* = .99, and the type of community in which they reported practicing, $\chi 2$ (6, *N* = 202) = 4.92, *p* = .55. The mean age for PhD respondents was 42.33 years (*SD* = 6.72), and the mean age for PsyD respondents was 45.10 years (*SD* = 8.11). A Welshes *t*-test revealed that this is a significant difference in age, *t* (174.09) = -2.61, *p* = .01, however, the effect size for age between the two samples was .19, considered "no effect" (Cohen, 2003) in a practical sense when taking the variability of the data into account.

Hypothesis One

To test the first hypothesis, that PsyD practitioners are more likely than PhD practitioners to see a diverse clientele, inferential tests were completed. Attitudes about serving diverse clientele, measured on a 6-point Likert scale, were not significantly different between PhD (*N* = 112, *M* = 1.98, *SD* = 1.07) and PsyD respondents (*N* = 89, *M* = 1.99, *SD* = 1.15), *t (199)* = -.04, *p* = .97. The power of the test was calculated at .06 and the effect size was .01, considered "no effect." PhD and PsyD respondents were asked to report the number of clients of ethnic minority status, of non-U.S. citizenship, with a confirmed physical disability, at the poverty level or below, or who identify as GLBT (gay, lesbian, bisexual, or transgender). To address the positive skew when analyzing the percentages of diverse clients served by PhD and PsyD respondents, rank orders were established for those indicating they saw less than or equal to 5 percent (Rank =

Table 1

Demographic Data for Study Sample

	Frequency		% of Total	
Demographic	PhD	PsyD	PhD	PsyD
Gender	114	91	55.6	44.4
Female	86	54	42.0	26.3
Male	28	37	13.7	18.0
Ethnicity	113	91	55.4	44.6
African American	1	1	.5	.5
Hispanic	5	3	2.5	1.5
Asian/Pacific Islander	3	1	1.5	.5
Caucasian	101	85	49.5	41.7
Other	3	1	1.5	.5
Practice Community	114	88	56.4	43.6
Rural	4	6	2.0	3.0
Small Town	17	16	8.4	7.9
Suburban	46	35	22.8	17.3
Urban	47	31	23.3	15.3

1), between 5.1 and 15 percent (Rank = 2), between 15.1 and 50 percent (Rank = 3), and over 50 percent (Rank = 4). Mann Whitney U tests are presented in Table 2. No significant differences were found between PhD and PsyD respondents in the diversity of populations served.

Table 2

Differences between PhD and PsyD for Diverse Populations Served

Clientele	PhD			PsyD			Mann-Whitney *U*	*p*
	N	*M*	*SD*	*N*	*M*	*SD*		
Ethnic minority	109	2.37	.99	90	2.30	1.06	4687.0	.58
Not U.S. citizen	100	1.15	.44	83	1.24	.62	3980.0	.42
Physical disability	105	1.78	1.03	88	1.65	1.04	4176.5	.19
Poverty level	103	2.19	1.14	86	2.15	1.17	4329.0	.78
GLBT	98	1.44	.66	88	1.42	.80	4031.0	.35

Hypothesis Two

The second hypothesis, that PsyD practitioners are more likely than PhD practitioners to act as public advocates, was tested by measuring both the inclination to make financial accommodations for clients and to provide pro bono professional services, and by endorsement of various methods of advocacy. In response to a 6-point Likert indication of how important the practitioner considered it to make financial accommodations for the financially disadvantaged, no significant differences were found, t (198) = .85, p = .39, between PhD practitioners (M = 1.93, SD = .97) and PsyD practitioners (M = 1.81, SD = .94). Cohen's d equaled .13, considered "no effect," and the statistical power measured at .23. Similarly, a comparison of means between PhD (M = 2.80, SD = 4.22) and PsyD practitioners (M = 2.96, SD = 3.22) found no differences regarding the number of pro bono hours provided in a typical month, t (195) = -.30, p = .76, with statistical power at .09 and an effect size of .04. A t-test was used to explore whether early

graduates (years 1995-1997; $N = 77$, $M = 2.71$, $SD = 3.73$) reported more pro bono than later graduates (1998-2000; $N = 125$; $M = 3.02$; $SD = 3.90$). No significant differences between groups was found $t\ (195) = .54$, $p = .59$, Cohen's $d = .08$. An "advocacy" variable was created by summing the number of indicated times the respondent wrote to or spoke with a political representative or legislator, contributed funds to lobbyists or social advocacy groups related to psychological interests, wrote a letter to the editor or spoke in a public forum with the intention of advocating for the field of psychology, and served on a community board or committee (i.e., the number of boards, not the number of meetings). A *t*-test, once again, revealed no significant differences, $t\ (197) = -.29$, $p = .78$, when comparing PhD ($M = 2.56$, $SD = 3.60$) and PsyD ($M = 2.69$, $SD = 2.92$) practitioners on their psychology advocacy behaviors. Cohen's *d* showed "no effect" with an effect size of .04, and the statistical power equaled .09.

Hypothesis Three

The third hypothesis suggested that PhD graduates spend greater amounts of time in research, scholarship, and teaching activities than PsyD graduates. When comparing the proportion of time in hours during a typical week practitioners spend conducting both psychological research and program evaluations by PhD ($M = .05$, $SD = .14$) and PsyD ($M = .03$, $SD = .06$), a Welshes *t*-test revealed no significant differences, $t\ (132.17) = 1.31$, $p = .19$, and effect size measured at 0.19, "no effect." Obviously, the majority of respondents spent very little time in research and program evaluation overall during their typical schedule. Scholarship was also examined by looking at the number of conferences attended in the past year, professional presentations made in a lifetime, journal articles and professional books read in a month, and authored publications over a lifetime. The results are presented in Table 3. The only significant difference appears to be in peer-reviewed journal articles, book chapters, or books authored or

co-authored in a lifetime. This difference remained significant after removing the three cases (all PhD graduates) who spend between 50 and 100 percent of their professional time in research settings, t (200) = 2.071, p = .04, yielding an effect size of 0.29, a "small effect" according to Cohen (2003). This was based on modifications of the PhD group statistics to N = 111, M = 3.1622, and SD = 5.97, whereas the PsyD group statistics remain the same as in Table 3.

Finally, when comparing the proportion of time in hours during a typical week practitioners spend teaching by PhD (M = .04, SD = .16) and PsyD (M = .02, SD = .05), a t-test revealed no significant differences, t (155) = 1.13, p = .26. Cohen's d was calculated at .17, "no effect," and the power of the test was .35.

