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Training for Geropsychology Supervision and Practice: Perspectives of Geropsychology Program Graduates

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Abstract

Addressing the geropsychology workforce shortage requires ongoing training of psychologists to develop geropsychology competencies, as well as expanding the number of geropsychology supervisors to train them. This study surveyed graduates of geropsychology doctoral and postdoctoral training programs regarding their current geropsychology practice and supervision activities and perceptions of their own training preparation for these activities. One hundred psychologists (87 who had completed all formal training and 13 current postdoctoral fellows) responded to an online survey. Of those who had completed geropsychology training, 82% reported currently engaging in clinical care, and 55% reported providing supervision; more than half of clinical and supervision activities focused on older adults. Participants reported generally strong quality of training to prepare them for providing geropsychology services; areas of more uneven preparation included family and group interventions and select consultation activities. Participants reported quite variable preparation for general supervision practice, and desire for more training and practice in supervisory roles. Geropsychology training programs may use feedback from graduates for ongoing program development, and professional geropsychology may wish to consider forums for enhancing geropsychology supervision skills.

Keywords

geropsychology; supervision; training; competencies; older adults

The United States is not prepared to meet the health and mental health care needs of our aging population (Institute of Medicine, 2008, 2012). Psychology as a profession has an important role to play in geriatric mental health workforce development. Like other professions, psychology has neither trained the number of geropsychology specialists projected to be needed nor addressed basic geropsychology competency development for generalist psychologists (Hoge, Karel, Zeiss, Alegria, & Moye, 2015).

Consistent with the growing “culture of competence” within professional psychology (Donovan & Ponce, 2009) and establishment of competency benchmarks (Hatcher et al., 2013) and evaluation methods (Kaslow et al., 2009), the field of professional geropsychology has developed a competency-based training model. The Pikes Peak Model for Training in Professional Geropsychology delineated competencies for psychological practice with older adults and defined core components of geropsychology training (Karel, Knight, Duffy, Hinrichsen, & Zeiss, 2010; Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009; Molinari, 2011). The training model set the stage for geropsychology being awarded American Psychology Association specialty status, informed efforts to create a tool to evaluate professional geropsychology knowledge and skill competencies (Karel et al., 2012), and guided the development of criteria for American Board of Professional Psychology (ABPP) certification in geropsychology (Molinari, 2013).

Competent geropsychology practice involves attitudes, knowledge, and skills regarding assessment, intervention, and consultation for older populations who may present with age or cohort specific needs. Geropsychology training programs at doctoral, internship, and fellowship levels have grown slowly but surely over the past few decades (Hinrichsen, Zeiss, Karel, & Molinari, 2010; Qualls, Scogin, Zweig, & Whitbourne, 2010). While these programs alone will not produce sufficient numbers of gero-competent psychologists, it is important to evaluate the perceived preparation of their graduates to provide clinical geropsychology services. Further, in order to train psychologists to work with older adults, the profession needs a cadre of competent teachers and supervisors of clinical practice. In fact, the Pikes Peak Model recommends that a core component for being trained as a geropsychologist is to have had supervisory training by supervisors who themselves were trained as geropsychologists:

Bona fide professional geropsychologists using observational methods are employed as supervisors in geropsychology training programs so that students can develop appropriate skills in working with older adults.

(Knight et al., 2009, p. 210)

The still-small published literature on geropsychology supervision suggests that geropsychology supervisors must be prepared to address complex clinical issues that can arise among older clients and care systems, and also be made aware of common blind spots and complex relational issues that can arise as psychology trainees learn to work with diverse older adults, families, and care systems (Abeles & Ettenhoffer, 2008; Duffy & Morales, 1997; Karel, Altman, Zweig, & Hinrichsen, 2014; Karel & Stead, 2011; Knight, 2010; Qualls, Duffy, & Crose, 1995). Psychologists who have received training in formal geropsychology programs are a critical resource for the education and supervision of current

and future generations of psychologists to develop competencies for work with older adults. It is important to determine whether these geropsychology specialists are engaged in training/supervision activities and how well prepared they feel to train others.

The aims of this survey were to learn from individuals who completed focused doctoral and/or postdoctoral training in geropsychology over the past 20 years: (a) the extent to which they are currently engaging in clinical geropsychology and/or supervision practice; (b) their perception of the quality of their formal training in preparing them to work with older adults in the domains of assessment, intervention, consultation, and program development/evaluation; and (c) their perception of the adequacy of formal training in clinical supervision skills. This feedback is important for ongoing development and improvement of doctoral and postdoctoral geropsychology training opportunities.

