From the Editor’s Desk

Reading through the many wonderful proposals I received for Grand Rounds articles, a theme emerged around how to best communicate with patients and engage their perspectives. Though this may seem natural, it takes deliberate effort to truly listen to another person and, in turn, speak their language. It is a practice that is missing all too often. In that vein, this issue focuses on open and honest dialogue about topics of interest in the clinical and educational spheres of some of our members. I hope the articles will provoke thought (and discussion!) about your own communication styles. I welcome submissions from our members for future editions of Grand Rounds on the clinical, educational, research, advocacy, and other professional missions that spark your interest and may lead to more engaging conversations!

“The great enemy of communication, we find, is the illusion of it.”

— William H. Whyte, in “Is Anybody Listening?” (Fortune, 1950)

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Weight bias has been defined as “negative stereotypes directed toward individuals affected by excess weight or obesity, which often lead to prejudice and discrimination.”\(^1\) Sometimes called the “last acceptable form of prejudice,”\(^2\) there is evidence suggesting that weight bias is increasing as a greater proportion of our country experiences overweight and obesity.\(^3\)

A variety of negative consequences of weight bias have been identified including depression, anxiety, low self-esteem, poor body image, social rejection, poor quality of interpersonal relationships, poor academic outcomes, and engagement in problematic health behaviors (e.g., binge eating, unhealthy weight control practices, avoidance of physical activity).\(^4\)-\(^7\) Although high levels of excess weight have been linked with morbidity and mortality, there is some indication that perhaps the stigma of obesity itself may be at least partly to blame; there is a growing body of literature which suggests that weight bias itself is related to weight gain, obesity, and increased risk of mortality.\(^8\)-\(^10\)

Health care in particular frequently has been identified as a source of stigma toward those at a higher weight (e.g., inappropriately sized gowns, exam tables and medical equipment, shorter appointment times for those with obesity).\(^11\)-\(^15\) Healthcare providers including physicians, nurses, dietitians, physical therapists, and exercise professionals have been identified as perpetrators of weight biased attitudes and behavior toward patients affected by obesity.\(^4,12,16-18\)

Unfortunately, psychologists are not immune to holding weight-biased attitudes; research has suggested that psychologists are more likely to label those with obesity as having more psychopathology, more severe psychological symptoms, more negative personal attributes, and worse prognosis in treatment.\(^2,4\) When patients experience weight bias from healthcare providers, they are less likely to adopt the health behaviors recommended and more likely to engage in maladaptive behaviors and avoid or cancel appointments, resulting in poorer care and health outcomes.\(^19\) It is imperative that healthcare providers, including psychologists working in academic medicine, take part in eliminating weight biased attitudes and behaviors from our institutions.

So what can we do?

1. Validate patient experiences. Give patients space to discuss discrimination they’ve experienced because of their weight and help brainstorm adaptive ways to cope.
3. Avoid commenting on patient’s appearance and/or weight loss. Focus discussions around promotion of functional behavior change toward health.

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4. Be aware of our own biases. Consider taking the Implicit Association Test on weight bias at https://implicit.harvard.edu/implicit/. You may also ask yourself the following:
   - How do I feel when I work with patients of different body sizes?
   - Do I make assumptions regarding a person’s character, intelligence, abilities, health status, or behaviors based only on their weight?
   - What stereotypes do I have about persons with obesity?
   - How do my patients affected by obesity feel when they leave my office?

5. Encourage positive self-talk and body acceptance among those who may be trying to lose weight. Patients can both love their bodies AND want to make behavior changes that may reduce weight; in fact doing so might make the latter easier to achieve.

6. Ask permission to weigh and/or discuss weight with patients. Allow the patient the autonomy to choose if and how to have this sensitive conversation. It’s important not to avoid discussions of weight altogether as research has suggested that patients want to have these critical conversations with their healthcare providers, but doing so sensitively and with modifications as needed (e.g., weighing in private) is key.

7. Treat obesity appropriately. Blanket recommendations that focus on diet and exercise alone often promote the pervasive stereotype that those with obesity exercise little and eat poorly. In fact, obesity is caused by a complex web of biology, evolution, genetics, environment, and behaviors. It is important to highlight these factors whenever discussing weight or weight loss with our patients.

