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Craig J. Gonsalvez

University of Wollongong, craigg@uow.edu.au

Judy Hyde

University of Sydney

Julie Barrington

Monash University

Sandra Lancaster

Victoria University

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Keywords

University, psychology, clinics, Australia, their, place, professional, training

Disciplines

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University psychology clinics in Australia: Their place in professional training

CRAIG J. GONSALVEZ^{1,2}, JUDY HYDE³, SANDRA LANCASTER⁴, & JULIE BARRINGTON⁵

¹*Department of Psychology, University of Wollongong, Wollongong, Psychology, Wollongong,* ²*Illawarra Institute for Mental Health,* ³*Department of Psychology, University of Sydney, Sydney, New South Wales,* ⁴*Department of Psychology, Victoria University* and ⁵*Department of Psychology, Monash University, Melbourne, Victoria, Australia*

Abstract

There is universal recognition of the need for developmentally appropriate supervised clinical experience in professional psychology training. University clinics were established to provide a bridging function for postgraduate clinical psychology students, assisting the integration of psychological theory and research into real-world clinical applications and professional identity development. The aim of training in university clinics is to provide opportunities for clinical practice and high-quality supervision to monitor and shape clinical skills. The experiences gained in external practicum settings complement this initial training but cannot replace it. The recent introduction of Medicare rebates for psychology services has threatened the survival of university clinics because low-cost psychological treatment is now available from experienced practitioners. This paper provides data on Australian university clinics collected before the introduction of Medicare. Concerted efforts are needed to protect university clinics in order to maintain standards required for accreditation of clinical psychology training programs. The potential impact of the loss of university training clinics is discussed and strategies to ensure their survival are suggested.

Key words: *Clinical/counseling psychology, clinical psychology training, psychology as a discipline, teaching of psychology, university psychology clinics.*

The need for developmentally appropriate clinical experience under expert supervision is recognised to be a vital aspect of professional psychology training (Aveline, 1997; Lewis, Hatcher, & Pate, 2005). In particular, the development of clinical competencies and processes leading to the effective treatment of mental health problems is of central importance to formal training in clinical psychology for the training institutions, the students, those receiving psychology services and society as a whole (Ronnestad & Ladany, 2006).

In Australia, provision of supervised clinical training in a university psychology clinic is a requirement for accreditation of postgraduate clinical psychology programs. The relatively protected environment provided by university training clinics allows inexperienced trainee psychologists to take

their first steps toward becoming competent practitioners and developing a professional identity as a psychologist.

The recent introduction of Medicare rebates for psychology services is threatening the survival of university clinics because low-cost psychological treatment is now available from experienced practitioners. Currently, the viability of university training clinics in some professional psychology courses is under question. This paper describes the role of university clinics in the training of clinical psychology students and reports results from a survey of Australian university clinics. We argue that clinics are necessary to protect standards of clinical training, the status of psychology as a profession and the quality of clinical psychology services provided to the community. Possible

strategies are suggested to increase the viability of university clinics.

Background

Clinical psychology training involves three components: theoretical knowledge, research skills and clinical practice. University clinics were established to facilitate the integration of conceptual knowledge into real-world clinical applications. The knowledge acquired during undergraduate study and postgraduate coursework units can be applied when students begin to see patients within the monitored environment of a training clinic.

Importantly, the environment provided by training clinics fosters the development of a specialist professional identity for trainees in clinical psychology. The identity of a profession is in part delineated by a distinct specialised body of knowledge and skills acquired during training and also by the recognition of the specialist expertise of the profession in society (Lancaster & Smith, 2002). The presence of more generic positions and case management models of service provision has reduced the opportunities for specific psychology skills to be practised within some workplaces (Smith & Lancaster, 2002).

Albee (1970) argued that without a “captive practicum” of its own, clinical psychology is like a cuckoo that has to “place its eggs in other birds’ nests” (p. 1072). Specialist training within a university clinic offers students the opportunity to access and interact with a range of psychologist clinical role models and obtain the support of peers and mentors, thus fostering the development of a specialist identity as a psychologist. In contrast, within an external practicum environment there may be less opportunity to foster the early development of a specialist identity in trainee psychologists because of the culture and multidisciplinary mix within most institutions.