Table 3

Comparing Scholarship in PhD and PsyD Graduates

	Descriptives				Comparison			Effect size	Power
	N	*M*	*SD*	*MED*	*t*	*df*	*p*	*d**	
Conferences					-1.22	202	.22	.17	.32
PhD	113	1.39	1.22	1.00					
PsyD	91	1.64	1.74	1.00					
Presentations					1.52	202	.13	.22	.50
PhD	114	7.55	20.11	3.00					
PsyD	90	4.15	7.68	1.00					
Reading					.32	203	.75	.04	.09
PhD	114	3.66	3.52	3.00					
PsyD	91	3.48	4.46	2.00					
Publications					2.35	200.68	.02	.33	.76
PhD	114	3.39	6.20	1.00					
PsyD	91	1.47	5.51	0.00					

* *Cohen's d*

Chapter 4

Discussion

Conclusions and Implications

In this sample, no significant differences were found between PhD and PsyD graduates who are currently practicing in regards to the diversity in populations served and in public advocacy and service. PhD and PsyD graduates provide services related to demand, and the diversity in their clients reflects the nature of clients seeking services. It also appears that PhD graduates and PsyD graduates are similarly likely to act as representatives to the field of psychology through political, civil, and community processes, and to provide pro bono services. The only significant difference found in regards to scholarship indicated that PhD graduates have published, on average, about two more peer-reviewed journal articles, book chapters, or books in their lifetime than their PsyD counterparts. The sample did not differ between the degrees in regards to publications read or in presentations made or attended. Similarly, the proportion of time spent in teaching, research, and program evaluation was not significantly different when looking at this sample group of PhD and PsyD practitioners.

It may be, despite the differences in training envisioned by those in the Boulder and Vail Conferences, a psychologist is just a psychologist when it comes to clinical practice. As hypothesized, however, PhD graduates more extensively contribute to the professional literature. In this way, the roles of scientist-practitioner and practitioner-scholar are upheld: PhD clinical psychologists both conduct research and, assumptively, put what they learn from research into

clinical practice; PsyD clinical psychologists act primarily as consumers of research, inferentially, to put what they read into clinical practice.

Limitations of the Study/Areas for Future Research

The first limitation of the study comes from a limited response rate and differences in demographics. The 34.6% response rate suggests that a sampling error may have confounded the results. Though the two groups were randomized on age, ethnicity, gender, and geographical location, the surveys returned showed significant differences in age and in the proportion of females to males between PhD and PsyD practitioners. Cohen's *d* indicated "no effect" in regards to the effect size for age, suggesting that this did not play a confounding role. Strikingly, an analysis regarding gender and age between sample and sampling frame did not reveal significant differences. This suggests that these factors are potentially characteristic of group membership between PhD and PsyD practitioners regarding age and gender versus a problem with accurate representativeness in the study sample. Significant differences in the representation among ethnic groups could also indicate confounding effects, however, while white practitioners were overrepresented in both PhD and PsyD groups in the sample as compared to the sampling frame, minority ethnic groups are not statistically under-represented in the sample as compared to the sampling frame.

A second limitation comes from the limited power of the statistical tests. Power analyses were conducted for all statistical analyses addressing hypotheses I, II, and III. Power ranged from .06 to .76. The power was below .7 for all of the analyses that were non-significant and had "no effect" according to Cohen's (2003) criterion. In other words, when the means are very similar, you would need huge sample sizes to find those trivial differences. For example, to be sensitive enough to pick up differences between the means of 3.66 for PhD and 3.48 for PsyD on

a question about reading professional literature, it would require sample sizes of 3000 people per group to achieve a power of .8. Thus, although the power is low, it is part of a constellation of variables including effect size, sample size, and alpha levels that are all consistent with no differences between those groups.

Many of the original NCSPP core competencies were not measured due to the parameters of this study, rather, this study attempted to focus on what might distinguish the two degrees: 1) research and evaluation, and 2) education (i.e., academic roles). The extension of the core competencies discussed by Edwall (1992) was represented in limited fashion by measuring service to diversity. Crossman, Horowitz, and Morrison's (2004) suggestions that the success of psychology training ought to be measured by looking at the relevance of practice and training to the local community, the relevance of training for diverse and marginalized populations, and the quality of practice, was limited in this study to measuring the service to diverse populations. Future studies might look at evaluating the quality of practice in the field as well as its success at serving the needs of the local communities in which the practice is carried out. Out of the five Pew Health Commission recommendations summarized by Kenkel et al. (2003), this study looked at the fifth area of "public service." Future studies may look at how well training prepares practitioners for the health care system and a variety of practice settings, diversity in the workforce, and interdisciplinary competence.

Importance of the Findings

The purpose of this study was to determine whether the envisioned roles for scientist-practitioner (PhD) and practitioner-scholar (PsyD) are carried into the practice of clinical psychology beyond graduation. Because previous studies focused on program admission rates and scores on the licensing exam, this study sought to provide measures of actual practice as it is

carried out by PhD and PsyD graduates. The visionaries that established the scientist-practitioner and practitioner-scholar models had disparate ideas about the relative importance of research and practice in the training of clinical psychologists, and the PhD and PsyD degrees were established to fulfill distinct roles. The results of this study demonstrate that few measurable differences exist five to ten years post-graduation from PhD and PsyD programs.

The study does confirm, however, that PhD psychologists may be more likely to publish research findings than are PsyD psychologists. When looking at the means, this comes down to a difference of about two publications over the period of their relatively brief careers, and it is uncertain whether these publications were pre- or post-licensure. It may be an important point to determine whether the publications are produced during graduate school or during employment to distinguish whether differences are maintained beyond the training period. The PsyD degree was established to provide training and education to individuals interested primarily in applied clinical practice rather than research and academia. From this study, it can be inferred that PsyD programs are successfully attracting candidates interested in the applied practice of psychology. It is clear, however, that PhD programs in clinical psychology are also attracting graduate candidates who are drawn primarily to applied practice, and that PhD and PsyD graduates are less distinct in their roles as practicing psychologists than might be assumed from the debate over admission rates and licensing exam scores.

References

Beutler, L.E., Williams, R.E., Wakefield, P.J., & Entwistle, S.R. (1995). Bridging scientist and practitioner perspectives in clinical psychology. *American Psychologist, 50* (12), 984-994.

Buchanan, T. (2002). Historically grounding the practice of psychology: Implications for professional training. *History of Psychology, 5* (3), 240-248.

Cohen, J. (2003). A power primer. In A. E. Kazdin (Ed), Methodological issues & strategies in clinical research (3rd ed.) (pp. 427-436). Washington, DC: American Psychological Association.

Crossman, R.E., Horowitz, M., & Morrison, A. (2004). Intended consequences. *American Psychologist, 59* (7), 645-646.

Davis-Russell, E., Forbes, W.T., Bascuas, J., & Duran, E. (1992). Ethnic diversity and the core curriculum. In R.L. Peterson, J.D. McHolland, R.J. Bent, E. Davis-Russell, G.E. Edwall, K. Polite, D.L. Singer, & G. Stricker (Eds.), *The core curriculum in professional psychology* (pp. 147-151). Washington, DC: American Psychological Association.