Method

Institutional Review Board Review

This study was approved by the Institutional Review Board at Washington University. Informed consent was obtained through electronic survey procedures.

Sample Selection

Clinical and counseling psychology doctoral training programs with formal geropsychology tracks and postdoctoral fellowships with a geropsychology focus were identified from three sources: (a) graduate and postdoctoral training program members of the Council of Professional Geropsychology Training Programs (CoPGTP) and the American Psychological Association Society of Clinical Geropsychology (Division 12, Section 2); (b) doctoral programs endorsing an “aging” emphasis in the *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology* (Norcross, Sayette, & Mayne, 2008); and (c) Association of Psychology Postdoctoral and Internship Centers (APPIC) postdoctoral programs identified through a search that included “full-time” postdoctoral experience, “APA-accredited,” and supervised experience in “Geropsychology,” and an available “Older Adult” population. Of note, this study did not recruit individuals on the basis of a completed geropsychology internship rotation, given the wide variability among such rotations in depth and breadth of experience. A rotation as part of generalist internship training would not likely prepare an individual in a manner comparable to a graduate program or postdoctoral fellowship offering extensive focus on geropsychology training.

Recruitment

We contacted the Directors of Clinical Training (DCTs) of 24 doctoral programs and 21 postdoctoral programs via e-mail. This e-mail explained the purpose of the study and invited their graduates' participation. We asked the DCTs to forward an e-mail invitation with an online survey link to trainees who completed their doctoral degree (PhD or PsyD) between 1990 and 2013, including those who were completing their clinical internships in 2013. Alternatively, DCTs were invited to forward their trainees' e-mail addresses to a research assistant, so we could contact them directly. As follow up, DCTs received up to three e-mail reminders and one phone contact from the study team. Sixteen DCTs indicated they had e-

mailed the survey link to graduates, and eight indicated they would forward information to trainees. The remaining DCTs indicated that their program did not have a geropsychology emphasis, did not have required information about trainees, or did not respond to our contacts. Interested individuals could take the online survey by clicking the link included in the e-mail forwarded by their DCT or the research assistant. Participants were offered the opportunity to participate in a lottery to receive one of four gift cards for their participation.

Measures

The data presented in this paper are part of a larger survey regarding career paths and perceptions of training of geropsychology program graduates. Overall survey content was informed by three considerations. First, we replicated portions of a previous survey of geropsychology postdoctoral fellowship graduates (Karel, Molinari, Gallagher-Thompson, & Hillman, 1999) in order to have a point of comparison. Second, survey content reflected delineation of competency domains for geropsychology practice and the research team's interest in graduates' self-evaluations of their preparation in these competencies (Knight et al., 2009). Finally, survey questions addressed important considerations for advancement of the field, namely graduates' sense of preparation and interest to assume a range of academic, training, and professional service/leadership roles. Survey questions were developed via team consensus; five clinical geropsychology experts outside of the research team reviewed and provided feedback on the survey. It was then piloted for understandability and time for completion by four psychology students, who reported taking 15–20 min to complete the survey.

The survey began with questions regarding demographic and training background, employment setting, and current professional activities. Questions then addressed critical domains related to the geriatric mental health workforce shortage. To understand concerns regarding recruitment and professional identity, questions inquired about (a) career paths to geropsychology and (b) involvement in and perceived barriers to leadership participation in professional organizations. To investigate the quality of training for clinical and supervision practice, questions addressed (c) training experience and professional activities in specific Pikes Peak skill domains as well as (d) training to supervise practice. To explore preparation for academic and scholarly work, questions explored (e) research and research training experiences and (f) preparation for university and other formal teaching roles.

This paper focuses on the survey findings related to clinical practice and supervision.

Clinical practice—First, participants rated the quality of their training regarding each of 24 previously defined Pikes Peak skill competencies (Knight et al., 2009). These named competencies appear in Figure 1 and include 8 assessment competencies, 8 intervention competencies, and 8 consultation competencies. On the online survey, each summary stem had a “pop-up” detailed description of each competency. Participants rated the quality of their training in preparing them to provide services to older adults, on a Likert-type scale from 0 (*poor*) to 4 (*excellent*).

