Processes Governing the Selection of Academic Clinical Training Directors

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Accreditation guidelines of the American Psychological Association require the formal designation of a program director, but readers may not be aware that the selection processes used by academic clinical psychology programs can vary widely. Clinical directors who were members of the Council of University Directors of Clinical Psychology surveyed in this article were either elected by a subset of program participants (clinical faculty, nonprogram faculty, and/or students) or appointed by a university administrator (chair or dean). About 15% of these 85 respondents assumed the directorship in the aftermath of a predecessor’s failure to secure reappointment, resignation under pressure, or removal. These “pressured transitions” did occur more frequently in programs that involved students in the selection process. It is hoped that these survey results will prompt further discussion regarding the methods used to select clinical directors and the impact of these governance decisions on faculty and student morale and program stability.

Just how do academic clinical psychology programs select their training directors, and do the processes governing the selection of clinical directors influence the long-term stability of the respective programs? Although programs accredited by the American Psychological Association (APA) must formally designate a training director, they are extended full latitude regarding the process implemented to meet this requirement. The present article provides information regarding leadership selection processes used today in academic clinical psychology training programs.

Statistics from the most recent APA Committee on Accreditation (CoA; APA, 2002a) annual report indicated that the average clinical training program comprised 9 faculty members and 70 enrolled graduate students. These clinical faculty members bear a heavy burden of responsibility that extends to teaching, supervision, research, and administration of the program. The development, implementation, and evaluation of the program must occur on an ongoing basis, and the director of clinical training (DCT) serves as steward to advance and protect the welfare and long-term interests of the program. The DCT assumes a multifaceted role (leader, mediator, legislator, historian, etc.) that requires capable management of time, resources, and risk. A complex network of student and faculty relationships must also be maintained, and DCT administrative actions can sometimes compromise collegial friendships that have been cultivated over many years. These responsibilities are often accepted with minimal financial compensation.

There has been little systematic investigation of the role of the clinical director. Wisocki, Grebstein, and Hunt (1994) conducted one of the first surveys of North American DCTs. They reported that most DCTs found the job to be rewarding and desirable, but there was also frequent mention of major stressors, which included extensive paperwork, disruption of research objectives, and on occasion, strained faculty and student relations. Other writers (McNeil, 2000; Rabin & Foster, 1999) have provided penetrating reviews of the many responsibilities assumed by contemporary DCTs. Their task analyses indicated that the clinical directorship was indeed a challenging, sometimes turbulent, administrative position. According to the Wisocki et al. survey, the average person sustains the DCT role for only 4 years. This high rate of leadership transition in clinical training programs has not been adequately discussed, and the governance processes typically followed to select new DCTs have not been formally identified in the literature.

Decisions regarding administrative leadership must occur for a wide variety of psychology training programs. The present survey focused on scientist-practitioner doctoral clinical training programs that are governed by faculty of regionally accredited universities. These particular clinical training programs meet the eligibility requirements for the Council of University Directors of Clinical Psychology (CUDCP). These survey results may or may not accurately describe processes governing the selection of directors of training in counseling, school, and professional psychology programs, which are represented by their own respective organizations: the Council of Counseling Psychology Training Centers (CCPTC), the Council of Directors of School Psychology Programs (CDSPP), and the National Council of Schools and Programs of Professional Psychology (NCSPPP). Directors of predoctoral training clinics (Association of Directors of Psychology Training Clinics [ADPTC]) and internship and postdoctoral training programs (Association of Psychology Postdoctoral and Internship Centers [APPIC]) must also be selected via their respective institutional appointment processes. The present analysis was restricted to processes governing directorship appointments and leadership stability in the subset of academic clinical training programs represented by the CUDCP membership.

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The Academic Training Director Survey

The Academic Training Director Survey generated for this article was distributed to the directors of all 163 CUDCP member programs during the 2000-2001 academic year. Survey questions were selected to provide basic information about the career history of the respondent, the circumstances under which his or her predecessor left office, the governance processes followed by the program to select new directors, and the DCT’s assessment of faculty satisfaction with their selection process.

Surveys were returned by 85 DCTs, for a participation rate of 52.1%. DCT appointments typically required the majority support of either the clinical (54%) or total department (8%) faculty (see Table 1), and a preference vote between opposing candidates occurred in a subset of cases (25%) that involved election processes. Student representatives were allowed to vote in 17% of these 53 programs that conducted these acceptability or preference votes to determine their leadership. The DCT was appointed unilaterally by the department chairperson or the college dean in 35% of the remaining cases. The selection method could not be determined from 2 survey respondents.

The average DCT responding to the present survey reported a tenure of 6.4 years, which indicated a higher level of leadership stability than suggested by Wisocki et al.’s (1994) survey. It remains to be determined if there is a trend toward DCT’s remaining in the role for longer tenures, but there was considerable variability in the administrative experience of the respondents in this sample. Only 21% of these DCTs have served for 10 years or more (range = 1–30 years), and 36% have been in the role for 3 years or less. Most respondents were senior in academic rank (75% were full professors, 24% were associate professors), but 4% were untenured.

