

# Guidelines for Postdoctoral Training in Rehabilitation Psychology

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**Objective:** This article describes the methods and results of a national conference that was held to (1) develop consensus guidelines about the structure and process of rehabilitation psychology postdoctoral training programs and (2) create a Council of Rehabilitation Psychology Postdoctoral Training Programs to promote training programs' abilities to implement the guidelines and to formally recognize programs in compliance with the guidelines. **Methods:** Forty-six conference participants were chosen to include important stakeholders in rehabilitation psychology, representatives of rehabilitation psychology training and practice communities, representatives of psychology accreditation and certification bodies, and persons involved in medical education practice and research. **Results:** Consensus guidelines were developed for rehabilitation psychology postdoctoral training program structure and process and for establishing the Council of Rehabilitation Psychology Postdoctoral Training Programs. **Discussion:** The Conference developed aspirational guidelines for postdoctoral education and training programs in applied rehabilitation psychology and established a Council of Rehabilitation Psychology Postdoctoral Training Programs as a means of promoting their adoption by training programs. These efforts are designed to promote quality, consistency, and excellence in the education and training of rehabilitation psychology practitioners and to promote competence in their practice. It is hoped that these efforts will stimulate discussion, assist in the development of improved teaching and evaluation methods, lead to interesting research questions, and generally facilitate the continued systematic development of the profession of rehabilitation psychology.

**Keywords:** rehabilitation psychology, psychology, training, education, guidelines

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## Impact and Implications

- The specialty of rehabilitation psychology is an important part of the health care workforce because it is applicable to important world health problems involving an estimated 10% of the world population who experience some form of disability—approximately 650 million people. Training is the pipeline to the rehabilitation psychology workforce, and issues of education and training are fundamental to the conceptualization and development of the specialty.
- The development of these training guidelines, and the establishment of the Council as a means of promoting their adoption by training programs, are designed to promote quality, consistency, and excellence in the education and training of rehabilitation psychologist practitioners, and to promote competence in their practice. The ultimate goal is to promote psychological services that are effective and responsive to the needs of people with disabilities, and that help to maximize their psychological welfare, independence and choice, functional abilities, and social participation.

## Introduction

Applied rehabilitation psychology is a health care specialty that uses psychological knowledge and skills on behalf of individuals with disabilities and chronic health conditions in order to improve health and function, improve psychological adjustment, maximize self-care, develop adaptive and compensatory behaviors, enhance caregiver functioning, effectively use assistive technology and personal assistance services, increase independence and social participation, and reduce secondary health complications. Practicing rehabilitation psychologists provide services to individuals with disability and chronic illnesses and their families, as well as to rehabilitation teams, institutions, and service agencies. Because disability arises from a person–task–environment interaction, consideration is given to the network of biological, psychological, social, cultural, physical, and political environments in which the individual exists, and to addressing barriers in these areas (Stiers & Stucky, 2008; Scherer et al., 2010).

A professional health-service psychology specialty requires competencies that are beyond the common, doctoral-level foundational and functional competencies required of all psychologists, that are acquired through a defined sequence of education and training involving didactic and experiential participation, and that involve specialized (a) populations; (b) psychological, biological, and social problems; and (c) procedures and techniques. Specialties can have areas that are both distinctive and shared with other specialties. The specialized populations, problems, and procedures that define rehabilitation psychology are shown in Appendix A.

Training is the pipeline to the rehabilitation psychology workforce. In rehabilitation psychology practice, as in all areas of professional health-service psychology, issues of education and training are fundamental to the conceptualization and development of the specialty. A specialty is shaped by its selection of residents, the structures and processes of its training programs, and the competencies expected of successful residents (Stiers & Stucky, 2008).

Training programs can be considered in a program evaluation framework, examining the structure and process of the programs. Program structures are the inputs to the program and determine whether adequate and appropriate resources are devoted to the program. Program structures include program mission statements and training objectives; policies and procedures for program operation; service delivery setting and patient

populations; staff and their relevant numbers, qualifications, and skills; residents and their relevant qualifications and skills; and resources such as money, physical facilities, and infrastructure. Program processes are how the program is operationalized and determine whether appropriate activities are implemented and intended services reach the intended recipients. Program processes include the numbers and types of experiential and didactic training activities that actually occur, the numbers and types of supervision and evaluation activities that actually occur, and the length of training.

Patterson and Hanson (1995) published the first formal guidelines for postdoctoral training in rehabilitation psychology. These guidelines specified that teaching and practice should be focused on persons with disability and chronic health conditions, but they primarily focused on the structural and process elements of training programs, modeled after the American Psychological Association (APA, 2002) requirements for accreditation of training programs, rather than on any specific competencies acquired by residents.

However, these guidelines have not translated into consistency among programs or coherence within programs in regard to the training structure and process. A survey during 2007 (Stiers & Stucky, 2008) of intern and resident psychology training programs that involved rehabilitation populations in the United States and Canada ( $n = 94$ ) found that at all sites the curriculum included activities such as supervised work with patients and seminars and coursework involving disabilities and chronic health conditions. Resident training sites ranged from 73% to 100% in meeting the general Patterson and Hanson 1995 guidelines. On the average, sites met 95% of the guidelines. Sixty-three percent of sites met 100% of the guidelines.

The American Board of Rehabilitation Psychology (ABRP) has established a set of core competencies for the practice of rehabilitation psychology (ABRP, 2011). The Stiers and Stucky survey found that the selected training programs, on average, taught only 69% of the ABRP core competencies, with only 21% of the sites formally teaching 100% of the competencies.

The authors suggested that without a consensus in the field about more detailed training guidelines *and* without a means of promoting their adoption by training programs, the specialty area of rehabilitation psychology may have difficulty establishing consistency and cohesion in training and practice. Based on this information, the Executive Board of the APA Division of Rehabilitation Psychology decided to convene a national conference to achieve consensus guidelines about the structure and process of rehabilitation psychology postdoctoral training programs and to create a Council of Rehabilitation Psychology Postdoctoral Training Programs that would promote training programs' abilities to implement the guidelines and formally recognize programs in compliance with the guidelines. This article describes the development and products of that national consensus conference.