Clinical supervision—If involved in clinical supervision, participants reported the level of supervision they provided (e.g., practicum, internship, fellowship), and if not, any

perceived barriers for providing clinical supervision as part of their professional roles. Those providing supervision then answered “can you explain what you find most rewarding about clinical supervision?” Next, participants rated the quality of their clinical supervision training in six domains on a Likert-type scale ranging from 0 (*poor*) to 4 (*excellent*). The six items, developed for this study and adapted from work on supervision competencies (e.g., Falender & Shafranske, 2007) were: (a) set supervision goals and objectives; (b) develop an effective supervisory approach; (c) evaluate student learning needs; (d) evaluate student development of attitude, knowledge, and skill competencies; (e) provide formative and summative feedback to students about developing competencies; and (f) elicit and integrate feedback from students.

Participants provided free responses to the following questions: (a) What was the most positive and/or most useful aspect of your clinical supervision training? (b) What was the most negative and/or least useful aspect of your clinical supervision training? (c) When doing clinical supervision, what do you find most challenging/difficult? (d) When doing clinical supervision, what would help you be more successful? Note that, for the first and second questions regarding training in clinical supervision, participants were asked to comment separately regarding training at graduate and fellowship levels.

Data Analyses

Data analyses were descriptive in nature, including calculation of frequency distributions and mean scores and standard deviations. Pearson correlation coefficients were calculated to determine extent of relationship between specified variables of interest. Responses to open-ended questions were reviewed for themes to enhance understanding of quantitative data. Two coders independently coded themes for the open-ended questions regarding clinical supervision, with strong interrater agreement on themes. Minor discrepancies regarding how broadly versus narrowly to categorize themes were resolved via consensus.

Results

Sample Description

Eighty-seven psychologists who had completed formal training in geropsychology, herein referred to as “psychologists,” and 13 postdoctoral psychology fellows in programs with geropsychology emphasis, herein referred to as “postdoctoral fellows,” comprised the total sample of 100 respondents (see Table 1). A majority were female (74%), White (87%), and had completed a PhD degree (81%). Two thirds (66.7%) of psychologists reported working in hospital/medical center/clinic settings, one third as university/college faculty (32.2%), and one quarter (26.4%) in independent practice.

Current Clinical Practice

Psychologists reported engagement in diverse professional activities. The large majority (81.6%) reported providing clinical care, more than half of which (54.8%) time was for older adults. Most were engaged in other activities including research (52.9%), clinical training or supervision (52.9%), teaching (48.3%), and administration (51.7%). For those

reporting clinical supervision activities, about half (55%) of the supervision was focused on older adults.

Preparation for Clinical Geropsychology Practice

Participants rated the quality of formal training they received, from graduate school onward, to provide clinical care with older adults (see Figure 1). Subscales were created to calculate mean scores in the domains of assessment ($M = 3.17$, $SD = .68$), intervention ($M = 2.71$, $SD = .83$), and consultation ($M = 2.71$, $SD = .90$). Internal consistency of these subscales was high as measured by Cronbach's alpha: assessment: $\alpha = .90$, intervention: $\alpha = .91$, consultation: $\alpha = .93$.

On average, participants reported feeling most prepared in the domain of assessment, with relative strength in preparation for utilizing screening instruments, conducting clinical and cognitive assessments, and relative weakness in assessment of risk and assessment of decision-making and functional capacities.

In the domain of intervention, participants reported feeling most well-prepared regarding individual interventions, with 79% reporting very good or excellent preparation, and less well-prepared regarding group and family interventions, with only 45% and 34% of respondents, respectively, reported very good or excellent training in these areas. There was variable sense of preparation regarding use of evidence-based interventions for older adults, of late life interventions, and of health-enhancing interventions.

In the consultation domain, participants reported feeling relatively well-prepared regarding participation in interprofessional teams but less so regarding provision of staff training, participating in a variety of models of aging service delivery, and implementing organizational change. Across all domains, there was a broad range of perception of quality of preparation for geropsychology practice in these areas.