8. Ask patients about behaviors they already are engaging in and strategies they have tried previously to manage their weight (if this is the focus of your work together). Utilize motivational interviewing to elicit change talk around weight that is patient-centered.

9. Don’t assume that everyone who is of higher weight wants or needs to lose weight. Again, let the patient be the guide for how to navigate any discussions about weight.

10. Focus on health rather than a goal weight or BMI. Helping patients to enhance health behaviors that align with their values should be our top priority.

References

The Catalyst: While the treatment of kids with Sickle Cell Disease (SCD) at Children’s Hospitals and Clinics of Minnesota has historically been strong, both the treatment team and the families of youth with SCD felt there could be more done to facilitate a focus on access and adherence to nonpharmacological recommendations for pain and SCD. Adherence to nonpharmacological recommendations often is lower than to medications (10% versus 48-89%).\(^1,2\) Recent work shows continued low adherence to nonpharmacological treatment and pain management skills when compared to general health behaviors and sickle cell management.\(^3\)

Putting together a collaborative, family-focused clinic: In June 2016, our SCD treatment team met with families who had a child/ren with SCD who received care through the Department of Hematology and Oncology. At that time, no consistent process was in place to provide access to nonpharmacological strategies through the Department of Pain, Palliative Care, and Integrative Medicine (PPCIM) other than during crisis-based inpatient consultation. In addition, we found the structure of our chronic pain program intake was simply not working for these families. From the time of day (mornings) to the structured follow-up schedule (weekly or every other week with most involved disciplines), what worked for many kids with chronic pain was not feasible for families with SCD. As a result, youth with SCD were not always aware of how to use nonpharmacological strategies to cope with SCD-related or chronic pain, often resulting in decreased functioning and frequent inpatient hospitalization. Of note, even when families were aware of nonpharmacological strategies, these approaches had not yet been normalized into their cultural perspective of SCD care and general health and wellness.

Families were contacted by our Sickle Cell Patient Advocate/Care Coordinator and agreed to gather for an evening family focus group. Youth ages 13-17, their caregivers, and Children’s staff participated in a 2.5 hour-long conversation about their hopes for the future of SCD care. Combined family and caregiver/youth groups met in order to have open conversations about concerns and hopes for long-term programming. Many of the themes that arose were similar to previous SCD family focus groups in other hospitals including a need for more support, education, and sensitivity to parents and patients.\(^4\)

Common overarching worries and hopes for the future included:
- A desire for an individually tailored program rather than a “one size fits all” approach
- Coaching the family and youth to self-advocate for their treatment needs and goals
- Nutrition/hydration needs and education
- SCD does not attract resources or funding like other diagnoses
- Lack of SCD role models and community connection
- An ability to see the future – “HOPE”

Common overarching needs included:
- MDs, nurses, clinical, and hospital staff to be genuine with families
- Compassion, patience, and understanding
- Education for parents and youth about SCD and pain
- Support for parents to raise kids with SCD just like kids without a SCD diagnosis
- Prepare kids for the real world/job/independence – “LIFE SKILLS”

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Common responses to “What Does Wellness Mean to You?” and what do you want a Wellness Clinic to look like included themes below:

- “Understanding invisible pain”
- Integrating nonpharmacological and integrative treatment options
- 1:1 sessions and group time to “share tips and tricks for dealing with SCD”
- Networking with other families to share resources and to identify shared experiences
- More autonomy and independence in life
- Medication management
- “How to have a full life and happiness”

From this group, we developed guiding principles for our workgroup (see our word cloud [previous page]) and began creating a clinic based on family needs. After 1.5 years of planning, we have an interdisciplinary treatment team who provides services on a monthly basis to families in our joint Hematology and PPCIM Sickle Cell Wellness Clinic (SCWC). We have a rotating team of 18+ staff and 10+ disciplines working together to help kids and families in two primary areas:

1. Monitor, track, and treat pain proactively.

2. Normalize daily life through increasing knowledge and skills to cope with pain, minimize chronic pain from developing, and improve quality of life through a focus on wellness and interdisciplinary support.

Ongoing Development: We are collecting clinical data to assess functioning over time and are working in conjunction with the Hematology Comprehensive Clinic to teach families coping and wellness skills. Thus far, we have addressed access to care issues by making changes to streamline services and follow-up scheduling after our two pilots and have run five successful monthly clinics since the winter of 2017.