## Development of the Consensus Conference

### Conference Participants

The Executive Board of the APA Division of Rehabilitation Psychology selected William Stiers, as Chair of the Division

Education and Training Committee, to be the Conference Chair. The Conference Chair, in consultation with the Executive Board, selected a Steering Committee and Advisory Board. The Conference Chair, Steering Committee, and Advisory Board then selected the additional participants. In total, 46 conference participants were selected to include important stakeholders in rehabilitation psychology, representatives of rehabilitation psychology training and practice communities, students in rehabilitation psychology training programs and early career practitioners, psychology accreditation and certification bodies, and persons involved in medical education practice and research. The important stakeholders included officers of the APA Division of Rehabilitation Psychology, officers of the Sections of the Division, Division Early Career and Student members, and representatives of Division Special Interest Groups and the Diversity Committee. Additional stakeholders included officers of the ABRP, the Academy of Rehabilitation Psychology, and the Foundation for Rehabilitation Psychology, as well as the incoming Editor of *Rehabilitation Psychology*. The representatives of rehabilitation psychology training and practice communities were solicited through an e-mail announcement to the members of the APA Division of Rehabilitation Psychology and were selected to include representatives of university, Veterans Affairs (VA), and Department of Defense training programs. The representatives of students and early career practitioners were also selected through e-mail solicitation. Overall, effort was made to include training faculty and students from larger and smaller programs, programs with adult versus pediatric emphasis, programs that focus on different patient populations, and programs serving more urban versus rural areas, while striving to achieve an overall mix of individuals in relation to sex and ethnicity. In addition, participants included representatives from the APA Education Directorate, from VA Central Office, and from the medical education community. Conference participants were from 18 states and held positions at 12 universities, seven major hospitals, seven DoD and Department of VA medical centers and offices, and the APA.

### Conference Format

The conference participants were divided into six work groups representing distinct constituencies: stakeholder organization representatives, university training faculty, VA/DoD training faculty, pediatric training faculty, practitioners, and student/early career members. These work groups each met to make constituency-specific recommendations regarding rehabilitation psychology postdoctoral training program structures and processes. The work groups then reconvened in the large group to discuss and debate their recommendations and to arrive at a large-group consensus.

### Products of the Consensus Conference

#### Participant Characteristics

Participant characteristics ( $n = 45$ , excluding the physician participant) were compared against the characteristics of the members Division of Rehabilitation Psychology of the APA ( $N = 1,185$ ) and against the total members of the APA ( $N =$

96,615) (data not shown) using chi-square and one-way ANOVA. Significance was set at  $p < .005$  to account for the 13 comparisons.

Conference participants were more often women than were members of the Division, but were not different from members of the Association (chi-square = 12.8,  $df = 2$ ,  $p < .002$ ). The race/ethnicity characteristics of the conference participants was not significantly different from the Division or Association members. Conference participants were younger than were Division or Association members ( $F = 8.65$ ,  $df = 2$ ,  $p < .000$ ) and had fewer postdegree years ( $F = 10.70$ ,  $df = 2$ ,  $p < .000$ ), due to the intentional overinclusion of students (7% doctoral students and 12% postdoctoral students). The geographic distribution of conference participants was not significantly different from the geographic distribution of Division and Association members, nor was the degree status (Ph.D., Psy.D. Ed.D., master's, bachelor's). Compared with Association members, conference participants were more often licensed psychologists, but conference participants were not different from Division members in license status (chi-square = 18.25,  $df = 2$ ,  $p < .000$ ). Conference participants were more often board certified through the ABRP than were Division or Association members (chi-square = 66.6,  $df = 2$ ,  $p < .000$ ). Conference participants, compared with Division and Association members, less often worked in independent practice and more often worked in medical schools (chi-square = 106.38,  $df = 18$ ,  $p < .000$ ), and their primary work activities were more often in rehabilitation and less often in traditional mental health services (chi-square = 87.26,  $df = 12$ ,  $p < .000$ ).

### Consensus Guidelines for Rehabilitation Psychology Postdoctoral Training Program Structure and Process

Consensus guidelines were developed using a program evaluation framework in regard to training program characteristics involving (1) structural elements (e.g., objectives; program, setting, population, and resources; faculty number and characteristics; and resident characteristics and length of training); (2) process elements (e.g., curricular design); and (3) outcome elements (e.g., program and resident evaluation). Although these guidelines were written with the APA accreditation guidelines closely in mind and will assist programs in pursuing APA accreditation, they are not specifically designed to correspond to the APA accreditation guidelines, which have a different intent and purpose than do these specialty education and training guidelines. However, for each of the specialty guidelines presented below, the corresponding APA accreditation guidelines are identified.

The six constituency groups were provided with a series of questions related to each of these issues. The groups reached their own consensus and then met in a plenary group to achieve an overall consensus. In each section below, the final consensus guideline is first provided, followed by clarifying discussion comments. The guidelines are to be addressed by training programs seeking recognition from the Council, and the comments provide further details and context for understanding each guideline.