Edwall, G.E. (1992). Broadening the core curriculum. In R.L. Peterson, J.D. McHolland, R.J. Bent, E. Davis-Russell, G.E. Edwall, K. Polite, D.L. Singer, & G. Stricker (Eds.), *The core curriculum in professional psychology* (pp. 129-131). Washington, DC: American Psychological Association.

Edwall, G.E., & Newton, N. (1992). Women and the core curriculum. In R.L. Peterson, J.D. McHolland, R.J. Bent, E. Davis-Russell, G.E. Edwall, K. Polite, D.L. Singer, & G. Stricker (Eds.), *The core curriculum in professional psychology* (pp. 141-146). Washington, DC: American Psychological Association.

Hergenhahn, B.R. (1997). *An introduction to the history of psychology* (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Jaffe, D.T. (2004). On the differences between academic research departments and professional schools. *American Psychologist, 59* (7), 647-648.

Kenkel, M.B., DeLeon, P.H., Albino, J.E., & Porter, N. (2003). Challenges to professional psychology education in the 21st century: Response to Peterson. *American Psychologist, 58* (10), 801-805.

National Council of Schools and Programs of Professional Psychology. (2004). *Advocacy as a professional value and attitude.* Retrieved June 29, 2006, from http://ncspp.info/Advocacyres.pdf

National Council of Schools and Programs of Professional Psychology. (n.d.). *The diversity competency.* Retrieved June 29, 2006, from http://ncspp.info/div.htm

Norcross, J.C., Castle, P.H., Sayette, M.A., & Mayne, T.J. (2004). The PsyD: Heterogeneity in practitioner training. *Professional Psychology:Research and Practice, 35* (4), 412-419.

Peterson, D.R. (2003). Unintended consequences: Ventures and misadventures in the education of professional psychologists. *American Psychologist, 58* (10), 791-800.

Peterson, R.L, Peterson, D.R., Abrams, J.C., & Stricker, G. (1997). The National Council of Schools and Programs of Professional Psychology educational model. *Professional Psychology: Research & Practice, 28* (4), 373-386.

Singer, D.L., Peterson, R.L., & Magidson, E. (1992). The self, the student, and the core curriculum: Learning from the inside out. In R.L. Peterson, J.D. McHolland, R.J. Bent, E. Davis-Russell, G.E. Edwall, K. Polite, D.L. Singer, & G. Stricker (Eds.), *The core*

curriculum in professional psychology (pp. 133-139). Washington, DC: American Psychological Association.

Templer, D.I., & Arikawa, H. (2004). Concerns about professional schools. *American Psychologist, 59* (7), 646-647.

Appendix A

Research Questionnaire

PRACTICE QUESTIONNAIRE **(Results shown in bold print; PhD = 1 & PsyD = 2)**

1. How many *total* hours in a typical week do you spend working professionally as a psychologist? _____ **(N_1 = 114, M_1 = 39.25, SD_1 = 13.10, MED_1 = 40; N_2 = 91, M_2 = 41.03, SD_2 = 12.82, MED_2 = 42)**
2. How many hours in a typical week do you spend:
   a. Providing direct clinical services (including therapy)? _____ **(N_1 = 111, M_1 = 19.03, SD_1 = 11.36, MED_1 = 20; N_2 = 88, M_2 = 22.93, SD_2 = 12.15, MED_2 = 23.5)**
   b. Conducting psychological assessments? _____ **(N_1 = 103, M_1 = 6.29, SD_1 = 8.47, MED_1 = 3; N_2 = 78, M_2 = 7.81, SD_2 = 10.32, MED_2 = 3)**
   c. Conducting psychological research? _____ **(N_1 = 93, M_1 = 1.60, SD_1 = 6.14, MED_1 = 0; N_2 = 71, M_2 = 0.81, SD_2 = 2.48, MED_2 = 0)**
   d. Conducting program evaluations? _____ **(N_1 = 93, M_1 = 0.63, SD_1 = 1.76, MED_1 = 0; N_2 = 66, M_2 = 0.41, SD_2 = 1.24, MED_2 = 0)**
   (Sum of items 2c and 2d: N_1 = 94, M_1 = 2.21, SD_1 = 6.91, MED_1 = 0; N_2 = 73, M_2 = 1.16, SD_2 = 2.78, MED_2 = 0)
   e. Consulting with other professionals or agencies? _____ **(N_1 = 102, M_1 = 3.54, SD_1 = 4.31, MED_1 = 2; N_2 = 79, M_2 = 2.60, SD_2 = 2.31, MED_2 = 2)**
   f. Supervising other professionals or trainees in clinical practice? _____ **(N_1 = 100, M_1 = 2.67, SD_1 = 3.91, MED_1 = 1.0; N_2 = 80, M_2 = 2.18, SD_2 = 2.64, MED_2 = 1.5)**
   g. Doing administrative activities? _____ **(N_1 = 107, M_1 = 7.57, SD_1 = 6.75, MED_1 = 6; N_2 = 86, M_2 = 7.95, SD_2 = 7.00, MED_2 = 6)**
   h. Teaching in a classroom or academic setting? _____ **(N_1 = 93, M_1 = 1.75, SD_1 = 5.13, MED_1 = 0; N_2 = 65, M_2 = 0.83, SD_2 = 2.07, MED_2 = 0)**
   i. *Other*: _____? _____ **(N_1 = 27, M_1 = 8.94, SD_1 = 10.28, MED_1 = 7; N_2 = 18, M_2 = 11.89, SD_2 = 22.78, MED_2 = 5.5)**
3. How many hours in a typical month do you spend:
   a. Presenting or publishing information for a professional audience? _____ **(N_1 = 109, M_1 = 1.08, SD_1 = 2.82, MED_1 = 0; N_2 = 82, M_2 = 0.78, SD_2 = 1.99, MED_2 = 0)**
   b. Presenting or distributing information to the public or lay audiences? _____ **(N_1 = 106, M_1 = 1.24, SD_1 = 2.74, MED_1 = 0; N_2 = 85, M_2 = 1.05, SD_2 = 1.74, MED_2 = 0)**
   c. Providing pro bono professional services (e.g., free presentations/seminars to the public, serving on community committees or boards, providing direct clinical

services for free, etc.)? _____ **($N_1 = 109$, $M_1 = 2.80$, $SD_1 = 4.22$, $MED_1 = 1$; $N_2 = 88$, $M_2 = 2.96$, $SD_2 = 3.22$, $MED_2 = 2$)**

4. I think it is important to make financial accommodations for the financially disadvantaged among those I serve. *Please circle one choice.*

1	2	3	4	5	6
Strongly Agree	Mostly Agree	Somewhat Agree	Somewhat Disagree	Mostly Disagree	Strongly Disagree

($N_1 = 110$, $M_1 = 1.93$, $SD_1 = 0.97$, $MED_1 = 2$; $N_2 = 90$, $M_2 = 1.81$, $SD_2 = 0.94$, $MED_2 = 2$)