Self-perceived quality of formal training was greater for participants with more years since their doctoral degree, in the domains of assessment, $r = .25$, $p = .016$, intervention, $r = .34$, $p = .001$, and consultation, $r = .33$, $p = .002$. Those who reported spending a greater proportion of their clinical and training/supervision time with older adults were also more likely to report higher quality training in the domains of assessment, intervention, and consultation. For example, greater percentage of clinical care time with older adults was correlated significantly with training quality in assessment, $r = .32$, $p < .01$, intervention, $r = .26$, $p < .05$, and consultation, $r = .30$, $p < .05$. Likewise, greater percentage of clinical training time with older adults was correlated significantly with training quality in assessment, $r = .32$, $p < .05$, intervention, $r = .34$, $p < .05$, and consultation, $r = .37$, $p < .05$.

Current Supervision Practice

When asked, "Do you provide clinical supervision?" 55 of 84 responding psychologists (65.5%) indicated that they do. These participants reported providing supervision across levels of training: practicum (28.7%), internship (37.9%), fellowship (31.0%), supervision for licensure (6.9%), postlicensure (12.6%), or other (6.9%). The "other" category represented interprofessional supervision, of psychiatry residents, nurse practitioners,

geriatric medicine fellows, and others. Of the 29 participants who replied that they do not provide clinical supervision, the reasons endorsed were: not interested ($n = 2$, 6.9%), insufficient time ($n = 14$, 48.3%), lacking skills ($n = 1$, 3.4%), not valued by work setting ($n = 5$, 17.2%), no method of receiving payment ($n = 5$, 17.2%), and not relevant to my work ($n = 9$, 31.0%).

When asked in an open-ended question what is most rewarding about clinical supervision, participant responses ($n = 38$) reflected four major themes: (a) contributing to the professional growth and development of others, (b) inspiring interest and promoting growth in the field of geropsychology, (c) collaborating in case conceptualization and clinical care, and (d) stimulating one's own professional learning and growth.

Participants were also asked what they find most challenging/difficult about doing clinical supervision. Responses reflected five major themes: (a) finding enough time to provide or prepare for supervision; (b) trainee resistance to or difficulty receiving supervisory feedback, sometimes related to limited trainee self-awareness; (c) communicating negative or corrective feedback to supervisees; (d) trainee lack of motivation or interest; and (e) need for supervisor growth in supervision knowledge or skills (e.g., needing to develop a supervision model/style, being an early career supervisor).

Finally, participants were asked what would help them to be more successful when doing clinical supervision. There were four major themes across 50 responses: (a) more supervision/mentoring/peer consultation regarding supervision activities; (b) more time, practice, and experience; (c) more formal training, didactics, continuing education, or resources to learn about supervision; and (d) increased administrative or training program support.

Preparation for General Supervision Practice

Psychologists and postdoctoral fellows responded to six questions regarding adequacy of formal training in clinical supervision (in general, rather than training in geropsychology supervision in particular). A total score was created across these six items, with a mean of 3.06 ($SD = 1.18$), with scores on each item ranging from 1 to 5. The internal consistency of this scale was very high ($\alpha = .97$ for the full 100 participants, and .98 for the 87 psychologists), reflecting very high interitem correlations on this scale. There was significant variability across respondents; approximately one quarter perceived poor or fair quality of supervision training, and approximately one third reporting very good or excellent supervision training, with the remainder reporting good supervision training. The perceived quality of supervision training did not relate to years since graduation or to type of doctoral degree (PhD vs. PsyD).

In open-ended questions, participants were asked to comment on both positive/useful and negative/least useful aspects of clinical supervision training, at both graduate and postdoctoral levels. Responses were very similar regarding training at graduate versus postdoctoral levels, so themes were combined across these levels of training. Reported most positive and/or useful aspects of clinical supervision training reflected four themes: (a) formal coursework/didactics on supervision; (b) opportunities to supervise junior trainees;

(c) receiving supervision of supervision activities; and (d) role modeling by one's own clinical supervisors (e.g., having diverse supervisors with different styles/strengths). Of note, when asked about positive aspects of clinical supervision training, a number of people reported that they received no supervision training in their training programs. Reported most negative and/or least useful aspects of clinical supervision training reflected four themes: (a) no formal coursework/didactics on supervision; (b) no or limited opportunities to supervise others; (c) limited time for supervision training due to multiple competing demands; and (d) insufficient or negative supervision by one's own clinical supervisors.