## Training Program Objectives

### Guideline 1: Program Objectives

It is recommended that postdoctoral education and training programs in applied rehabilitation psychology

1.1. Have a clearly specified rehabilitation psychology training model consistent with these recommended guidelines, including a mission statement, goals and objectives (specified in terms of resident competencies expected upon program completion and minimal level of achievement required to satisfactorily progress through and complete the training program), and the methods by which the goals and objectives will be achieved (types and numbers of specific activities), with formal written documents related to each of these areas ([Commission on Accreditation, 2007](#): Domain B, Items 1 and 3; Domain E, Item 4; Domain G, Item 1)

1.2. Provide education in which residents achieve competencies (knowledge, skills and abilities, and attitudes) sufficient for independent practice and eligibility for board certification in rehabilitation psychology ([Commission on Accreditation, 2007](#): Domain A, Item 1; Domain B, Item 1)

1.3. Are structured and operationalized in ways that would make them eligible for APA accreditation ([Commission on Accreditation, 2007](#): Domain A)

### Comments

1.1. Training programs have a significant responsibility to their residents to ensure an organized program of study that is clearly articulated. Understanding this model is fundamental to the individual's informed choice regarding his or her training. A clearly defined training model also creates internal consistency for the operationalization and measurement of minimal program standards. The training model should be consistent with the guidelines described here.

1.2. Residents should develop appropriate competencies to be prepared for practice and to be eligible for board certification. By placing emphasis on competencies, the focus is on skills development. Board certification itself can be characterized as an outcome, not an objective, of postdoctoral education.

1.3. APA accreditation should be supported but not required of a program to be recognized as a postdoctoral training program in rehabilitation psychology. Therefore, programs should be structured such that they would be eligible for APA accreditation, but actual accreditation would not be considered essential.

## Training Program Structural Elements

### Guideline 2: Program, Setting, Population, and Resources

It is recommended that postdoctoral education and training programs in applied rehabilitation psychology

2.1. Take place as a formal, organized program, based in or affiliated with a nationally accredited or certified institution, agency, or consortium (e.g., CARF, JCAHO) that provides direct interdisciplinary services (in an interdisciplinary model) to individuals with rehabilitation needs. Service recipients and services provided should be of sufficient depth and breadth to provide

residents with adequate experience to meet the education and training goals and objectives and to develop the range of competencies needed for general practice and board certification in rehabilitation psychology ([Commission on Accreditation, 2007](#); Domain B, Item 1)

2.2. Incorporate training site(s) that involve direct applied experience with persons with acquired disabling conditions resulting in cognitive and physical impairments ([Commission on Accreditation, 2007](#): Domain A, Items 1 and 2; Domain B, Item 2)

2.3. May exist within an independent practice when this is affiliated in some way (referral, consultation, privileges, etc.) with an accredited or certified institution providing direct interdisciplinary rehabilitation services, that involves residents working regularly and closely with other rehabilitation practitioners and that involves an appropriate didactic series and scheduled supervision ([Commission on Accreditation, 2007](#): Domain A, Item 2; Domain B, Item 2; Domain C, Item 7)

2.4. Have committed sufficient resources to financially and materially support residents, trainers, and the training process and that all residents are funded consistent with comparable doctoral-level professionals in training with similar responsibilities at the institution and with provisions for health and liability insurance ([Commission on Accreditation, 2007](#): Domain C, Item 5)

### Comments

2.1. In regard to program setting, the importance of training experiences in an accredited or certified service delivery setting, working with other rehabilitation practitioners, is identified as essential.

2.2. Postdoctoral training in rehabilitation psychology should be completed in settings in which physical/cognitive disabilities are primary, although training experiences should include experience in treating those with comorbid mental health or substance abuse disorders. There are not strict guidelines about populations served, but training sites should demonstrate that there is sufficient opportunity for residents to gain exposure and experience in direct assessment, intervention and consultation service delivery, in collaboration with other rehabilitation practitioners, with some variety of patients receiving rehabilitation services. In regard to rehabilitation research training programs, research activities that involved primarily working with data rather than with patients would not lead to the development of assessment, intervention, and consultation competencies and therefore would not meet the guidelines for postdoctoral training in rehabilitation psychology practice. Research programs that involve working primarily with patients through the implementation and evaluation of treatment protocols might meet the guidelines for postdoctoral training in rehabilitation psychology practice if they provided residents with additional experiences that allowed for the development of a breadth of competencies in clinical discernment, overall patient care, and interdisciplinary consultation with a variety of patients receiving rehabilitation services.

2.3. Although ideally training would occur in a setting that serves individuals with a variety of rehabilitation-related diagnoses, criteria could also be met via a combination of rotations among collaborating sites, and/or didactics or other exposure/experience opportunities. The focus of postdoctoral training should

be on developing skills that address the depth and breadth of competencies as defined by APA and ABPP/ABRP.

2.4. Training programs should not have unfunded or underfunded training positions.

### **Training Program Structural Elements: Faculty Number and Characteristics**

#### **Guideline 3: Faculty Number and Characteristics**

It is recommended that postdoctoral education and training programs in applied rehabilitation psychology

3.1. Be developed, implemented, and evaluated by two or more formally designated training faculty, at least one of whom has achieved an advanced level of competence in rehabilitation psychology, such as the American Board of Professional Psychology (ABPP) diploma, fellow status in APA or Canadian Psychological Association (CPA), a record of clinical and research productivity in the specialty, or other evidence of professional competence and leadership in the specialty. If there are no training faculty with board certification in rehabilitation psychology, there should be a plan and timeline for achieving this or a formal plan for regular program consultation with an external board certified rehabilitation psychologist ([Commission on Accreditation, 2007](#): Domain B, Items 4 and 7; Domain C, Items 1, 2, and 3)

3.2. Have a designated psychologist who is responsible for the integrity and quality of the training program and who has administrative authority commensurate with those responsibilities ([Commission on Accreditation, 2007](#): Domain C, Item 1)

3.3. Include training faculty who are licensed to practice psychology in the jurisdiction where the program exists, who provide services in the specialty practice area, who have primary professional/clinical responsibility for the cases on which they provide supervision, and who have broad knowledge of disability issues, including disability law and social issues ([Commission on Accreditation, 2007](#): Domain B, Item 4; Domain C, Items 1, 2, and 3)

#### **Comment**

3.1. The ABRP has been the recognized certifying board for advanced competence in rehabilitation psychology since 1995. The training director or at least one other supervising psychologist should be board certified or working to achieve board certification. Given that one of the recommended training objectives is for residents to achieve competencies sufficient for independent practice and eligibility for board certification in rehabilitation psychology, it is expected that training programs would demonstrate a commitment to board certification. It is aspirational that at least one supervisor achieve this, and the best means of accomplishing this aspiration is to have a plan and a timeline for achievement. A training program could also contract with an ABRP diplomate in the community to provide program consultation, didactics, or supervision.