5. To about how many people have you provided direct clinical services in the past month? _____ **($N_1 = 109$, $M_1 = 41.22$, $SD_1 = 41.17$, $MED_1 = 30$; $N_2 = 86$, $M_2 = 47.16$, $SD_2 = 33.05$, $MED_2 = 40$)**

6. About what percentage of your clients/patients:

a. Identify as an ethnic minority? _____% **($N_1 = 109$, $M_1 = 25.65$, $SD_1 = 23.59$, $MED_1 = 20$; $N_2 = 90$, $M_2 = 24.13$, $SD_2 = 26.43$, $MED_2 = 10$)**

b. Do not have United States citizenship? _____% **($N_1 = 100$, $M_1 = 2.50$, $SD_1 = 6.57$, $MED_1 = 0$; $N_2 = 83$, $M_2 = 4.16$, $SD_2 = 12.87$, $MED_2 = 0$)**

c. Have a confirmed physical disability? _____% **($N_1 = 105$, $M_1 = 16.05$, $SD_1 = 25.26$, $MED_1 = 5$; $N_2 = 88$, $M_2 = 14.48$, $SD_2 = 26.39$, $MED_2 = 5$)**

d. Are at the poverty level or below? _____% **($N_1 = 103$, $M_1 = 22.93$, $SD_1 = 27.00$, $MED_1 = 10$; $N_2 = 86$, $M_2 = 25.45$, $SD_2 = 31.16$, $MED_2 = 10$)**

e. Identify as gay/lesbian/bisexual/transgendered? _____% **($N_1 = 98$, $M_1 = 6.70$, $SD_1 = 8.26$, $MED_1 = 5$; $N_2 = 88$, $M_2 = 8.12$, $SD_2 = 17.84$, $MED_2 = 2.5$)**

7. I think it is important to serve a diverse population. *Please circle one choice.*

1	2	3	4	5	6
Strongly Agree	Mostly Agree	Somewhat Agree	Somewhat Disagree	Mostly Disagree	Strongly Disagree

($N_1 = 112$, $M_1 = 1.98$, $SD_1 = 1.07$, $MED_1 = 2$; $N_2 = 89$, $M_2 = 1.99$, $SD_2 = 1.15$, $MED_2 = 2$)

8. I specialize in a particular population. *Please circle* YES *or* NO.

If yes, please identify: _____

9. My practice setting is best characterized as a(n):

Check all that apply. For each check, please indicate the percentage of your professional time spent in this setting. (Total should = 100%).

- ❑ Community Mental Health Center _____% **($N_1 = 15, M_1 = 36.33, SD_1 = 44.66, MED_1 = 10; N_2 = 21, M_2 = 60.19, SD_2 = 41.44, MED_2 = 80$)**

- ❑ Private or group practice _____% **($N_1 = 67, M_1 = 77.84, SD_1 = 33.49, MED_1 = 100; N_2 = 70, M_2 = 72.09, SD_2 = 36.44, MED_2 = 98.5$)**
- ❑ Outpatient medical/psychiatric _____% **($N_1 = 17, M_1 = 56.18, SD_1 = 46.05, MED_1 = 75; N_2 = 12, M_2 = 40.33, SD_2 = 36.81, MED_2 = 37.5$)**
- ❑ Research institute _____% **($N_1 = 10, M_1 = 20.00, SD_1 = 34.96, MED_1 = 0; N_2 = 5, M_2 = 19.80, SD_2 = 44.27, MED_2 = 0$)**
- ❑ Student Mental Health or Counseling Center _____ % **($N_1 = 15, M_1 = 45.47, SD_1 = 48.99, MED_1 = 16; N_2 = 6, M_2 = 21.50, SD_2 = 39.82, MED_2 = 0$)**
- ❑ School-based practice _____ % **($N_1 = 12, M_1 = 19.17, SD_1 = 27.37, MED_1 = 0; N_2 = 9, M_2 = 30.44, SD_2 = 38.22, MED_2 = 20$)**
- ❑ Child guidance clinic _____ % **($N_1 = 9, M_1 = 6.11, SD_1 = 16.54, MED_1 = 0; N_2 = 5, M_2 = 19.80, SD_2 = 44.27, MED_2 = 0$)**
- ❑ Forensic/Justice (e.g., jail, prison) _____ % **($N_1 = 13, M_1 = 30.77, SD_1 = 40.15, MED_1 = 10; N_2 = 18, M_2 = 48.72, SD_2 = 44.47, MED_2 = 32.5$)**
- ❑ Department clinic (psychology clinic run by school or dept.) ____ % **($N_1 = 10, M_1 = 36.00, SD_1 = 47.89, MED_1 = 0; N_2 = 6, M_2 = 18.17, SD_2 = 39.80, MED_2 = 0$)**
- ❑ Inpatient hospital _____ % **($N_1 = 16, M_1 = 41.88, SD_1 = 45.93, MED_1 = 20; N_2 = 14, M_2 = 40.64, SD_2 = 43.79, MED_2 = 22.5$)**
- ❑ Military _____ % **($N_1 = 11, M_1 = 16.09, SD_1 = 32.06, MED_1 = 0; N_2 = 7, M_2 = 39.86, SD_2 = 50.13, MED_2 = 0$)**
- ❑ Clinic and hospital _____% **($N_1 = 21, M_1 = 46.71, SD_1 = 43.37, MED_1 = 30; N_2 = 14, M_2 = 36.14, SD_2 = 42.96, MED_2 = 15$)**
- ❑ Industrial/Organizational consultation _____ % **($N_1 = 15, M_1 = 25.33, SD_1 = 36.23, MED_1 = 10; N_2 = 6, M_2 = 33.17, SD_2 = 51.38, MED_2 = 0$)**

10. How many national or regional psychology conferences did you attend in the past year? _____ **($N_1 = 113$, $M_1 = 1.39$, $SD_1 = 1.22$, $MED_1 = 1$; $N_2 = 91$, $M_2 = 1.64$, $SD_2 = 1.74$, $MED_2 = 1$)**

11. Approximately how many professional presentations at national or regional conferences have you made in your lifetime? _____ **($N_1 = 114$, $M_1 = 7.55$, $SD_1 = 20.11$, $MED_1 = 2.5$; $N_2 = 90$, $M_2 = 4.15$, $SD_2 = 7.68$, $MED_2 = 1$)**

12. Approximately how many peer-reviewed journal articles or professional books do you read on average during a month? _____ **($N_1 = 114$, $M_1 = 3.66$, $SD_1 = 3.52$, $MED_1 = 3$; $N_2 = 91$, $M_2 = 3.48$, $SD_2 = 4.46$, $MED_2 = 2$)**

13. About how many peer-reviewed journal articles, book chapters, or books have you authored or co-authored and published in your lifetime? _____ **($N_1 = 114$, $M_1 = 3.39$, $SD_1 = 6.20$, $MED_1 = 1$; $N_2 = 91$, $M_2 = 1.47$, $SD_2 = 5.51$, $MED_2 = 0$)**