Discussion

The need for geropsychology specialists who can contribute not only to geropsychology practice but also to training others for such practice is growing. This study aimed to explore the extent to which psychologists who graduated from geropsychology doctoral and/or postdoctoral programs were participating in, and felt prepared for, both geropsychology practice and supervision. This study's sample of 100 psychologists and geropsychology fellows were, for the most part, actively engaged in geropsychology practice, as well as supervision, teaching, research, and administration activities. Overall, participants rated a fairly high quality of formal training, from graduate school onward, to provide services to older adults, across the Pikes Peak competency model skill domains.

While training for geropsychology service-delivery was viewed as generally quite strong, participant responses suggest important areas for guiding geropsychology training program development. Programs were perceived as doing very strong training overall in the area of geropsychology assessment. However, results suggest that programs may wish to consider even more emphasis in the critical practice areas of risk assessment and the evaluation of decision making and functional capacities among older adults. Risk assessment issues are critical given relatively high suicide rates among older adults, as well as risks for elder abuse and functional safety concerns. Capacity assessment of older adults is an emerging area for geropsychologists given changes in law and practice (Moye, Marson, & Edelstein, 2013).

In the intervention domain, areas of lower average perceived training quality include group and family psychotherapy interventions, which are critical and frequent areas for geropsychology practice (e.g., Molinari, 1999; Qualls & Williams, 2013). An earlier study of geropsychology postdoctoral fellowship graduates found similar feedback regarding relatively less training in group, couples, and family psychotherapy approaches (Karel et al., 1999). One possible explanation is that the evidence base for group, family, and couples interventions with older adults continues to be less robust than the more traditional and structured individual psychotherapeutic modalities. In addition, there remains room for improvement in training for particular late-in-life and health-enhancing interventions. Geropsychologists play important roles in addressing a wide range of late life adjustment and health concerns (caregiving stress; behavioral health, such as insomnia, pain, and sexual concerns; end-of-life care, including life review and grief). As research continues to demonstrate the effectiveness of these approaches with older adults, it will be important for training programs to ensure that their students are taught to utilize them.

Consultation activities are core to geropsychology practice, given the common contexts of providing services in interprofessional health, residential, and/or community care settings. While participants reported very strong quality of training to participate in interprofessional teams and to collaborate and communicate geropsychological conceptualizations in these contexts, they had quite variable perceptions of quality of training for consultation activities such as providing staff training, participating in a variety of models of aging service delivery, and implementing organizational change. To promote integrated geriatric behavioral and mental health programs to meet population needs, geropsychologists need formal training to take on important consultation and organizational leadership roles.

The majority of participants reported providing clinical supervision, yet varied widely in perceived adequacy of their own training for this activity. Open-ended comments suggest that both coursework on supervision and the opportunity to receive supervision of supervision with junior trainees were valued. Many participants expressed interest in ongoing opportunities for education, training, consultation, and mentoring regarding supervision activities.

Historically, practicing psychologists have received little formal training on how to be a supervisor (American Psychological Association, 2015; Falender & Shafranske, 2007). In the past decade, there have been explicit efforts to define competencies for psychology supervision (Falender et al., 2004; Falender & Shafranske, 2007; Fouad et al., 2009), with recent publication of American Psychological Association (2015) *Guidelines for Clinical Supervision in Health Service Psychology*. Further, the American Psychological Association (2013) *Guidelines and Principles for Accreditation of Programs in Professional Psychology* acknowledge the importance of supervision as a competency for potential development during internship and postdoctoral training years. These relatively new developments will be very helpful to address the need for supervision training, across psychology specialties (e.g., recently survey of neuropsychology supervisors showing need for supervision training (Shultz, Pederson, Roper, & Rey-Casserly, 2014).

It is critical to develop methods and contexts for supporting development of supervision skills among geropsychologists, as well as potential geropsychology-specific supervision skills. The Pikes Peak training model did not address the development of competencies for geropsychology supervision. Conferees at the 2006 National Conference on Training in Professional Geropsychology, which produced the Pikes Peak model, made the decision to focus on competencies for geropsychology practice (foundations, assessment, intervention, consultation), rather than the full spectrum of professional psychology competencies that might have geropsychology-specific adaptations (i.e., including supervision, teaching, research, administration). However, there likely are unique issues that arise in supervision of clinical work with older adults and their families and care teams that require specific supervisory competencies; such issues include development of rapport with the older adult, ageist stereotypes, therapeutic nihilism, common countertransference experiences, recognition of cognitive impairment and appropriate intervention or referral, appreciation of wide diversity of historical and individual experiences among older adults, confrontation with death and dying, and working in complex, interdisciplinary geriatric care settings (e.g., Karel et al., 2014; Knight, 2010; Vacha-Haase, 2011).