Goals of university clinics

The ideal university clinic includes the following: (a) a judicious selection of patients with less difficult problems to match the early developmental stage of the clinical trainee, (b) staff with specialist clinical expertise who adhere to the scientist–practitioner model, exemplify best practice in clinical psychology and engage in clinical research, (iii) intensive supervision, and (iv) utilisation of a range of observational methods and audiovisual technology techniques (e.g., one-way mirrors, video recordings) to enable appropriate monitoring, review and feedback in order to shape clinical skills. Training clinics vary in their capacity to meet all of the above criteria. Results from a recent study (Pachana, O’Donovan, & Helmes, 2006) indicate that differences exist in the

level of resourcing of university clinics and the capacity to pay for high-quality supervision, with rates ranging from \$AUD25 to \$AUD160 per hr.

Place of university psychology clinics in professional training

The model of systematic progression from academic coursework to university clinic and supervised field practicum to independent clinical practice is not universal across the health professions. Several allied health disciplines (e.g., social work and occupational therapy) allow trainees to progress from preparatory coursework to fieldwork experience (under supervision) without a bridging university clinic-based practicum. In contrast, supervised practice at university clinics has been a distinguishing component of clinical psychology training in Australia and is arguably important to the identity of the profession in Australia and overseas.

Training for professional psychology in the United States involves an intensely supervised pre-internship practicum stage followed by a less intensely supervised, full-year internship program (Lewis et al., 2005). In that country there has been an acceptance that early experiential training in professional psychology should take place within the training program, with later stages of training supplemented through external placements (Belar & Perry, 1992). Research conducted in the United States suggests that awareness of training philosophies and goals and their implementation is much greater in faculty-based training programs than in external practicum (Rodolfa, Kaslow, Stewart, Keilin, & Baker, 2005).

Any discussion on the place of Australian university clinics in professional training in psychology should address the crucial question of whether there are any essential differences between psychology training at university clinics and external practicum settings. Previous literature has not systematically addressed this issue.

Professional training in university psychology clinics and external practicum settings

In contrast to the training provided in university clinics it has been suggested that training in external practicum sites differs primarily in the areas of case load, supervision and staffing. Overseas research has reported that in university clinics compared to external practicum sites, student case loads are lower, staffing levels and the amount of supervision are higher, and there is more regular observation of therapist–patient sessions. These observed differences have been attributed to the different primary tasks of the two settings: service delivery in external agencies and training in university clinics (Dodds,

1986; Lewis et al., 2005). This critical distinction means that, in external practicum sites, willingness to accept trainees is often guided by whether the benefits derived from patient services offered by the trainee outweigh the costs of providing training and supervision (Lewis et al., 2005). As a consequence, agencies prefer students with experience who can function well with minimal monitoring and supervision (Dodds, 1986). In the Australian context, in which many of the trainees have entered postgraduate courses directly after completing a 4-year psychology degree, this means that most agencies will not accept students until the second year of their training and after they have had clinical experience in their university clinic.

Differences in clinical supervision practices between university clinics and external field settings have also been highlighted in overseas studies and in the limited Australian research that is available (Gonsalvez, Oades, & Freestone, 2002; Kavanagh et al., 2003; O'Donovan, Dyck, & Bain, 2001). According to studies conducted overseas inadequate supervision is one of the most common grievances among psychology students (Gross, 2006). Similarly in Australia, psychology supervisees (O'Donovan et al., 2001) as well as supervisees from a range of health professions, have reported inadequate or inaccessible supervision (Kavanagh, et al., 2003). Field supervisors have acknowledged this limitation and expressed the view that trainees should ideally receive more frequent supervision than they were able to provide (Gonsalvez et al., 2002).

The regular use of observational methods (one-way mirrors, audio or video taping) during supervision is specified in postgraduate coursework psychology accreditation standards and Australian Psychological Society (APS) College guidelines (Australian Psychological Accreditation Council [APAC], 2008; APS, 2006). There is an emphasis on these observational methods in university training clinics (Table 1), but supervision of clinical work outside university training clinics has been more reliant on trainees' report of ongoing casework (Goodyear & Nelson, 1997; Townend, Iannetta, & Freeston, 2002). The limited Australian evidence

available from clinical psychology supervisors and allied health staff (37% psychologists) in external settings indicates that there is little observation of clinical practice, skills practice, or use of audiovisual aids in supervision (Gonsalvez et al., 2002; Kavanagh et al., 2003). This is a matter of concern because pedagogic reasons and empirical data indicate that observational methods are central to the training of professional psychology competencies (for a review of clinical supervision in the Australian context, see Gonsalvez & McLeod, 2008).

While there is, to date, no systematic research conducted in Australia that has compared the use of observational methods in supervision across the two settings, the information reported below on university clinics suggests regular use of observational methods.