14. To which APA divisions do you hold memberships? _____

15. How many times in the past year have you advocated for the field of psychology by:

a. Writing to a political representative or legislator? _____ **($N_1 = 108$, $M_1 = 0.94$, $SD_1 = 2.05$, $MED_1 = 0$; $N_2 = 76$, $M_2 = 1.05$, $SD_2 = 1.72$, $MED_2 = 0$)**

b. Speaking with a political representative or legislator? _____ **($N_1 = 105$, $M_1 = 0.28$, $SD_1 = 1.15$, $MED_1 = 0$; $N_2 = 71$, $M_2 = 0.41$, $SD_2 = 1.29$, $MED_2 = 0$)**

c. Contributing funds to lobbyists or social advocacy groups? _____ **($N_1 = 106$, $M_1 = 0.64$, $SD_1 = 0.95$, $MED_1 = 0$; $N_2 = 76$, $M_2 = 0.84$, $SD_2 = 1.31$, $MED_2 = 0.5$)**

d. Writing a letter to the editor of a newspaper or magazine? _____ **($N_1 = 103$, $M_1 = 0.11$, $SD_1 = 0.42$, $MED_1 = 0$; $N_2 = 66$, $M_2 = 0.08$, $SD_2 = 0.32$, $MED_2 = 0$)**

e. Meeting with a community board or committee? _____ **($N_1 = 105$, $M_1 = 1.94$, $SD_1 = 4.88$, $MED_1 = 0$; $N_2 = 73$, $M_2 = 1.52$, $SD_2 = 3.18$, $MED_2 = 0$)** *If so, how many different boards did you serve on in the past year?* _____ **($N_1 = 61$, $M_1 = 0.66$, $SD_1 = 0.96$, $MED_1 = 0$; $N_2 = 46$, $M_2 = 0.65$, $SD_2 = 0.79$, $MED_2 = 0$)**

f. Speaking at a public forum such as a town hall meeting? _____ **($N_1 = 103$, $M_1 = 0.34$, $SD_1 = 1.18$, $MED_1 = 0$; $N_2 = 71$, $M_2 = 0.41$, $SD_2 = 0.98$, $MED_2 = 0$)**

16. What is the designated primary subspecialty of your doctorate in psychology?

Please check one:

__ Clinical (adult track) **($N_1 = 34$; $N_2 = 26$)** __ Health **($N_1 = 2$; $N_2 = 1$)**

__ Clinical (child track) **(N_1 =12; N_2 =7)**
__ Clinical (general) **(N_1 = 20; N_2 =45)**
__ Counseling **(N_1 = 32; N_2 =1)**
__ Developmental **(N_1 = 0; N_2 = 0)**
__ Educational **(N_1 = 0; N_2 = 0)**
__ Neuropsychology **(N_1 = 5; N_2 = 6)**
__ School **(N_1 = 2; N_2 = 0)**
__ Respecialization Program **(N_1 = 0; N_2 = 0)**
__ Combined (*Specify:* _____) **(N_1 = 7; N_2 = 3)**
__ Other (*Specify:* _____) **(N_1 = 0; N_2 = 1)**

17. What degree did you receive? *Please check one:*

__ PhD **(114)** __ PhD/J.D. **(2 Subsumed under "PhD")**

__ PsyD **(91)** __ Certificate/Respecialization (*Specify:*_____) **(0)**

18. What year did you earn your doctoral degree? _____ **(N_1 = 113, M_1 = 1997.15, SD_1 = 1.83, MED_1 = 1997; N_2 = 89, M_2 = 1997.27, SD_2 = 1.67, MED_2 = 1997)**

19. What year did you initially become licensed as a psychologist? _____ **(N_1 = 113, M_1 = 1998.48, SD_1 = 2.45, MED_1 = 1999; N_2 = 89, M_2 = 1998.45, SD_2 = 2.21, MED_2 = 1998)**

20. What was the status of your doctoral training program at the time of your graduation? *Please check one:*

__ APA-Accredited **(N_1 = 107; N_2 = 79)** __ CPA-Accredited **(N_1 = 1; N_2 = 2)**

__ APA-Accredited, on probation **(N_1 = 0; N_2 = 1)** __ CPA-Accredited, on probation **(N =0)**

__ Not APA- or CPA-Accredited **(N_1 = 5; N_2 = 6)** __ Not sure **(N_1 = 1; N_2 = 3)**

21. If not APA/CPA- accredited, was the school regionally accredited? Yes / No

22. Your psychology graduate program was: *Please check one:*

__ University or college affiliated **(N_1 = 97; N_2 = 46)**

__ A free-standing (independent) institution **(N_1 = 17; N_2 = 45)**

23. What was your Department's Training Model? *Please check one:*

__ Clinical Scientist **(N_1 = 5; N_2 = 3)** __ Practitioner-Scholar **(N_1 = 8; N_2 = 24)**

__ Scientist-Practitioner **(N_1 = 97; N_2 = 36)** __ Practitioner **(N_1 = 3; N_2 = 21)**

__ Other – *Specify:* (e.g., Developmental, Specialty, Apprentice, Local Clinical Scientist) _____ **(N = 0)**

__ Not sure **(N_1 = 1; N_2 = 7)**

DEMOGRAPHICS

24. Current age: _____ **(N_1 = 114, M_1 = 42.33, SD_1 =6.72, MED_1 = 41; N_2 = 91, M_2 = 45.10, SD_2 = 8.11, MED_2 = 44)**

25. Gender (*Please circle one*): Male **(N_1 = 28; N_2 =37)** Female **(N_1 = 86; N_2 = 54)**

26. Ethnicity (put an "X" next to the one with which you most closely identify):

__ African American **($N_1 = 1$; $N_2 = 1$)** __ Asian/Pacific Islander **($N_1 = 3$; $N_2 = 1$)**

__ Caucasian **($N_1 = 101$; $N_2 = 85$)** __ Hispanic **($N_1 = 5$; $N_2 = 3$)** __ Native American **($N = 0$)**

__ Other: _____ **($N_1 = 3$; $N_2 = 1$)**

27. The community in which I grew up would best be described as:

Please check one:

__ Rural **($N_1 = 10$; $N_2 = 11$)** __ Small Town **($N_1 = 27$; $N_2 = 20$)**
__ Suburban **($N_1 = 54$; $N_2 = 38$)** __ Urban **($N_1 = 23$; $N_2 = 21$)**

28. The community in which I currently practice would best be described as:

Please check one:

__ Rural **($N_1 = 4$; $N_2 = 6$)** __ Small Town **($N_1 = 46$; $N_2 = 35$)**

__ Suburban **($N_1 = 46$; $N_2 = 35$)** __ Urban **($N_1 = 47$; $N_2 = 31$)**

Appendix B

Informed Consent and Cover Letter

November 7, 2005

Dear Colleague:

Greetings to you! I am a doctoral psychology student conducting dissertation research, and am asking for your help in examining the current attitudes and practices of licensed psychologists. (In this instance, I am hoping your attitude is helpful toward desperate doctoral students working on dissertations and your practice is one of completing and mailing this survey). In order to get a representative sample, your participation will be of vital importance.