Larger departments appeared to gravitate toward more manageable processes that restrict the decision making to program faculty. Smaller programs were more likely to utilize more inclusive selection methods. There were significant differences between the three selection methods (election by clinical faculty, election by department, administrative appointment) in total number of department faculty, $F(2, 69) = 3.2, p = .04$, and specialized areas of training, $F(2, 75) = 2.97, p = .05$. Student Newman–Keuls multiple-range post hoc comparisons indicated that departments with smaller faculties and fewer doctoral specialties were most likely to utilize department elections to select the clinical director. Departments that conducted full-faculty DCT elections had no more than 17 total faculty members (25th percentile in department size) and two areas of doctoral specialization. Conversely, the majority of departments restricting the DCT selection process to administrators or clinical faculty (and sometimes to students) had three or more PhD programs managed by faculties that ranged as high in number as 65 members. Clinical faculty sizes were much less variable and did not differ on the basis of DCT selection method, $F(2, 77) = 1.41, p = .25$.

None of the three selection methods was distinguished by higher or lower levels of clinical faculty dissatisfaction with the process, $F(2, 74) = 0.36, p = .70$, or program dissension over the past decade, $F(2, 76) = 1.24, p = .30$. DCTs also described levels of personal satisfaction with the rules that governed their selection that were statistically equivalent across the three groups, $F(2, 74) = 0.36, p = .70$. DCT terms of appointment were typically 3–5 years, which did not differ significantly as a function of selection method, $F(2, 52) = 1.33, p = .27$. DCT tenures did not differ significantly across the three selection approaches, $F(2, 80) = 0.35, p = .70$.

Graduate student voting was reported within 17% of departments in which clinical leadership was determined by elections involving clinical or other department faculty. Students or their representatives cast an average of 13.7% ($SD = 7.9\%$) of the total votes within programs in which student voting was permitted. DCTs reported greater program dissension over the past decade over directorship decisions that involved ($M = 3.10, SD = 2.28, n = 10$) rather than excluded ($M = 1.97, SD = 1.35, n = 73$) student voting, $F(1, 76) = 5.01, p = .03$. Personal DCT satisfaction ratings, $F(1, 79) = 1.75, p = .49$, and estimates of program faculty approval of the selection process, $F(1, 74) = .01, p = .97$, appeared unrelated to the presence or absence of student voting provisions.

DCT reports of faculty dissatisfaction (Likert ratings greater than 4) with the leadership selection process were infrequent. Only 10% reported lasting program dissension over DCT selection outcomes, and only 7.8% of respondents estimated that their average clinical faculty colleague was dissatisfied with the rules that governed the DCT selection process. About 11% of respondents described personal dissatisfaction with the rules that govern the selection process. The three selection methods could not be differentiated in their frequency of elevated ratings (Likert ratings greater than 4), suggesting program dissension, $\chi^2(2, N = 79) = 2.91, p = .23$, or faculty, $\chi^2(2, N = 79) = 1.06, p = .59$, or DCT, $\chi^2(2, N = 79) = 0.09, p = .96$, disapproval of the selection process.

Most (85%) respondents to this survey assumed the directorship after the uncontested termination of their predecessor’s term (resignation, declined reappointment, occasionally death). About 15% of the DCT predecessors, however, failed in their effort to secure reappointment ($n = 6$), resigned under pressure ($n = 3$), or were removed from office ($n = 4$). We conducted additional analyses in an effort to identify program qualities that might increase the likelihood of such “pressured transitions” in leadership. The number of clinical faculty, $F(1, 80) = 0.04, p = .85$, department faculty, $F(1, 72) = 0.44, p = .51$, and areas of department specialization, $F(1, 78) = 0.13, p = .72$, did not differ statistically between programs distinguished by pressured ($n = 13$) versus unremarkable ($n = 72$) most-recent transitions. Pressured DCT transitions occurred with equal frequency in programs that relied on administrative appointment, the vote of the clinical faculty, or approval of a majority of the department faculty, $\chi^2(2, N = 83) = 1.13, p = .57$. A trend was observed for pressured transitions to occur more frequently within programs that permitted student voting, $\chi^2(1, N = 52) = 3.62, p = .057$.

Finally, many respondents commented on the lack of specified governance procedures for the selection of the DCT in their program (e.g., “your questions imply hard-and-fast formal procedures,” “rules are covert and complex,” “lots of informal behind the scenes politics”). More typical, however, was an emphasis on the difficulty programs have persuading someone to accept the

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1 A copy of the Academic Training Director Survey may be obtained from the author.
position. A surprising 20% of respondents added written comments to emphasize the undesirability of the position (e.g., "the DCT is not a prize," "nobody wants to do it," "we have to twist arms"). A few respondents even offered an extended anecdotal account of the problems that can accompany the failure of a program's leadership or governance process.