Psychology clinics in Australia

Psychology training in university clinics in Australia is regulated by external accreditation standards of APAC (APAC, 2008), Guidelines of Colleges of the APS (APS, 2006) and, to some extent, by university-based philosophies and pedagogies of education. These standards and guidelines specify principles that should underlie training (such as the scientist-practitioner approach) and also minimum standards including (a) staffing requirements, (b) supervision requirements, (c) supervisor eligibility criteria (e.g., eligibility for college membership), and (d) case load.

There have been only limited data published on university psychology clinics in Australia. Apart from a paper describing the operation of a single university clinic (Murrell, Steel, Gaston, & Proudfoot, 2002), only one previous publication (Pachana et al., 2006) has made reference to the functioning of university psychology clinics across Australia. This study involved a survey of clinical psychology program directors conducted in 2004 with the goal of facilitating communication between clinical psychology training programs. Results of the survey also included some limited data about the training clinics of 19 universities.

The most comprehensive information available on Australian university psychology clinics is from an unpublished survey conducted in 2004 before the introduction of Medicare rebates for psychology services. A description of this survey and some of the results are presented here.

Methods

Between July and September 2004, a survey of all Australian university clinics was conducted by the second author. The purpose of the survey was to collect information that would provide a profile of

Table 1. Clinical supervision methods used in clinics

Supervision methods	Clinics <i>n</i> (%)
Live observation only	2 (6)
CP	2 (6)
Recording only	2 (6)
CP + live observation	2 (6)
CP + recording	10 (30)
CP + live observation + recording	15 (45)

Note: CP = case presentation.

training clinics in Australia. An 88-item Clinic Profile Questionnaire was developed to collect information on management structure, services offered, types of patients seen, supervision, fees for services, funding, income and expenditure, and clinic resources, including staffing and space. Questions related to the students undertaking placements in the clinics and the clinic placement requirements were also included.

The Clinic Profile Questionnaire took approximately 20 min to complete and consisted of multiple-choice questions, questions requiring numerical or categorical responses and 13 open-ended questions (e.g., "Please tell us about areas of greatest difficulty for you and the clinic"). The questionnaire was emailed to 34 of the 35 (one clinic was inadvertently omitted) university training clinics in Australia connected to postgraduate training in vocational psychology programs (identified through website listings of the Australian Government Department of Education and the Australian Psychological Society). The response rate was maximised by a reminder email and up to two reminder telephone calls.

Results

Thirty-three of the 34 clinics (97%) returned completed questionnaires. The majority of clinics ($n=27$; 81%) were involved in training Master or Doctor of Clinical Psychology students, with 15 of these clinics also providing training experiences for other specialties including clinical neuropsychology ($n=7$; 21%), forensic psychology ($n=5$; 15%), educational psychology ($n=3$; 9%), health psychology ($n=2$; 6%), and counselling psychology ($n=2$; 6%).

Some of the results from this survey are highly relevant to the topic under discussion and these are presented here. A full copy of the results can be obtained from the second author.

Service provided

The average number of patients treated in clinics annually was 238, with an Australia-wide total of approximately 9,000 patients per year. There was, however, a large variation in the number of patients seen across clinics, ranging from services provided for fewer than 100 patients annually in three clinics (9%) to more than 400 patients being seen per year by three clinics (9%). The number, range, and nature of services offered in the clinics varied substantially, according to requirements of the training programs utilising the clinic and the expertise of clinic supervisory staff. Patients were not differentiated in terms of presenting problems or

their complexity and the majority of clinics were prepared to accept for assessment all but actively suicidal or psychotic patients, or those involved in legal proceedings. Such patients were referred to more suitable services.

As shown in Table 2, most clinics offered a range of services, with clinical assessment and therapy for adults being the most common ($n=30$; 91% of clinics), followed by child/adolescent clinical assessment and therapy ($n=25$; 76% of clinics). Twenty-two clinics (67%) offered psychometric assessments for children, and 15 (45%) provided them for adults. A small number of clinics ($n=7$; 21%) offered more specialised services, such as clinical ($n=5$; 15%) or neuropsychological ($n=2$; 6%) medico-legal assessments for adults; child and family medico-legal assessments ($n=2$; 6%) and educational planning for children ($n=1$; 3%).