Enclosed you should find a survey with instructions as well as an already-addressed response envelope with no postage necessary. Personal information will be kept confidential, so please refrain from indicating your name on the survey. All data will be presented in aggregate form to assure further anonymity. The survey is only 28 questions, so will be a snap compared to the MMPI-2.

George Fox University's Human Subjects Research Committee has approved this project, but it is up to you to make it a reality. If you have any questions or concerns, you may contact me by email at elkupko@georgefox.edu or by mail at Counseling Center, 601 University Drive, San Marcos, TX 78666-4616.

Thank you for your participation and candid responses.

Sincerely,

Elizabeth N. Wood

Elizabeth N. Wood, MA
Psychology Intern

NOTE: This research is supervised by Clark D. Campbell, PhD., who may be reached at ccampbel@georgefox.edu or George Fox University, 414 N. Meridian St., Newberg, OR 97132.

Appendix C

Reminder Postcard

Dear Colleague,

Hello again! This is a reminder from that desperate doctoral student about that "Practice Questionnaire" you should have received a couple of weeks ago. If you sent it off already – you have my deepest gratitude. If you have not yet sent it, this is your invitation to go on a treasure hunt in that snail mail inbox of yours to track it down, sit back, put your feet up, and fill it out in service to the future of psychology. Consider it an exercise in self-reflection.

Again, if you have any questions or comments, please contact me at elkupko@georgefox.edu or Counseling Center, 601 University Drive, San Marcos, TX 78666-4616. Enjoy your day!

Elizabeth N. Wood, MA

Appendix D

Curriculum Vita

Curriculum Vita

Elizabeth N. Wood, MA

[redacted]

EDUCATION

2001-present **Student in the Graduate School of Clinical Psychology, APA Accredited**
George Fox University, Newberg, OR
Doctor of Psychology: projected for September, 2006.

2001-2003 **Master of Arts: Clinical Psychology**
George Fox University, Newberg, OR

1995-1999 **Bachelor of Arts: Psychology, Magna Cum Laude**
Gonzaga University, Spokane, WA

SUPERVISED CLINICAL EXPERIENCE

2005-present **Internship** *(508.75 Direct Hours)*
Facility: Texas State University Counseling Center, San Marcos, TX
Duties: Provide individual and group psychotherapy to students; conduct crisis interventions; administer, score, and interpret psychological assessments and generate comprehensive reports; conduct career assessments; process intakes and make appropriate referrals; supervise practicum students, consult with psychiatric residents and physicians.
Supervision: Weekly: 2 hours of individual supervision, 1.5 hours supervision of supervision, one hour group supervision, one hour of clinical review, and two hours of psychiatric consultation
Supervisors: Kathlyn Dailey, Ph.D.; Pamela Moore, Ph.D.
Assessment Supervisor: Scott Janke, Psy.D.

2004-2005 **Preinternship** *(225 Direct Hours)*
Facility: Yamhill County Mental Health, McMinnville, OR
Duties: Conduct play therapy, co-lead therapy groups, conduct comprehensive assessments, provide individual therapy to adolescents enrolled in Willamina High School, provide family therapy, and conduct intakes.
Supervision: Weekly staff meetings and individual supervision.
Supervisor: Dawn Hoffman-Gray, Ph.D.

2005-2005 **Cancer Support Group** *(6 Direct Hours)*
Facility: Providence Newberg Hospital, Newberg, OR
Duties: Co-facilitate support group for cancer patients and spouses.
Supervision: Weekly supervision
Supervisor: Mary Peterson, Ph.D.

2004-2005 **Psychodynamic Training** *(~83 Direct Hours)*
Facility: Oregon Psychoanalytic Society
Duties: Provide individual psychodynamic psychotherapy.
Supervision: Weekly group supervision.
Supervisor: Kurt Free, Ph.D.

2004-2004 **Group Therapy** *(11 Direct Hours)*
Facility: George Fox University, Newberg, OR
Duties: Co-facilitate process group for undergraduate students.
Supervision: Weekly check-ins in group therapy class.
Supervisor: Ken Kornelis, Psy.D.

2003-2004 **Practicum II** *(198 Direct Hours)*
Facility: George Fox University Health and Counseling Center, Newberg, OR
Duties: Provide individual therapy, conduct alcohol assessments, personality assessment, and comprehensive evaluation.
Supervision: Weekly supervision and inservice training.
Supervisor: William Buhrow, Psy.D.

2003-2004 **Behavioral Health Consultation** *(32 Direct Hours)*
Facility: Providence Newberg Hospital, Newberg, OR
Duties: Consult with hospital staff in an on-call basis in assessing dangerousness of patients to self or others, mental status, and competency to care for self. Contribute to inservice trainings for hospital staff.
Supervision: Two-hour weekly supervision and phone consult during calls.
Supervisors: Clark Campbell, Ph.D., Sally Hopkins, Psy.D., Scot Cook, Psy.D., Wayne Adams, Ph.D., ABPP

2002-2003 **Practicum I** *(210 Direct Hours)*
Facility: Columbia River Mental Health Services, Vancouver, WA
Duties: Counseled persistently mentally ill adults in individual psychotherapy, treatment planning, and crisis intervention services. Consulted with multi-disciplinary team.
Supervision: Weekly individual supervision. Specialized training in solution-focused brief therapy.
Supervision: Doug Park, Ph.D.

2002-2002 **Pre-practicum** *(39 Direct Hours)*
Facility: George Fox University, Newberg, OR
Duties: Diagnosis and treatment planning, case presentations, intake interviews, and termination.
Supervision: Weekly individual supervision and clinical team meetings.
Supervisor: Carol Dell'Oliver, Ph.D.

RELEVANT WORK EXPERIENCE

2003-2005 **Graduate Assistant to the Director of Clinical Training**
Facility: George Fox University, Newberg, OR
Duties: Perform administrative duties to support the Director of Clinical Training in the tasks of monitoring student progress, maintaining efficient student progress, and facilitating quality placement and training.

2001-2003 **On-call employee, Yamhill County Mental Health**. *(158 hours)*
Facility: Premier Living Enhanced Care Facility, McMinnville, OR
Duties: Facilitated socialization activities among residents, discussed emotional or relational difficulties, and charted activities and behavior.