3.2. APA accreditation requirements specify that there be a designated psychologist who is responsible for the training program, with appropriate administrative authority.

3.3. Postdoctoral residents providing direct clinical care should receive direct clinical supervision from supervisors engaged in ongoing clinical care. Additional supervisors may be available for

consultation (such as a senior PI of a research project who is available for consultation but who does not provide regular care) as long as traditional supervision as previously outlined is also available and routinely practiced. Training faculty should have an understanding of disability law and the social psychology of disability.

### **Resident Characteristics and Length of Training**

#### **Guideline 4: Resident Characteristics and Length of Training**

It is recommended that postdoctoral education and training programs in applied rehabilitation psychology

4.1. Consist of a distinct, formal training program provided to individuals who have successfully completed doctoral education and internship training in psychology. The doctoral education should be from programs accredited by the APA or the CPA. Applicants from nonaccredited programs would be required to demonstrate successful completion of an organized, sequential, cumulative course of study consistent with APA requirements for doctoral education. Internship training should be from a training program that is accredited by the APA or is a member of the Association of Psychology Postdoctoral and Internship Centers (APPIC); APA accreditation would be preferred ([Commission on Accreditation, 2007](#): Domain B, Item 2; Domain C, Item 4)

4.2. Provide the equivalent of 2 years full-time education, with a minimum of the equivalent of 1 year full-time education if applicants are chosen from doctoral and/or internships programs with a strong rehabilitation psychology focus, with objective criteria demonstrating the acquisition of the competencies sufficient for independent practice and board certification in rehabilitation psychology ([Commission on Accreditation, 2007](#): Domain A, Item 4)

#### **Comment**

4.1. The path to specializing in rehabilitation psychology begins at the doctoral level with a foundation in general psychology and core competencies for practice. Complementary to this is the essential role internship plays in the full development of core functional competencies necessary to practice as a psychologist. Applied psychology aspires to have all professional psychologists educated in accredited programs and internships. Accreditation reflects a systematic evaluative review process to ensure that fundamental training components are addressed and is therefore valued as an indicator of educational quality and comprehensiveness. Although it is expected that postdoctoral students have graduated from APA-accredited doctoral programs, individuals demonstrating equivalent credentials could be eligible for consideration for rehabilitation psychology postdoctoral training, as well as individuals from doctoral programs moving toward accreditation. The current crisis in applied psychology involves limited internship positions for the larger number of doctoral candidates. In 2012, approximately 53% of applicants did not match to an accredited internship program, 29% of applicants did not match to any internship site, and approximately 18% did not match with an APA/CPA accredited internship program ([Association of Psychology Postdoctoral and Internship Centers, 2012](#)). Therefore,

limiting student eligibility to those who graduate from APA-accredited internships would eliminate many potentially highly qualified residents. Internship program APPIC membership could be acceptable. Some didactic, applied, or experiential exposure to rehabilitation psychology is preferred but not required.

4.2. APA requirements emphasize the need for sufficient depth and breadth to ensure advanced competence. Two years of full-time training is expected in order for the resident to acquire all competencies necessary for specialization in rehabilitation psychology. Although some states do not require 2 years of supervised postdoctoral experience for licensure, the 2-year expectation is consistent with other specialties, and a 2-year model is an aspirational guideline to ensure the breadth and depth needed for students to receive comprehensive, high-quality training for competent practice. Under specific circumstances, a 1-year program may be sufficient if applicants are chosen from doctoral and/or internships programs with a strong rehabilitation psychology focus.

### Training Program Process Elements

#### Guideline 5: Curriculum

It is recommended that postdoctoral education and training programs in applied rehabilitation psychology

5.1. Consist of an organized, cumulative, logically sequenced program of didactic and experiential education and training activities that are graduated in complexity and that are directly linked to the competency goals of achieving knowledge, skills, and attitudes sufficient for independent practice and eligibility for board certification in rehabilitation psychology. These competency goals as defined by ABRP include the following:

Conduct assessment activities in the areas of

- Adjustment to disability: patient
- Adjustment to disability: family
- Extent of extent and nature of disability and preserved abilities

ties

- Educational and vocational capacities
- Personality/emotional functioning
- Cognitive abilities
- Sexual functioning
- Decision-making capacity
- Pain
- Substance use/abuse identification
- Social and behavioral functioning

Conduct intervention activities in the areas of

- Individual therapeutic interventions as related to adjustment to disability

disability

- Family/couples therapeutic interventions as related to adjustment to disability

- Behavioral management
- Sexual counseling with disabled population(s)

Conduct consultation activities in regard to the areas of

- Behavioral functioning improvement
- Cognitive functioning
- Vocational and/or educational considerations
- Personality/emotional factors
- Substance abuse identification and management

- Sexual functioning and disability

In addition to the ABRP-defined core competencies involving assessment, intervention, and consultation, APA-defined core competencies also include

Understanding and applying effective strategies of scholarly inquiry

- Locating evidence from scientific studies relevant to specific health problems, applying knowledge of research design and statistical methods to the appraisal of study findings, and using evidence on diagnostic and therapeutic effectiveness to improve patient care

- Developing and implementing research questions in clinical rehabilitation activities and in health care systems in order to improve the organization, delivery, and effectiveness of care

Providing effective teaching and supervision

- Provide supervision to psychology graduate students, interns, and postdoctoral residents that emphasizes skill building in providing patient care, consulting with other professionals, identifying relevant scientific data and conducting research, and practicing management

- Provide effective teaching in case conferences, seminars, didactics, and journal clubs

Provide effective organization, management, and administration of psychological service delivery and practice, training, and research activities

- Understand and apply appropriate diagnostic and procedure codes for billing.