Cost of services

Fees varied between clinics and according to the type of service provided. The range of fees charged is shown in Figure 1. In five clinics fees were on a sliding scale according to income, all but three clinics (9%) offered discounted fees for those in financial hardship (e.g., persons with a health care card) and no fees were charged by three clinics (9%). The range of fees charged for the most frequently offered service, adult and child therapy was from \$AUD20 to \$AUD90 per session, an average of \$AUD41/session, with the average reduced fee for this service being \$AUD18/session (range from no charge to \$AUD40). At the time of the survey the low fee structure of clinics made it relatively easy for most people to access psychological services.

Training and supervision provided

Approximately 481 Masters and professional Doctorate students were trained annually across the 31 clinics that reported student numbers. Case loads per student varied from two to five patients at any one time, depending on the program. In most cases

Table 2. Type of services and no. clinics offering these services

Type of service	Adult <i>n</i> (%)	Child <i>n</i> (%)
Clinical assessment and therapy	30 (91)	25 (75)
Couple therapy	15 (45)	
Group therapy	15 (45)	12 (36)
Family therapy		14 (42)
Psychometric assessment	15 (45)	22 (67)
Specialised neuropsychology assessments	15 (45)	12 (36)

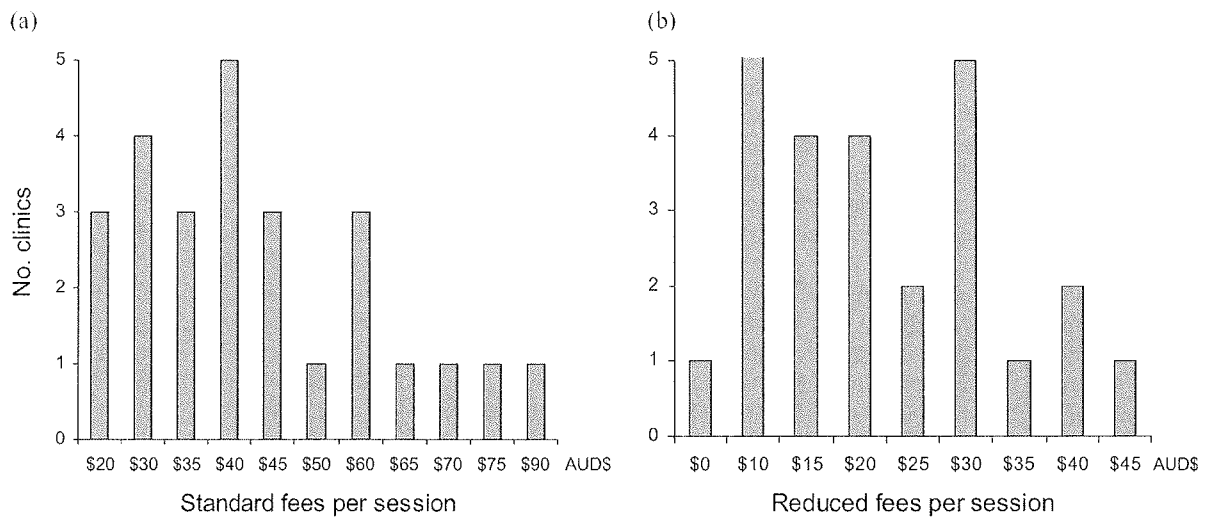


Figure 1. (a) Standard and (b) reduced fees per session charged by university clinics.

the placements provided by clinics for students represented the student's first experience of practical training before commencing external placements. Several clinics provided more than one placement (or their clinic placement continued throughout the duration of the course) in the clinic; while one provided only advanced doctoral placements.

Supervision of students' clinical work was provided through individual supervision: up to 2 hr/week in 25 clinics (76%), group supervision in 24 clinics (72%) and both individual and group supervision in 20 clinics (61%). Those providing supervision were either academic staff with clinical training/experience or experienced clinical psychologists employed for this purpose. Some clinics used supervisors from both categories. Almost all clinics (94%) reported that direct observation of students' clinical work was undertaken concurrently via viewing through a one-way screen, watching a monitor, or through the supervisor being present in session, and/or through post-session observation by video or audio recording. Direct observation was generally utilised at the assessment phase. Direct observation and other methods of supervision, such as case presentations and/or presentation of detailed case notes, were used in varying degrees for post-assessment sessions (Table 1). Students were involved in observing sessions as a team in 19 clinics (58%).

Funding

According to the information provided, clinics were well resourced. They varied in size from one to 13 rooms; and all clinics were equipped with one-way

screens, and/or video and audio recording facilities in most rooms (Figure 2). Staffing of clinics (administrative and clinical) represented the main costs of running clinics. Most clinics (94%) generated income by charging fees that were generally used to offset costs, but the operations of psychology training clinics required a substantial investment by universities.