1998-1998 **Shelter Staff/Support Staff, Volunteers of America** *(4 months, 323 hours)*
1) Facility: Crosswalk Youth Shelter, Spokane, WA
Duties: Performed intakes and needs assessment, enforced facility rules and standards, supervised recreational activities, cooperated with law enforcement and other social services as appropriate, logged ongoing activities, and maintained client confidentiality.
2) Facility: Alexandria's House, a home for pregnant and parenting adolescent girls, Spokane, WA
Duties: Supervised house activity and chores; logged ongoing activities and observations concerning each resident; maintained client confidentiality; supported the residents by education and encouraging greater self-efficacy.

1998-1998 **Caregiver, Catholic Charities** *(June-August, on-call employee, ~24 hours)*
Facility: St. Anne's Therapeutic Child Care, Spokane, Washington
Duties: Provided structured programming for underprivileged and (physically, mentally, or emotionally) underdeveloped children (ages 0-4), engaged them in play, introduced them to developmentally appropriate activities, employed behavior management techniques, and encouraged appropriate interactions between the children and their parents during required lunchtime visits.

VOLUNTEER EXPERIENCE

Service Learning Project, Catholic Charities: St. Anne's Therapeutic Child Care. *(February-May, 1998; ~30 hours)* Observed and interacted with the children (as mentioned above under "Relevant Work Experience"), and noted the methods and interventions used by the employees.

Long-term Volunteer, Providence Volunteer Ministry. *(July, 1999 - June, 2000; 1776 hours)*
Service Placement: Child Care Worker, Providence Self-Sufficiency Ministries, New Albany, Indiana.
Duties: Provided childcare in three settings:

1) a foster group home for children, ages 4-12 years old,
2) a before-and-after school program for elementary school-aged children, and
3) a day-care in various age-specific rooms, ranging from infancy to school-aged.

Planned curriculum for a summer program. All locations served the underprivileged population.

Critical Incident Response, Crescent City, CA. *(September, 2002)* Community charity event barely began when a driver lost control of her vehicle and hit 17 community members. With colleagues originally present to provide psychoeducation and information for the community, provided on-the-spot crisis debriefing and co-led a crisis debriefing group the day following. Supervised by Clark Campbell, Ph.D.

RESEARCH EXPERIENCE

Research Vertical Team Member. *(September 2002-May 2005)* Met bi-weekly to discuss current research of team members and facilitate progress on dissertations. Topics included: issues related to family health and functioning, rural mental health, social responsibility, and professional issues in psychology. Supervisor: Clark D. Campbell, Ph.D.

Richter Scholar. *(2005-2006)*. Awarded grant money to carry out dissertation research.

Richter Scholar. *(2003)*. Awarded grant money to carry out research regarding how supervisors utilize videotape review of therapy sessions for training purposes.

Student Leadership Survey Data Analysis. *(2004)*. Utilized SPSS in analyzing survey results and then communicated the results to Dirk Barram who co-conducted the research in the Management Dept. at George Fox University.

Volunteer Rater of Qualitative Data. *(February 2002)*. Codified open-ended survey responses regarding rural pastors' attitudes toward making referrals to mental health providers (Chandler, A., dissertation completed 2003).

Paid Research Assistant, Washington Institute for Mental Illness Research & Training, Washington State University, Spokane. *(June 1998-July 1999; 545 hours)* Performed data

entry, organized data, created charts and graphs, developed databases, reviewed literature and grants, prepared conference mailings, analyzed psychological data, discussed results with supervisors, and, in general, became familiarized with the processes involved in quantitative research. Supervisors: Dennis Dyck, Ph.D. and Robert Short, Ph.D.

Research Assistant, Gonzaga University, Spokane, Washington. *(August 1998-May 1999; ~75 hours)* Reviewed articles on qualitative research, transcribed interviews, performed qualitative analysis, discussed results weekly with research team, and utilized assessment tool--Mary Ainsworth's Strange Situation--to evaluate mother-infant attachments.
Supervisors: Nancy Worsham, Ph.D. and Molly Kretchmar, Ph.D.

PROFESSIONAL PRESENTATIONS AND PUBLICATIONS

Campbell, C. D., **Kupko, E. N.**, Bock, S., Fruhauff, K., Kearns, L., & Weniger, R. (2003, January). Practicum training: Facilitating constructive connections between students and sites. Pre-conference paper presented at the mid-winter meeting of the National Council of Schools and Programs in Professional Psychology, Scottsdale, AZ.

Kupko, E.N. Videotape review in supervision: A survey of directors of clinical training. Poster presentation at the Richter Scholars 2003 round-table in Newberg, OR.

Johnson, W. B., Porter, K., Campbell, C. D., & **Kupko, E. N.** Character and fitness requirements for professional psychologists: An examination of state licensing application forms. *Professional Psychology: Research & Practice, 36*(6): 654-662.

PROFESSIONAL AFFILIATIONS

- Psi Chi Honor Society member since 1997.
- Western Psychology Association student affiliate 1997-2000.
- American Psychological Association student affiliate since 2002.

UNIVERSITY INVOLVEMENT

- **Clinical Training Committee,** 2003-2005.

- **Graduate School of Clinical Psychology Student Council**
  Elected cohort representative, 2001-2003.
  Spring Banquet Committee, 2001-2002.
  Advocacy Committee, 2002-2003.
  Peer Mentor Committee, 2001-2003.

- **Admissions interviewer**, co-conducted with faculty member, 2002, 2003, and 2004.

- **Peer Mentor**, 2002-2003 and 2003-2004.
  Provided peer support and information to first year graduate students regarding personal and professional development within graduate school.

- **Gonzaga University Psychology Club**
  Member, 1996-1997.
  Treasurer, 1997-1998.
  Vice-president, 1998-1999.

TEACHING EXPERIENCE

Assessment Seminar *(May 18, 2006).*
Setting: Texas State University Counseling Center
Topic: A Comprehensive Case Study

Stress Series Lecture *(February 22, 2006).*
Setting: Texas State University
Topic: Stress Management: The Heart of the Matter

Research Lunch *(February 9, 2006).*
Setting: Texas State University Counseling Center
Topic: Obsessive-Compulsive Disorder Treatment Approach

Stress Symposium Lecture *(October 6, 2005).*
Setting: Texas State University
Topic: Academic Skills: Time Management, Study Skills, and Talking to Professors

Guest Lecture *(September 9, 2005).*
Setting: Texas State University Freshman Seminar
Topic: Counseling Center Services

Hospital Staff Training *(July 7, 2004).*
Setting: Providence Newberg Hospital Staff In-service
Topic: Managing the Care of Patients with Difficult Personality Traits

Guest Lecture *(March 9, 2004).*
Setting: GFU Health & Counseling Center In-service Training
Topic: Positive Psychology in Practice

Guest Lecture *(January 20, 2004).*
Setting: Theories of Personality and Psychotherapy Course
Topic: Types and Traits, The Expressions of Dispositions