A Clinic Day: When a family participates in clinic, they come to the PPCIM clinic space for lunch and a full afternoon (11:30am-4:30pm).

Caregivers are involved throughout the clinic day and families have opportunities to meet one another and hear each other’s stories. Partnering with families, we discuss wellness areas to continue addressing through follow-up appointments. Our Sickle Cell Patient Advocate/Care Coordinator assists in getting follow-up appointments scheduled that same day.

Our team strives for SCWC to continue to be a family-focused, wellness-informed clinic that uses family feedback for improvement. We have been able to roll out a clinic using the family focus group themes of: mental strength, physical strength, guidance, sleep, nutrition, spirituality, guidance, hope, team support, and family support. Based on our clinic satisfaction surveys, we have made changes in clinic flow and clinical assessment measures. We have received encouraging feedback from families including kids’ overall satisfaction (4.5/5.0) and caregivers reporting they especially appreciate meeting with other caregivers. The best feedback we received was from a parent, who said she most appreciates “the whole team working together for a beautiful cause.” We feel the same way!


Respect for autonomy is one of the core principles of medical ethics; however, the culture of medicine continues to sustain many practices that contribute to unbalanced power in patient-provider relationships. One such practice – the use of hierarchical language – constructs and emphasizes a power dynamic that decreases effective interpersonal communication and patient autonomy, while also increasing authoritarian control and physician frustration and burnout. Hierarchical language is any use of language in which a power structure is either explicit or implied. Some hierarchical language may be used to communicate hierarchy on a team (e.g. use of titles). However, other forms of hierarchical language can serve to communicate or reinforce ideas of power and control.

The use of hierarchical language has become so ubiquitous in medical culture that even well-meaning providers are unaware of when they are contributing to it. In more subtle instances, the provider’s language can fail to acknowledge the patient’s role in medical decision making or behavior change, which can both disempower the patient and increase provider frustration and burnout when they do not take patient agency into account. For example, statements such as “I’ll send him to a neurologist,”* “I am going to bring you back into the office,” or “I kept him alive,” communicate that the provider’s actions are what dictate outcomes. These sentences could be changed to “I plan to refer him to a neurologist,” “I would like you to return to the office,” or “I prescribed Medication X which stabilized his heart rate,” to more accurately convey the power the provider does and does not have.

In more extreme instances, hierarchical language can be used to completely objectify patients, which decreases provider empathy, interferes with the patient-provider relationship, and can lead to the provider taking full credit -- or full blame -- for patient outcomes. Examples such as “We should Lovenox him,” “I’m gonna spec her,” or “I’ve had patients with fertility problems, and I’ve gotten them pregnant by putting them on Metformin” could be changed to “We should prescribe Lovenox,” “I am going to perform a speculum exam,” or “I have prescribed Metformin for patients with fertility problems, and they have been able to get pregnant after starting the medication.”

A particular challenge is that often individuals are unaware of how their language contributes to hierarchical relationships. Although the entire medical education encounter has exchanges of power woven throughout, these well-meaning providers may be unintentionally contributing to a power hierarchy, and thus may further influence learners and future physicians.

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* all examples are physician quotes observed by the authors
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To address the aspects of healthcare culture that contribute to hierarchical thought, language, and behavior, new and innovative curricula are needed that challenge the status quo.

We employ two curricular exercises to attempt to reduce the use of hierarchical language in our residencies. Both exercises aim to increase empathy on the part of the medical provider.

**Reframing Patient Identity Exercise**

One challenge is that providers often do not recognize when they are using hierarchical language. One exercise that can be used when a provider utilizes language that emphasizes the power hierarchy with a patient is the Reframing Patient Identity Exercise. Ask the learner to imagine if the patient’s identity were one that equalized or reversed the power dynamic. Examples include:

- A colleague
- A family member
- An attending physician or supervisor

Ask them to consider how their language would change if the patient had one of these identities. Would they alter their language in any way? How? It can be explicitly pointed out that if the provider would change their language when the power dynamic changed, then their original statement used hierarchical language. Ask learners to consider performing this mental exercise with all patients to reduce the use of hierarchical language and mindset.