- Practice cost-effective health care and resource allocation.

- Reflect on critical incidents to identify strengths and weaknesses and perform systematic practice evaluation and improvement activities

Overarching competencies that are important for all psychologists also include the following content areas:

- Professional conduct, ethics and law, and other standards for providers of psychological services

- Issues of cultural and individual diversity that are relevant to all of the above ([Commission on Accreditation, 2007](#): Domain A, Item 1; Domain B, Items 1, 2, and 3)

5.2. Have a written didactic and experiential curriculum that describes the process by which residents achieve competency in the specialty practice area of rehabilitation psychology ([Commission on Accreditation, 2007](#): Domain B, Item 3)

5.3. Primarily consist of supervised service delivery in direct contact with service recipients. Residents' service delivery activities are primarily learning oriented, and training considerations take precedence over service delivery and revenue generation ([Commission on Accreditation, 2007](#): Domain B, Items 2 and 6)

5.4. Provide a minimum of 4 hours structured learning activities per week, at least 2 hours of which are individual, face-to-face supervision, and at least 2 hours of which involve didactic seminars, colloquia, symposia, mentorship, observation, case conferences, rounds, journal clubs, and so forth ([Commission on Accreditation, 2007](#): Domain B, Items 2, 4, and 5)

5.5. Include at least two supervisors during any one training year. In addition to case-based supervision, trainees should have a mentor during the entire training period who provides guidance in regard to overall professional career development ([Commission on Accreditation, 2007](#): Domain B, Items 2 and 4; Domain E, Item 2)

5.6. Provide opportunity for residents' involvement in training and education activities and decisions, and incorporation of personal training goals into the program, with respect for the diversity needs of residents (Commission on Accreditation, 2007: Domain A, Item 5; Domain C, Item 4; Domain D, Items 1 and 2)

5.7. Have written procedures for responding to resident conflicts or grievances (Commission on Accreditation, 2007: Domain A, Item 6; Domain E, Items 4 and 7)

## Comment

5.1. Specialty education and training is based on the foundational and functional competencies developed in the broad and general education and training of doctoral and internship programs and proceeds to develop advanced competencies in the specialized populations, problems, and procedures that define rehabilitation psychology. This specialty education and training should consist of a coherent program, rather than simply on-the-job training and should develop knowledge and skills in the ABRP-defined competencies.

5.2. A written curriculum is necessary in order to explicitly provide a set of goals and objectives that can then be modified in response to program outcome data (supervisor evaluations of residents, resident satisfaction, and posttraining professional achievements).

5.3. The emphasis of the postdoctoral program is on training that includes supervised service delivery, and training needs should take precedence over service delivery or revenue generation. Residents should not be viewed simply as junior staff members who help bring in revenue or reduce the work load of the supervisor, although they certainly may bill for services rendered in the course of their training for which they are legally authorized. Residents would be expected to learn how to meet the service needs of patients and the team in the context of a fiscally constrained service delivery environment. Residents should participate in at least 50% clinical service delivery activities. This is important in two respects. First, residents need enough depth and breadth of exposure to ensure appropriate clinical skill development opportunities. Second, if training programs do not include 50% direct applied experiences, the resident's credentials might be questionable for eligibility for board certification. Research skills are viewed as key to the advancement of the field, broadly defining research to include scholarly activities such as literature reviews, outcome evaluation, grant writing, and publishing.

5.4. APA requirements for accreditation dictate that full-time residents receive a minimum of 2 hours of individual, face-to-face supervision per week. At least one of the face-to-face supervision hours should consist of uninterrupted individual time in the office and at most 1 hour could consist of time taken during patient care activities (bedside teaching). Regardless of design, there needs to be an articulated plan for supervision and provision of feedback. These activities could be verified by a log or timesheet submitted to the training director and maintained as part of a training portfolio.

5.5. APA requirements for accreditation dictate that residents receive supervision from at least two different supervisors during each year of training. Clearly, it is important to provide a breadth of supervisory experiences to promote resident development. In addition,

ongoing mentorship during the entire training period in regard to professional career development is also an important need.

5.6. It is important to recognize the diversity needs of residents. Rehabilitation psychology fundamentally embraces the concept of diversity, and training programs have a responsibility to incorporate the individual resident's personal training goals into their program.

5.7. Concerns or complaints can arise in any setting. Such concerns should, when possible, be raised with the person to whom they pertain, and be resolved in an informal and collegial manner that reflects support and respect for the resident. However, in the event that informal discussion fails to resolve a dispute, there must be a formal process specified for attending to grievances.

## Training Program Outcome Elements

### Guideline 6: Evaluation

It is recommended that postdoctoral education and training programs in applied rehabilitation psychology

6.1. Have a formal ongoing evaluation program, directly linked to the competency goals and the training curriculum, that collects and analyzes data on individual and program structure, process, and outcome elements

#### 6.1.1. Evaluation of Residents

- Provide at least two formal evaluations of residents' performance in the program each year, focused on measurable goals or behaviors and the extent to which residents are meeting the performance requirements and expectations, with written policies and procedures for continuation in or termination from the program. Each evaluation includes a face-to-face meeting and a written report

- Essential types of evaluation include

- Performance appraisals by self, supervisors, peers, and colleagues

- Behavioral observation checklist ratings

- Ratings based on record or chart review

- Useful types of evaluation include

- Oral and written examinations and clinical vignettes

- Written products, such as topic essays and literature reviews

- Student portfolios providing evidence of learning, self-reflection on development, and identification of future learning needs