Discussion

Some limitations of the data reported from the survey of university psychology clinics need to be acknowledged. Clinical training and supervision in university clinics is ideally provided, in accordance with the scientist-practitioner model, by highly skilled clinicians who also conduct clinical research in their specialty, but in practice this may not always be the case. The level of supervision provided by university clinics is assumed to be intensive for postgraduate students early in their training, but more details are needed to show this advantage. There is a need for future studies to examine improvement in students' clinical skills, trainee satisfaction and patient outcome. An outcome measure such as the Depression Anxiety and Stress Scales (Lovibond & Lovibond, 1995) has been used effectively by Murrell et al. (2002) to demonstrate clinical improvement for patients attending their university clinic. The incorporation of such measures within a study that focused on the effectiveness of training in university psychology clinics would strengthen the case for the value of university clinics in training future generations of clinical psychologists for the benefit of the community.

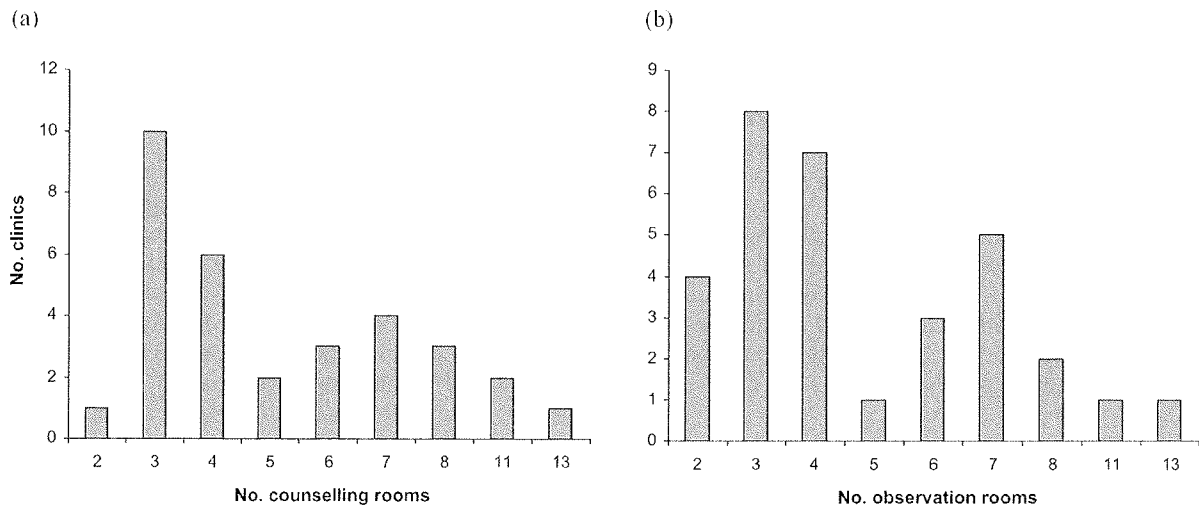


Figure 2. Number of (a) counselling and (b) observation rooms in university clinics.

Training of specialist psychologists is a costly enterprise but, as shown in the above results, prior to the introduction of Medicare rebates, university clinics successfully provided psychology services to the general public at no added cost to the government and low cost to the community. Little recognition has been given to training clinics in the past for the provision of these services and, as a consequence, in the implementation of the Medicare rebate system for psychologists they have been overlooked as major service providers. Recently released data from Medicare Australia indicate that the cost to patients (average gap payment for services that were not bulk billed) was \$AUD33.41 for services from general psychologists and \$AUD27.97 for clinical psychology services (Giese, Littlefield, & Mathews, 2008). With the advent of Medicare, it is now cheaper in 2008 to access therapy from a registered psychologist than it was to receive therapy from a trainee at a university Clinic in 2004. The capability of university clinics to provide the patients required for clinical training is likely to become further compromised because of Federal Government initiatives to increase the number of clinical psychology training places in universities, and the recent provision of 222 new postgraduate scholarships for psychologists in rural and regional areas (Littlefield, 2008).

Potential impact of the loss of university training clinics

The loss of clinical training within university clinics has implications for external practica. In a previous study (Pachana et al., 2006) the difficulty of finding appropriate placements for students in postgraduate clinical psychology courses was reported to be a problematic issue in clinical training.