**Expert Opinion Exercise**

The Expert Opinion Exercise helps providers to reframe their role from being in control of their patients to being skilled experts who can help their patients. In this exercise, which can be done individually or in a group, learners are asked to remember a time that they faced a significant decision and sought an expert’s advice (e.g. getting a major car repair, buying a house). They should then be encouraged to list the positive and negative aspects of the experience. Educators should rephrase these answers in more general terms that would apply to medicine (see table on next page), with a focus on items that pertain to power differentials. Allow discussion, noting how making decisions about one’s body are often more important and personal than the decision used in the exercise:

- In what ways do we providers do the positive things on the list?
- In what ways do we providers do the negative things on the list?
- How can we improve these?
- How might that impact our patients?
- How might that impact us?

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Regardless of the type and number of exercises that are employed, use of hierarchical language will not change in a widespread manner without a cultural shift in the residency. This type of language can be so subtle and so common that it must be caught and corrected repeatedly, and accompanied by an attitudinal change related to the role of patients and providers. In order to change culture, these exercises may be needed with medical students, residents, attendings, and administrators.

References:
Calling all members—submit an idea for a Grand Rounds story!

We are seeking submissions of approximately 1,000 words for upcoming installments of Grand Rounds.

E-mail your proposals to the Editor at:

Impenwell-waines@novanthealth.org

Or to the Fall 2019 Guest Editor, Ashley Junghans Rutelonis, at:

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APAHC Award Winners at the 2019 Conference

Congratulations to the 2019 APAHC Award Winners!

Mary Amanda Dew, PhD, Bud Orgel Award for Distinguished Achievement in Research

Sharon L. Berry, PhD, ABPP, Ivan Mensh Award for Distinguished Achievement in Teaching

Terry Stancin, PhD, ABPP, Joseph D. Matarazzo Award for Distinguished Contributions to Psychology in Academic Health Centers

Stacy A. Ogbeide, PsyD, ABPP, Outstanding Early Career Psychologist

Lisa Kathryn Kearney, PhD, ABPP, Outstanding Mid-Career Psychologist

Kelsey J. Sala-Hamrick, MA, TLLP, Outstanding Student Contributions
Laura Shaffer, PhD, and Bill Robiner, PhD, ABPP, attended the AAMC Learn, Serve, Lead (LSL) Conference in November as representatives for APAHC to the Council of Faculty and Academic Societies (CFAS). The annual conference attracted more than 4,600 attendees involved in multiple roles (e.g., deans, department heads, faculty, teaching hospital administrators, scientists) in academic healthcare and education.

At least a dozen psychologists attended the 2018 LSL, including APAHC members John Linton, PhD, ABPP (Associate Vice President and Dean, School of Medicine-Charleston, Professor and Vice Chair, WVU Behavioral Medicine) and Patrick Smith, PhD, ABPP (Chief Faculty Affairs Officer at the University of Mississippi Medical Center), participating due to their roles in their institutions. Serina Neumann, PhD (EVMS Department of Psychiatry and Behavioral Sciences) attended at the EVMS Faculty Representative to CFAS), a role that other APAHC members might consider seeking within their own institutions. Suzanne Danhauer, PhD, and her colleague, Carol Shively, PhD, accepted the 2018 AAMC Group on Women in Medicine and Science Leadership Award on behalf of their work promoting women in medicine and science at the Wake Forest School of Medicine.

LSL is known for excellent plenary sessions that are like highly polished TED talks, addressing leadership issues and a range of timely topics in academic healthcare. Psychology was front and center as the first plenary session speaker was Angela Duckworth, PhD; she discussed how the role of grit, self-control, sustained passion, deliberate practice, and talent affect skill development and achievement.

The conference had numerous excellent presentations and sharing opportunities. The list of presentations is long and varied, including topics such as: scientific innovation; health professional burnout, resilience, and wellbeing; addressing sexual harassment in academic healthcare; community engagement and partnerships; diversity, inclusion and workforce; gun violence; academic-industry relationships; drug costs and economic challenges in healthcare, and so on.

A particularly riveting presentation emphasized the importance of mental health problems and mental health care by Pulitzer-prize winning journalist, Ron Powers. It was titled after his 2017 book, No One Cares About Crazy People: The Chaos and Heartbreak of Mental Health in America. His discussion was uniquely personal, addressing societal and family impact of mental illness, and the psychiatric problems of his two sons, including the heartbreak of discovering the younger son just after he suicided. He called upon the audience, and our constituencies, to develop more effective strategies for providing compassion and care to the seriously mentally ill. His talk reviewed the failures of society and the mental health professions to adequately address mental illness, including the history of cruel punishments, inadequate resources, homelessness, the criminal justice system, bad science, and ignoble pharmaceutical dealings. He also conveyed hope for better solutions in the future. His candor in writing his book serves a larger purpose, “to arm other families with a sense of urgency that perhaps came to us too late.”