Implications

The present survey provides descriptive data regarding the processes that govern the selection of training directors in CUDCP scientist–practitioner clinical programs today. Parallel surveys would be needed to determine the degree to which these governance procedures generalize to other training programs represented by organizations such as CCTCP, CDSP, NCSP, ADPTC, and APPIC. There appears to be little information in the literature at present regarding the similarities and differences in the manner in which clinical, counseling, school, internship, and professional doctoral psychology training programs are administered. Doctoral psychology programs could possibly benefit from an exchange of information of the sort provided in this article.

A qualitative review of these survey results suggested that many CUDCP programs relied on informal (as opposed to by-law) selection guidelines that did not articulate a precise process to govern the selection and transition of the DCT. The absence of formal guidelines could jeopardize the stability of some programs, and this report might prompt discussion of alternative models and by-law language that could be used to govern the selection process. APA accreditation guidelines even allow the directorship position to be shared by more than one individual. The availability and discussion of alternative options could be particularly useful to psychologists involved in the development of new, yet to be accredited training programs.

Larger CUDCP programs (greater than 17 department faculty members) appear to designate their DCT primarily on the basis of either administrative appointment (55%) or majority vote of the clinical faculty (54%). Table 1 shows that these two selection methods were associated with virtually equivalent DCT tenures, estimates of program stability, and faculty satisfaction with the selection process. In fact, only 10% of programs showed evidence of dissatisfaction with DCT selection issues, and these programs could not be differentiated on the basis of selection method (including the small number of programs that relied on full department votes).

Table 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Chairperson appointment</th>
<th>Election</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Clinical faculty (no. of)</td>
<td>8.4</td>
<td>2.1</td>
</tr>
<tr>
<td>Total faculty (no. of)</td>
<td>27.1</td>
<td>12.4</td>
</tr>
<tr>
<td>Department areas (no. of)</td>
<td>3.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Appointment tenure (years)</td>
<td>6.3</td>
<td>5.9</td>
</tr>
<tr>
<td>Appointment term (years)</td>
<td>3.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Program Dissension (decade)</td>
<td>1.9</td>
<td>1.2</td>
</tr>
<tr>
<td>Satisfaction of current DCT</td>
<td>2.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Faculty approval of process</td>
<td>2.4</td>
<td>1.1</td>
</tr>
<tr>
<td>N</td>
<td>30 (35%)</td>
<td>46 (54%)</td>
</tr>
</tbody>
</table>

None. DCT = director of clinical training.

Program dissension and pressured transitions did appear to occur more frequently in programs that permitted student voting. Conversely, respondents from these programs indicated both personal and, at least assumed, colleague satisfaction with the selection process despite the episodic problems that can accompany student voting. Programs must ultimately weigh the balance between the potential liabilities (e.g., student dissatisfaction, distraction from scholarship, unwelcome political pressure, etc.) and benefits of student inclusion and empowerment (e.g., awareness of broader professional issues, enhanced role responsibilities, increased faculty contact, facilitation of program change, etc.). Student voting might be opposed by some on the grounds that it diminishes the inherent authority of core faculty to make autonomous decisions about program direction, but the propriety of student or nonprogram faculty voting has not been addressed in the CoA guidelines. The most central requirement remains that accredited programs assure respectful and courteous interactions between students and faculty (Domain E: Student–Faculty Relations; APA, 2002b). Student voting could serve to either foster or compromise student–faculty relations, depending on the program and manner in which the voting policy is implemented. The present survey may prompt further discussion of the merits of student involvement in different aspects of program governance.

The DCT role continues to be an unstable one commonly described by directors as heavy in responsibility but light in authority. Only 21% of the present sample of directors served in the role for more than a decade, and about 1 in 3 have been in the role for less than 3 years. The surprising 4% of untenured respondents may face additional challenges to their authority and ability to generate the scholarly credentials necessary to achieve later...
tenure and promotion. An unexpected 20% of the total sample went on to offer unprompted comments regarding the undesirability of the position, which would be gratefully relinquished to a suitably interested and qualified colleague. Broader recognition of the challenges faced by program directors does appear to have occurred over the years. Professional organizations such as CUDCP and APPIC now provide formal mentorship programs for new DCTs. Some experienced directors volunteer their time to interested junior colleagues, and a number of professional organizations also provide director training workshops that are invaluable resources to the entire membership. Internet listserves and annual directorship meetings further extend the sense of community among many contemporary program directors.

A transition of leadership, on average every 6 years, can serve to introduce new energy and ideas into a clinical training program, and periodic rotations of the directorship among senior clinical professors appears to occur in some CUDCP programs. The accrued wisdom and experience of a DCT must also have a value, and a legitimate question remains as to the optimal tenure of a program director. The mixed consequences of leadership transitions warrant further analysis.

References


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