- Patient satisfaction and patient outcomes

- Evaluation feedback is given early enough in the program to serve as a basis for correction and includes documentation about intended corrective actions. Subsequent feedback involves the extent to which these corrective actions are or are not successful in addressing any areas of concern (APA Guidelines and Principles for Accreditation of Programs in Professional Psychology: Domain E, Items 4 and 6; Domain F, Item 1)

#### 6.1.2. Evaluation of Faculty and Program

- Elicit residents' evaluations of the faculty and program at least twice per year, including residents' views of how effective the faculty and program are in helping them achieve the program goals and objectives as well as their personal goals and objectives and the adequacy of program resources, training activities, and faculty teaching and supervision

- Gather data about residents' performance post-program, for example, licensing and board certification rates, employment in the

practice area, professional participation and productivity, alumni surveys of perceived achievement of program goals and objectives (Commission on Accreditation, 2007: Domain F, Item 1)

6.2. Have a formal ongoing process for using resident, faculty, and program evaluation data for improving resident competencies and program functioning (Commission on Accreditation, 2007: Domain F, Item 1)

### Comment

6.1. Feedback is an essential element of effective clinical teaching. It is only through the provision of feedback that residents can evaluate the extent to which their performance abilities have successfully approached the desired goal and recommendations for further improvement can be developed. APA accreditation requirements specify that training programs collect both proximal and distal outcome data. Proximal outcome data are collected as residents progress through the program and include objective evaluation of resident competencies by the training faculty (and perhaps others). These formative evaluations are part of an ongoing process of evaluation and reevaluation during the course of training and serve to monitor and improve resident competencies and program performance. Semiannual feedback is the minimal standard, but more frequent formal feedback may be inherent to specific program designs. Regardless of the frequency of formal feedback, evidence of inadequate foundational knowledge or training performance should be addressed as soon as identified. Although most rehabilitation psychology training programs rely on supervisor ratings of resident competencies (Stiers & Stucky, 2008), interdisciplinary interaction is a hallmark of rehabilitation psychology, and peer reviews that include other team members can provide essential information regarding interpersonal functioning and team integration. Distal outcome data are collected after residents graduate from the program and include information about how well the program training goals were achieved. In addition, structured evaluation of the faculty and program by the residents and feedback from the residents about the extent to which the program is meeting their training needs are essential for program development and improvement.

6.2. Proximal and distal outcome data are necessary but not sufficient to ensure the successful completion of program goals. It is also necessary that these outcome data are used in a systematic fashion to compare program outcomes against intended goals and to make adjustments as necessary in program structures and processes. APA accreditation requirements specify that training programs must use outcome data for program improvement and development.

### Consensus Recommendations for Establishing the Council of Rehabilitation Psychology Postdoctoral Training Programs

In order to establish consistency and cohesion in rehabilitation psychology training and practice, there needs to be consensus in the field about postdoctoral training guidelines and a means of promoting the adoption of these training guidelines by postdoctoral training programs. This is consistent with other psychology specialties that also have organizations recognizing training programs in compliance with established training guidelines, such as the Association of Post-

doctoral Programs in Clinical Neuropsychology, the Council of Clinical Health Psychology Training Programs, the Council of Counseling Psychology Training Programs, the VA Psychology Training Council, and the Council of Professional Geropsychology Training Programs. All of these organizations, along with others, form the Council of Chairs of Training Councils, an organization that provides a forum for discussion of professional education of psychologists among doctoral, internship, and postdoctoral training associations in psychology and represents these issues to the boards and committees of the American Psychological Association.

The national conference described here achieved consensus about the guidelines, and also achieved consensus to create a Council of Rehabilitation Psychology Postdoctoral Training Programs that would promote training programs' abilities to implement the guidelines and formally recognize programs in compliance with the guidelines. The Council was designed to function as a membership body rather than an accrediting body. Membership would potentially include any and all programs that prepare professional psychologists for practice in the field of rehabilitation psychology. The mission, vision, goals and objectives of the Council are provided in Appendix B.

Although these training guidelines represent a consensus regarding best practices, they are aspirational and not intended to be exclusionary. For example, although the aspirational goal is for all programs to provide 2 years of postdoctoral training, it was recognized that many existing programs are designed as 1-year programs and that length of training should not be a barrier to Council membership. Likewise, programs that emphasize research could be affiliate members, as might new programs that do not initially meet minimum standards.

A mandate of the inaugural Council is to clearly set forth aspirational criteria in a way that facilitates maximal training program participation while also encouraging and supporting best practices. This would include encouraging all training directors to be or become board certified in rehabilitation psychology within a certain period of time. The Conference deferred to the inaugural governing Council to clarify how strictly to apply these aspirational guidelines when determining whether a program would be eligible for full or affiliate membership.

### Conference Evaluation

Average participant evaluation responses ranged from "strong" (4 of 5) to "outstanding" (5 of 5) in regard to four questions: how well did the conference identify the most important issues, incorporate all viewpoints, reach a true consensus, and produce guidelines that will be useful for future development of the specialty ( $M = 4.59$  to  $4.73$ ,  $SD = 0.51$  to  $0.63$ ). However, for each of the questions, there were 1–2 participants who gave ratings of "fair" (2 of 5) or "ok" (3 of 5), and there were no "poor" (1 of 5) ratings. There were no significant differences among the responses to the four questions ( $F = 0.61$ ,  $df = 3$ ,  $p < .61$ ). It appears that most participants felt that the conference produced guidelines that represented an accurate consensus, that had content validity, and that were practical and useful.

### Discussion

The participants in this conference were similar to the members of the Division of Rehabilitation Psychology and the overall mem-

bers of the APA in race/ethnicity, geographic distribution, and degree status. They were more often female, younger, licensed, and board certified in rehabilitation psychology and worked in medical schools with rehabilitation populations. They included individuals in training or early in their career, as well as midcareer individuals and senior leaders in the field, involving work with different patient populations and settings and with important relevant organizations. They evaluated the work of the conference to have been inclusive, valid, and useful.