LSL includes diverse networking opportunities. At CFAS meetings, there was a great deal of discussion about burnout, stress, and resilience in healthcare. Other topics CFAS and the AAMC are seeking to tackle are gender equity and eradicating sexual harassment within healthcare, including AHCs. These topics are all highly relevant to psychologists in AHCs.

It was a privilege to attend LSL on behalf of APAHC. Being there underscored the importance of psychology throughout healthcare and education. There are myriad ways in which psychologists’ contributions, advocacy, and engagement help AHCs fulfill their missions.

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Psychologists’ presence in AHCs is mutually beneficial to the profession and to the institutions where we work. Our visibility in all of academic healthcare’s missions (i.e., clinical care, education, scientific research) is critical to our perceived relevance in healthcare and to the future of the discipline. We encourage APAHC members to consider how they may heighten their own profiles within their institutions and the profession, as APAHC’s special role as a bridge between psychology and academic healthcare through the AAMC provides unique opportunities. Perhaps some of you will consider providing presentations at LSL in coming years.

Clockwise from top left:
John Linton, PhD, ABPP; Suzanne Danhauer, PhD; Dan Shapiro, PhD; Debra Kirsch, PhD; Bill Robiner, PhD, ABPP, and Laura Shaffer, PhD; Betsy Williams, PhD, and Mary Turco, EdD; Ryan Landoll, PhD; Serina Neumann, PhD

Center: Carol Shively, PhD
Interviewer: Benjamin A. Bensadon, EdM, PhD, University of Florida College of Medicine  
Interviewees: Sharon Berry, PhD, ABPP, Children’s Minnesota  
Jason Washburn, PhD, Northwestern University Feinberg School of Medicine  

As a psychologist in medical education for the last nine years, I have been delighted to see psychology flood the AHC discourse. However, integration of psychologists into the clinical and educational missions of AHCs remains variable. At some institutions, medical students and residents may spend their entire training exposed to only one psychologist. More often than not, they instead learn to address the psychological impact of medical illness from clinical staff with less specialized psychology training. When I've engaged them -- medical trainees, providers, and patients/families themselves -- most seemed to agree this was suboptimal. But what can be done? With this backdrop I noticed APA’s recent decision to accredit master’s programs in health service psychology (HSP). To learn more, I posed some questions to Drs. Sharon Berry, PhD, Past Chair of APA Board of Educational Affairs (BEA), and Jason Washburn, PhD, Member of the BEA Task Force to Develop a Blueprint for APA Accreditation of Master’s Programs in Health Service Psychology. Here’s what they shared (of note, the following are their own perspectives, not necessarily those of the APA, BEA, or the Task Force).

**BB**: Traditionally clinical psychologists have had a difficult time articulating their role and value within health care. How will APA accreditation of master’s level psychologists improve this clinical reality?

**SB**: Developing a model for accreditation of master’s level psychology graduates (within or outside of APA) is the first step in a multistep process to move forward with re-invigorated investment in Master’s trained providers of psychological services. A follow-up step will be to identify the scope of practice (how [it] compares to or is different from the scope of practice for doctoral level psychologists), appropriate naming terminology (“psychologist” is reserved for those with doctoral degrees as mandated through APA governance), and the competencies to be established at each level.

**JW**: A couple thoughts before I address the core of your question. First, most clinical psychologists that I work with are able to articulate both their role and their value in the healthcare systems that they work. That role/value is often within specialty behavioral health, although I find it is increasingly in primary and specialty medical care as well. As such, I don’t fully agree with the first part of your question. Second, when discussing accreditation of psychology at the master’s level in areas APA already accredits [HSP], I strongly doubt that master’s level providers will be referred to as “psychologists.” All indicators suggest that the title of “psychologist” will be reserved for doctoral-level practitioners in HSP. Given that master’s level non-HSP providers (e.g., licensed clinical social workers, licensed counselors, licensed marital and family therapists, etc.) currently comprise the majority of non-medical (MD,DO,etc.) mental health providers in the US, doctoral-level HSP providers already face a need to articulate their role and value. The arrival of master’s level providers trained in the unique qualities of HSP (e.g., scientific foundation of human behavior, provision of science-based psychological services, use of data to guide psychological services), however, will likely sharpen the value-added characteristics and qualities of doctoral level HSP providers. For example, I wouldn’t be surprised to find doctoral level HSP providers increasingly developing and using their specialty and subspecialty clinical competencies, as well as competencies in addition to direct provision of psychological services (e.g., research, program development/evaluation, academic/clinical leadership, policy, prevention, and clinical innovation).