This study has several important limitations that restrict generalizability of its findings. Although we contacted 24 doctoral programs and 21 postdoctoral programs with geropsychology emphasis, we do not know from how many or from which programs participants responded. Programs approached varied in their histories, some “in the business” of training geropsychologists for at least 20 years and others more newly developed. It is possible that several programs—with longer histories and/or larger class sizes—may be overrepresented.

We do not have a good sense of the response rate, neither regarding the number of individuals who received the forwarded survey link and chose to respond or not, nor the total universe of individuals trained in the targeted programs since 1990. It may be that individuals who are currently more engaged in geropsychology professional activities were more likely to respond. We also appeared to have greater response from individuals who completed doctoral and/or postdoctoral training in the past 10 years; it was likely more difficult to track down those who trained in earlier years.

Finally, retrospective perceptions of quality of training are likely influenced by many factors unexplored in this study. For example, current levels of self-perceived confidence or competence in core skill areas may influence perceptions of training quality, rather than the reverse, and more research is needed to explore the directionality of the relationship between more clinical time spent with older adults and higher quality training.

This study suggests several important “next steps” for geropsychology educators and supervisors to consider. First, geropsychology training programs are advised to evaluate the adequacy of their training across the Pikes Peak competency domains, by tracking both the training program offerings and trainees’ sense of preparation for core clinical activities over time.

Second, it is not clear to what extent training and supervision in geropsychology is generally provided by professionals with expertise in the field and whether perceived quality of training relates to the “gero-competence” of one’s trainers/supervisors. It is important to create ongoing opportunities for professional development in the field for psychologists who are not formally trained in geropsychology yet who are supervising clinical care of older adults.

Third, delineating attitude, knowledge, and skill competencies for geropsychology supervision is important for guiding training of the next generation of geropsychology supervisors and is critical for growing a competent geropsychology workforce. Updates to the Pikes Peak training model might well consider delineation of geropsychology-specific supervision competencies, to facilitate development of training opportunities in this area (e.g., Molinari, 2012).

Fourth, there appears to be interest among geropsychologists engaging in supervision activities to enhance their knowledge and skills in this area. Professional development resources might include development of continuing education offerings, compilation of readings in geropsychology supervision, virtual consultation groups, and mentorship focused on supervision.

Finally, we must continue to grow the number of psychologists who provide clinical geropsychology services and supervision, both through specialty and generalist practices. It is important for professional geropsychology to foster career development, including enhanced supervisory skills, for those enrolled in and graduating from geropsychology specialty training programs. It is equally important to encourage the core cadre of geropsychology practitioners and educators/trainers to introduce geropsychology content into generalist graduate psychology training curricula and to offer continuing education offerings and consultation for postlicensure psychologists who wish to develop skills for working with older adults.

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Figure 1.

Frequency distributions on perceived quality of training: Percentage of responses by Pikes Peak skill competency.

Table 1

Characteristics of Sample

	Full sample (N = 100)			Psychologists (N = 87)			Postdoctoral fellows (N = 13)		
	M/n	SD/%		M/n	SD/%		M/n	SD/%	
Age	38.7	7.5		39.3	7.3		29.5	3.32	
n, Range	59	27–68		55	29–68		4	27–34	
Gender									
Male	26	26		23	26.4		3	23.1	
Female	74	74		64	73.6		10	76.9	
Transgender	0	0		0	0		0	0	
Race									
African American/Black	2	2		2	2.3		0	0	
Asian	6	6		5	5.7		1	7.7	
Native Hawaiian/Pacific Islander	1	1		1	1		0	0	
White	87	87		76	87.4		11	84.6	
Multiracial	4	4		3	3.4		1	7.7	
Hispanic	4	4		4	4.6		0	0	
Graduate degree									
PhD	81	81		70	80.5		11	84.6	
PsyD	18	18		16	18.4		2	15.4	
EdD	1	1		1	1.1		0	0	
Years since graduate degree	8.25	5.26		9.15	5.04		2.17	.94	
n, Range	93	1–22		81	2–22		12	1–4	