The Conference developed aspirational guidelines for the structures and processes of postdoctoral education and training programs in rehabilitation psychology. Although standards are mandatory specifications that are used as a rule or basis for measuring, judging, or comparing professional activities, guidelines are non-mandatory suggestions or recommendations that are aspirational in nature, that may not be applicable to every situation, and that are not intended to take precedence over the judgment of program-specific education and training faculty or of those individuals more generally responsible for education and training institutions.

These guidelines apply to postdoctoral education and training for practice in rehabilitation psychology. They do not apply to doctoral education, internship training, or professional continuing education. They do not apply to rehabilitation psychologists who are not in practice or to other areas of professional psychology. These guidelines apply to students and faculty in formal organized postdoctoral programs in institutional settings, but not to self-study, peer consultation, or individualized mentorship or supervision.

The development of these training guidelines and the establishment of the Council as a means of promoting their adoption by training programs are designed to assist in the creation, implementation, and evaluation of formal postdoctoral education and training programs in rehabilitation psychology practice. The intent is to promote quality, consistency, and excellence in the education and training of rehabilitation psychologist practitioners and to promote competence in their practice. It is hoped that these efforts will stimulate discussion, assist in the development of improved teach-

ing and evaluation methods, lead to interesting research questions, and generally facilitate the continued systematic development of the next generations of rehabilitation psychologists. The ultimate goal is to promote psychological services that are effective and responsive to the needs of people with disabilities and that help to maximize their psychological welfare, independence and choice, functional abilities, and social participation.

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(Appendices follow)

## Appendix A

### Specialized Populations, Problems and Procedures That Define Rehabilitation Psychology

#### Populations

Persons who experience

Catastrophic injury or illness, such as spinal cord injury, traumatic brain injury, burn injury, stroke, amputation, and multiple trauma resulting in permanent change

Chronically disabling conditions, such as progressive or static neurological disorders, progressive or static developmental disorders, chronic pain, orthopedic and musculoskeletal problems, sensory impairment, cardiovascular conditions, cancer, and HIV/AIDS

Other major injury or illness requiring prolonged or complicated recovery with concomitant disability

#### Problems

Sequelae to injury, illness, or disability that create difficulties with

Individual and family psychosocial adaptation

Self-care and activities of daily living

Psychological/emotional/personality functioning

Cognitive functioning

Pain and pain management

Achievement of developmental age transitions

Psychosexual functioning

Protection from abuse and exploitation

Treatment adherence, including prevention of secondary complications

Self-determination and consumer choice of services received

Access to appropriate rehabilitation services

Social integration and community participation

Educational, vocational, and recreational functioning

Community access due to environmental and attitudinal barriers

Self-advocacy in relation to local, state, or national laws (including but not limited to ADA), as well as

Difficulties with rehabilitation team functioning

#### Procedures

Assessment and treatment of

Individual and family coping and adaptation

Psychological/emotional/personality functioning

Neuropsychological functioning, including decision-making capacities, and involving adaptation of standardized assessments for persons with sensory and motor impairments

Behavioral functioning

Sexual functioning

Acute and chronic pain

Health behaviors (e.g. substance use and abuse, nutrition, exercise, medication management, prevention of secondary complications)

Self-care and independent living skills

Educational and vocational functioning

Social and recreational functioning

Care-giver functioning

Rehabilitation team functioning

#### Interventions

Educational interventions about illness and injury in a manner appropriate to developmental level and cognitive functioning

Individual psychotherapy

Individual health and behavior interventions and motivational enhancement

*(Appendices continue)*

Group psychotherapy	Consulting with health care professionals and legal and service agencies about behavioral, cognitive, affective/personality, vocational/educational, social/recreational, substance abuse, sexuality, and pain issues as appropriate
Family systems interventions	
Cognitive and behavioral modifications	
Cognitive retraining and remediation	Supervising psychology practicum, internship, and postdoctoral residents
Enhancing appropriate use of adaptive/assistive technology	Evidence-based knowledge and inquiry regarding intervention efficacy including the measurement of rehabilitation outcomes
Facilitating interdisciplinary and transdisciplinary rehabilitation team functioning	Research investigation of issues related to injury/illness and disability
Life-care planning with individuals, caregivers, and other relevant parties, including life span issues related to disability	Advocating for patient rights, accessibility, and justice including efforts towards injury and or illness prevention
Consultation, Teaching, and Supervision, Research and Evaluation, and Advocacy	

## Appendix B

Mission, Vision, Goals, and Objectives of the Council of Rehabilitation Psychology Postdoctoral Training Programs

### The Council of Rehabilitation Psychology Postdoctoral Training Programs

The Council of Rehabilitation Psychology Postdoctoral Training Programs is a membership body open to any and all postdoctoral training programs that prepare professional psychologists for practice in the field of Rehabilitation Psychology. The Council seeks to facilitate maximal training program participation while also encouraging and supporting best practices.

#### Mission Statement

To promote quality, consistency, and excellence in the education and training of Rehabilitation Psychologist practitioners.

#### Vision Statement

The purpose of the Council of Rehabilitation Psychology Postdoctoral Training Programs is to promote the advancement of rehabilitation psychology training at the postdoctoral level. The Council seeks to promote postgraduate psychology training that results in the production of competent Rehabilitation Psychologists who are able to assist individuals with disabilities and chronic

health conditions, their families, and rehabilitation teams; to maximize health and welfare, independence and choice, functional abilities, and social role participation; and to minimize secondary health complications.

#### Goals

To promote excellence and consistency in rehabilitation psychology postdoctoral training by establishing formal standards that lead to the development of competency in the practice of the specialty

To recognize, organize, support, and encourage the development and maintenance of member programs and future programs

To ensure consistency and quality in postdoctoral training in Rehabilitation Psychology so that trainees will be prepared for independent practice and to seek board certification in Rehabilitation Psychology

To promote the care, welfare, and quality of life for individuals with disability and/or chronic health conditions by improving the overall training of clinicians dedicated to serving them

To serve as an advocate for students/residents in rehabilitation psychology.