**BB**: As health care continues to be shaped by cost containment, in primary care, mid-level (i.e., master’s level) medical providers are replacing physicians, and with the growth of yearlong online psychiatric/mental health nurse practitioner programs, potentially psychologists as well. How will developing master’s level psychologists fit within this shifting primary care landscape?

**SB**: Again, the terminology will never be “master’s level psychologist.” Instead, the current focus of development is with enhancing master’s level training in psychology, many of whom will be direct service providers, and will be highly competitive in the market place in many jurisdictions. Estimates by APA work force center suggests that we do not have sufficient doctoral graduates to cover all of the needs in many areas, and master’s prepared providers could be a valuable resource, particularly in underserved areas. Core learning outcomes have been approved as policy for all psychology master’s programs, so these individuals will be well versed in psychological principles and evidence based practice in a way that likely differentiates them from other master’s level providers.

**JW**: As noted in response to your first question, the majority of non-medical mental health practitioners are master’s level providers, not doctoral-level HSP providers. Based on my review of the existing data, I argue that “medical” healthcare is catching up to mental health care in the use of mid-level practitioners! This is apparent in the health system where I work.  

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When it comes to the psychotherapeutic treatment of common mental disorders, my clinic has only hired LCSWs, not psychologists, for well over a decade. Psychologists are hired for clinical practice when there is specialty or subspecialty clinical needs, or when they also bring other qualities to the table (e.g., research, education, leadership, etc.). My hope is that the arrival of HSP Master’s level providers will provide our health system with another and more attractive option when they consider hiring master’s level providers.

BB: Historically, in medicine, biopsychosocial care has been discussed as physician-nurse-social worker. As such master’s level social workers have more effectively integrated into medical practice than have clinical psychologists. Their specific role has been both social work (i.e., admissions/discharge planning, connection to resources) and that of “therapist.” IOM data have shown this to be inadequate. How might further promotion of master’s level behavioral health clinicians help or hinder this?

SB: Many teaching hospitals credential only licensed social workers who provide front line case management, but generally little diagnostic, assessment, or intervention care; instead, licensed doctoral psychologists are generally embedded within teaching hospitals to provide an advanced level of care. I know of no hospital-based practice that allows for master’s level counselors based on credentialing, and I do not foresee this happening in the near future. There are many other venues where those with master’s degrees in psychology can practice outside of a hospital setting, including group homes, social service agencies, community counseling programs, etc.

JW: My hope is that it will help greatly. Although I anticipate that there will still be a strong need for both the unique qualities of medical social workers and doctoral-level HSP providers, I also believe there will be a role for master’s level HSP providers in identifying and treating common mental disorders.

BB: To what extent is there concern that formal promotion of master’s level psychologists might make doctoral psychologists obsolete? If a concern, how is this addressed?

JW: Although I can’t speak for the Blueprint Task Force or any other organization, personally, I’ve heard similar concerns from doctoral level HSP providers, including concerns about “competition” from master’s level HSP providers. My response to this is simple: You are already competing with master’s level providers! As noted previously, psychologists are vastly outnumbered by non-HSP master’s level providers. I expect that the arrival of a master’s level HSP accreditation system will provide greater choices for students that are interested in master’s level clinical training, as well as greater choice among healthcare systems who are already selecting master’s level providers. Although it is possible that doctoral level HSP providers who treat common mental disorders may continue to experience more competition and greater fiscal pressures going forward, I believe that will be true regardless of the arrival of HSP providers. As such, doctoral level HSP must continue to adjust and adapt to a changing academic, healthcare, and research landscape, using their unique skills and abilities to address the burden of mental illness. As someone who runs a PhD program in Clinical Psychology, I don’t see any threat to doctoral level HSP providers; again, that threat has already been realized for well over a decade. We will not become obsolete because we will continue to adapt and adjust, just as we’ve been doing all along.