Field supervisors in clinical settings rely on students having already received some training in their university clinic and therefore on being able to meet certain standards of clinical assessment and treatment before going on placement; in the absence of such training field supervisors would be reluctant to take on students. Field supervisors are often under pressure to maintain a full case load with little or no allowance for time to supervise students. The loss of university clinics would place even greater expectations on field supervisors who believe trainees should receive more supervision than they were able to provide (Gonsalvez et al., 2002).

The issue of retaining university training clinics is one of maintaining high levels of training and competence for professional psychologists in Australia. Any departure from university clinic training for professional psychology could also widen the gap between professional psychologists in Australia and our colleagues overseas, diminishing opportunities for mutual recognition and exchange.

The clinical experience gained in university clinics and external practica are predominantly shaped by the Clinical College Guidelines (APS, 2006). These guidelines stipulate minimum hours of supervision (180 hr), practicum (1000 hr) and face-to-face patient hours (400) for the Clinical Masters degree. Although several of these requirements apply to practicum at university clinics and external sites, it is the university training program that is granted APAC accreditation and APS College approval. In the past, if the requirements (e.g., the number of supervision hours) could not be met through the external placements, training programs have often compensated for shortfalls in order to maintain accreditation.

If university clinics cannot be sustained, postgraduate clinical psychology courses may fail to meet

current recommended guidelines of the Clinical College and so graduates may not meet eligibility for College membership. The alternative would be for the Clinical College to remove the requirement of university clinic training, but it is unlikely that this could be done without lowering the standards of clinical training, particularly the development of specialist competencies in psychological assessment, formulation and treatment that is central to clinical psychology expertise. Concerted efforts are needed to protect university clinics and maintain the standards required for accreditation of clinical psychology training programs.

Strategies to preserve university psychology clinics

A possible solution to the decreasing opportunities for training in university clinics is to compensate for the shortfall with additional training in external placements. It is true that a functional university clinic is expensive in terms of space, staffing, technology (requirements of audiovisual equipment) and other resources (e.g., a wide range of psychological tests and questionnaires appropriate for different populations ages and problems), and closing university clinics could appeal to administrations committed to cost saving. It is also true that even the best equipped agencies offering field placements could not match the range of resources available for training in university clinics. Moreover, as indicated above, the substantive differences between training at university and external practicum sites means that neither is a substitute for the other. Instead, the two forms of training are complementary and both are essential.

A systematic monitoring of evidence of changes in numbers and types of patients attending university clinics, income loss and other relevant changes as compared with information available from the pre-Medicare Australia-wide survey referred to in this paper would prove beneficial and is currently underway. Second, one possibility that has been under discussion is that Medicare rebates might be provided for psychological services offered by post-graduate clinical psychology interns working in psychology clinics, in the same way that rebates are available for GP registrars working in accredited clinics. To become effective, such a proposal would require Government approval, and opportunities to argue for this option should be sought out and pursued vigorously. The advantages of such a proposal are that it would ensure better access to services at no cost to the community (services would be bulk-billed at a subsidised rate), aspects of the Medicare initiative that the Government is keen to preserve and extend (Littlefield, 2008). Third, before the Medicare initiative for psychologists

commenced, private psychology services were expensive, and university clinics experienced no compelling need to advertise their services widely to gain referrals. In the current environment, university clinics should ensure that appropriate audiences are targeted and suitable strategies are used in their advertisement campaigns. Fourth, information should be sought regarding how university clinics are funded in professional psychology programs elsewhere in the world, and the viability of such funding models considered. Finally, the range of stakeholders should be identified and information disseminated to gain support, financial and otherwise, to address the threat to university clinics and professional psychology training in Australia.

Conclusions and recommendations

The implementation of the Medicare rebate system for psychologists has represented a major advancement for the profession of psychology and the availability of psychological services for the public. There have been, however, inadvertent consequences for the training of clinical psychologists.

One of the main limitations of the data reported from the survey of psychology clinics is that the survey was conducted in 2004, 2 years before the introduction of Medicare in 2006. Feedback from a number of clinic directors has been that university clinics have struggled to survive since the introduction of Medicare, but no systematic data have yet been published to clarify the magnitude of the problem or to document how university programs have responded to the changes. The impact of Medicare rebates for psychologists on the ability of training clinics to provide services and train specialist psychologists requires further study.

As a requirement for accreditation of clinical psychologists, and a much-desired component of training for other specialties, university training clinics, with their dedicated focus on training and high-quality supervision and resources, are considered a pivotal and irreplaceable component of training of specialist professional psychologists in Australia.

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