ADDITIONAL CLINICAL TRAINING

Weekly Intern Seminar and Assessment Seminar Current and Former Counseling Center Staff	2005-2006 San Marcos, TX
Coping with Grief in a "Get Over It and Move On!" World Presenter: Harold Ivan Smith, Ed.S, D.Min.	April 2006 Austin, TX
Substance Related Disorders Presenter: Blanca Sanchez-Navarro, LPC, LCDC	April 2006 San Marcos, TX
Blue Collar Roots, White Collar Dreams Presenter: Alfred Lubrano	April 2006 San Marcos, TX
Treatment of Individuals with Angry and Aggessive Behaviors: A Lifespan Perspective Presenter: Donald Meichenbaum, Ph.D	November 2005 San Antonio, TX
Motivational Interviewing: Theory, Practice, and Evidence Presenter: Denise Walker, PhD	April 2005 Newberg, OR
Acceptance and Commitment Therapy Presenter: Vijay Shankar, Ph.D. Licensed Clinical Psychologist	October 2004 Newberg, OR
Monthly Psychodynamic Seminar Leader: Kurt Free, Ph.D. Licensed Clinical Psychologist	Spring 2002 & 2003-2005 Newberg, OR
American Psychological Association Annual Conference	Summer 2004 Honolulu, HI
WISC-IV: An Overview and Discussion of Changes Presenter: Jerome Sattler, Ph.D., ABPP/CL	June 2004 Newberg, OR
Advocacy 101 Presenters: Susan Patchin, Ph.D., Cynthia Hansen, Ph.D. Oregon Psychology Association Alan Tresidder, and Damiana Merryweather, Lobbyists	April 2004 Newberg, OR
Domestic Violence: Training for Psychologists Presenter: Patricia Warford, Psy.D. Licensed Clinical Psychologist	May 2003 Newberg, OR

Practicum Weekly Training on Various Topics Leader: William Buhrow, Psy.D.	2003-2004 Newberg, OR
Introduction to Dialectical Behavior Therapy Presenter: Brian Goff, Ph.D. Portland DBT Program, PC	October 2003 Newberg, OR
Psychiatric Emergencies Sponsor: PESI Healthcare	September 2003 Clackamas, OR
Northwest Annual Assessment Conference Featuring the new Stanford-Binet 5 Presenter: Gale Roid, Ph.D.	June 2003 Newberg, OR
Current Guidelines for Working with Gay, Lesbian, and Bisexual Clients Presenter: Carol Carver, Ph.D. Licensed Clinical Psychologist	May 2003 Newberg, OR
Profitable Behavior: Using Psychological Knowledge and Skills to Consult with Businesses Presenter: Steven T. Hunt, Ph.D. Steven T. Hunt Consulting	March 2003 Tigard, OR
Guilt, Loneliness, and Despair Presenter: William Buhrow, Psy.D. George Fox University	February 2003 Newberg, OR
Integration of Religion and Psychotherapy: Explicit, Implicit or What? & Interpreting Personality Dynamics with the Wechsler Scales. Presenter: Robert Lovinger, Ph.D., ABPP Walden University	October 2002 Newberg, OR
Assessment and Treatment of Traumatized Children Presenter: Sophie Lovinger, Ph.D., ABPP. Walden University	October 2002 Newberg, OR
Attachment Disorder, Post-Traumatic Stress and Inter-Generational Trauma: Etiological Implications for Brain Function in Tribal/Native Behavioral Health Treatment Presenter: Joseph B., Stone, Ph.D., CAC Level III, ICADC Confederated Tribes of Grand Ronde Behavioral Health Program	April 2002 Newberg, OR

Prevalence Rates of Full and Partial PTSD and Lifetime Trauma in a Sample of Adult Members of an American Indian Tribe Presenter: Thomas J. Ball, Ph.D. Oregon Social Learning Center	April 2002 Newberg, OR
Object Relations: A Christian Perspective. Presenter: Kurt E. Free, Ph.D. Christian Association for Psychological Studies	March 2002 Portland, OR
Western Psychology Association Annual Convention	April 1999 Irvine, CA
Western Psychology Association Annual Convention	April 1997 Seattle, WA

ASSESSMENT EXPERIENCE

Measure	# Administered & Scored	# Reports Written
Adult Attention Deficit Disorders Evaluation Scale	3	2
BASC Monitor for ADHD	1	1
Campbell Interest and Skill Survey	1	0
Controlled Oral Word Association Test	2	2
Grooved Pegboard	1	1
Halstead-Reitan Category Test	2	2
Halstead-Reitan Finger-Tapping Task	2	2
Halstead-Reitan Finger-tip Number Writing	2	2
Halstead-Reitan Grip Strength Task	2	2
Halstead-Reitan Tactile Finger Recognition	2	2
Halstead-Reitan Tactile, Auditory, and Visual Screenings	2	2
Halstead-Reitan Tactual Performance Test	1	1
Halstead-Reitan Trails A and B	2	2
The House-Tree-Person Figure Drawing Test	1	1
Integrated Visual and Auditory Continuous Performance Task	2	2
Minnesota Multiphasic Personality Inventory-2	7	6
Millon Clinical Multiaxial Inventory-III	2	2
Myers-Briggs Type Indicator	5	2
Peabody Picture Vocabulary Test-3	1	1
Personality Assessment Inventory	2	2
16PF	2	2
Roberts' Apperception Test for Children	1	1
Rorschach Inkblot Test	3	2
The Rotter Incomplete Sentences Blank	3	3
Scholastic Abilities Test for Adults	1	1
The Strong Interest Inventory	3	2
The Substance Abuse Subtle Screening Inventory	2	1

The Thematic Apperception Test	1	1
Wechsler Adult Intelligence Scale-III	5	5
Wechsler Intelligence Scale for Children-III	2	2
Wechsler Individual Achievement Test-II	1	1
Wechsler Memory Scale	2	2
Wide Range Intelligence Test	3	3
Wide Range Achievement Test-3	3	3
Wide Range Assessment of Memory & Learning	1	1
Wide Range Assessment of Memory & Learning - 2	1	1
Woodcock Johnson Test of Achievement	1	1

RELEVANT COURSEWORK

Cumulative GPA: 3.95

THEORY & PRACTICE:	Psychopathology Human Development Theories of Personality & Psychotherapy Learning, Cognition, & Emotion Social Psychology History & Systems of Psychology Cognitive/Behavioral Psychotherapy Psychodynamic Psychotherapy Systems of Integration-Theory & Therapy Behavioral Medicine Marriage & Family Therapy Multicultural Therapy The Biological Basis of Behavior Object Relations Theory Psychopharmacology Child and Adolescent Therapy Group Psychotherapy
ASSESSMENT:	Personality Assessment Intellectual & Cognitive Assessment Projective Assessment Comprehensive Assessment Neuropsychological Assessment Clergy Assessment
RESEARCH:	Psychometrics Statistical Methods Research Design
PROFESSIONAL ISSUES:	Ethics for Psychologists Professional Issues for Psychologists