BB: What would you say to psychologists concerned that formal APA accreditation will benefit APA more than psychologists or public health?

SB: At this time, any recommended accreditation system has not yet been determined (and will require a vote by the APA Council of Representatives). I see no identified “benefit” to APA that is driving this process and opening the door to master’s level individuals other than the need for more providers to cover psychological and psychosocial needs in the community, as well as the pressure from other accrediting groups that was experienced as threatening to those in the specialty of Counseling Psychology. APA is responding to requests from the field to pursue this option, and the Council of Representatives voted to move this forward.

JW: I personally believe that HSP has a lot to offer healthcare and public health; HSP has unique qualities. As such, extending the benefits of HSP through master’s level providers has the potential to bring science-based assessment and treatment to those currently not receiving services (e.g., underfunded, rural, marginalized groups), or those not receiving services grounded in science. Increasing the provision of efficacious services through the most efficient means possible is a public health imperative. As such, I believe the development of master’s level HSP accreditation is fully con-
sistent with a public health approach to addressing the burden of mental illness. As a Director of Graduate Studies and Director of Clinical Training for a PhD program in Clinical Psychology that is housed within an academic medical center, I am not threatened in the least bit by the development of an accreditation system for master’s level HSP. Indeed, we are continually discussing with our doctoral students how they can use their unique skills and abilities to provide value-added psychological services to their patients, as well as what they can do to improve healthcare and science more broadly. As mentioned previously, our faculty has already adjusted and adapted to the presence of master’s level clinicians, and we will continue to do so regardless of the availability of master’s level HSP providers.

**BB:** In terms of priorities, what would you say to psychologists concerned that formal APA accreditation of master’s programs will not help longstanding challenges of the doctoral internship imbalance or continued exclusion from the CMS physician definition? Anything else you’d like the APAHC membership/readership to be aware of regarding this development?

**SB:** The recent internship balance has been nearly eliminated through an almost 10 year effort across APA constituencies to work together to increase the number of internship positions, encourage accreditation across all doctoral and internship programs, and help all programs move toward accreditation. This is a success based on collaboration and eliminating competition and in-fighting over the historic “model wars.” There are new mechanisms for accreditation, $3+ Million spent through APA to provide $15,000-20,000 grants to programs seeking accreditation, mentoring and consultation programs through many groups (APA, CoA, APPIC, Clover). All of this is cause for celebration! To my knowledge there is absolutely no connection between exploration of options for those trained in psychology master’s programs and the CMS physician definition (still in the works and a high priority for APA).

**JW:** Well, the imbalance flipped this last year, with slightly more internship positions than interns, and trends this year look consistent with last year. As such there is not currently an imbalance. The accreditation standards for master’s level HSP providers has yet to be written, so it is unclear if the clinical training of master’s level providers will have any influence on the doctoral level match. Although it is possible that internship programs may close entry to doctoral level students in favor of master’s level students (assuming a similar internship system for master’s level students, which is not a safe assumption), that is an option that is already available to internships; they could take masters level social workers, counselors or marital and family therapists. Even if internships start to close internships to doctoral students, however, the field has demonstrated that it can adjust and adapt to address an imbalance, and I expect that it will do so in the future if such an imbalance occurs for any reason.

In sum, respondents suggest additional master’s (i.e., ‘mid’) level providers, whose training is formally accredited by professional psychology, will likely cause some positive disruption. Their presence could allow doctoral psychologists to further clarify and perhaps expand their AHC role, and at the same time this could boost an area of the clinical workforce where supply continues to fall short of demand for services. My own concern, however, is that these differences in skill set and training are much clearer to psychologists than non-psychologists, and that adding lesser trained clinicians, regardless of accreditation status, may not solve the greater challenge of integrating psychologists into standard medical care. Of course it is premature at this point to know the actual impact of this initiative. As United States health care remains characterized by uncertainty, it is safe to say psychologists in AHCs will need to continue to adapt.

For more information about APA’s move to accredit master’s programs in HSP, see:

Blueprint for APA Accreditation of Master’s Programs in Health Service Psychology: [https://www.apa.org/ed/governance/bea/masters-accreditation-blueprint](https://www.apa.org/ed/governance/bea/masters-accreditation-blueprint)

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