*(Appendices continue)*

## Objectives

- To develop and communicate coherent and consistent policies and procedures that promote quality, consistency, and excellence in the education and training of rehabilitation psychology practitioners, and to promote competence in their practice
- To develop a set of general conceptual and operational documents that can assist rehabilitation psychology postdoctoral training programs in their organization and management
  - To provide a forum for consultation and discussion of common issues among postdoctoral training programs in rehabilitation psychology to enhance collaboration and cooperation
  - To disseminate information about postdoctoral training in rehabilitation psychology to other organizations within psychology, to potential residents, and to the general public
  - To develop a partnership with other professional organizations involved in policy formation, planning, and coordination of education and training standards relevant to accreditation and certification procedures for postdoctoral training programs in rehabilitation psychology, including the Commission on Accreditation, the American Board of Professional Psychology, the APA, the Association of State and Provincial Psychology Boards, the National Register of Health Service Providers in Psychology, the Council of Specialties, the Council of Chairs of Training Councils, and the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology.

## Values

- Commitment to professionalism and excellence in training programs, training faculty, and trainees
- Understanding of and respect for diversity in faculty, residents, patients, and others in a manner that reflects psychology's ethical principles and professional standards
- Belief in and emphasis on the human worth of all persons and the importance of their integration into the society at large.

## Conference Participants

The Executive Board of the APA, Division of Rehabilitation Psychology, selected the current Chair of the Division Education and Training Committee as the Conference Chair. The Conference Chair, in consultation with the Executive Board, selected the Steering Committee (7), including the President of the Division, representatives from the Department of VA (1) and non-VA (3) training programs, and representatives of the ABRP and the Academy of Rehabilitation Psychology. An Advisory Board (7) was also selected to add additional consultative depth, consisting of the Presidents of the two Sections of the Division (Pediatrics and Women's Issues), a Division Early Career representative, a Division Student representative, a single representative of the five Division Special Interest Groups (Assistive Technology, Deafness, Outcomes Measurement, Integrated Health and Living, and Of-

fenders with Disabilities and the Justice System), a DoD representative, and a representative of the Foundation for Rehabilitation Psychology. All Steering Committee and Advisory Board members were licensed psychologists practicing in the specialty of rehabilitation psychology (with the exception of the Student Representative).

The Conference Chair, Steering Committee, and Advisory Board then selected the additional 31 participants from among those expressing interest in attending. E-mail announcements were made on the Division e-mail list soliciting persons interested in participating. Nine additional non-VA training directors, five additional VA training directors, six rehabilitation psychology practitioners, and five additional students were selected. These participants were selected to represent larger and smaller programs, programs with adult versus pediatric emphasis, programs that focus on different patient populations, and programs serving more urban than rural areas, while striving to achieve an overall mix of individuals in relation to sex and ethnicity. Six additional participants were selected based on their unique contribution to the conference proceedings: a VA Central Office representative, the incoming Editor of *Rehabilitation Psychology*, a representative of the Division Diversity Committee, a representative of the Division Disability Special Interest Group, a representative of the APA Education Directorate, and a physician involved in medical education practice and research.

## Participants at the Baltimore Conference on Rehabilitation Psychology Postdoctoral Training

The number of participants is in parentheses.

Chair: William Stiers

Steering Committee (7)

- President of Division 22: Janet Niemeier
- University Training Representatives: Teresa Ashman, Wanda McEntyre, and Kirk Stucky
- VA Training Representative: Aaron Turner
- American Board of Rehabilitation Psychology: Mary Hibbard
- Academy of Rehabilitation Psychology: Bruce Caplan

Advisory Board (7)

- Division 22 Student Representative: Merry Sylvester
- Division 22 Early Career Representative: Mary Brownsberger
- Foundation for Rehabilitation Psychology: Daniel Rohe
- DoD Rehabilitation Psychologist: Kathleen Brown
- Division 22, Section 1—Pediatrics: Marie vanTubbergen
- Division 22, Section 2—Women's Issues: Michelle Meade
- Division 22 Special Interest Groups: Marcia Scherer

University Training Directors (9)

- University of Missouri: Eric Hart
- University of Missouri: Renee Stucky
- University of Washington: Jeffrey Sherman
- Rancho Los Amigos National Rehab Center: Fernando Gonzalez

(Appendices continue)

- Rehabilitation Institute of Michigan: Robin Hanks
- Kessler Foundation Research Center: Jeannie Lengenfelder
- Barrow Neurological Institute: Heather Caples
- University of Michigan: Jacqueline Kaufman
- Kennedy-Krieger Institute: Cynthia Salorio

VA Training Directors (5)

- Tampa VA: Glenn Curtiss
- Denver VA: Lisa Brenner
- Richmond VA: Treven Pickett
- Palo Alto VA: Carey Pawlowski
- Syracuse VA: Judy Hayman

Practice (6)

- Drexel University: Maria Schultheis
- University of Florida: Stephanie Hanson
- University of Florida: Tom Kerkhoff
- University of Kansas: Monica Kurylo
- University of Denver: Kim Gorgens
- Baylor Institute for Rehabilitation: Mark Barisa

Students (5)

- University of Missouri: Angela Bodling
- Richmond VA: Anne Molloy
- Tampa VA: Angela Kuemmel
- Ohio State University: Colleen Sheehan
- Ohio State University: Krystal Drake

Others (6)

- Incoming Editor, *Rehabilitation Psychology*: Stephen Wegener
- Division 22, Diversity Committee: Vicky Lomay
- Division 22, Disability Special Interest Group: Michael Dunn
- VA Central Office: Robert Zeiss
- APA Education Directorate: Catherine Grus
- Medical Educator: Jennifer Kogan

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