CLINICAL PSYCHOLOGY

Assessment, Treatment, and Research

Edited by **David C. S. Richard**
Steven K. Huprich

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Editors

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Preface

The profession of clinical psychology is a noble enterprise. Individuals choosing to enter the profession do so knowing that their training will take several years and that the financial rewards are modest at best. Despite these realities, applications to clinical training programs remain especially competitive — it is common for doctoral training programs to report acceptance rates in the single digits.

It is the nobility of the profession, however, that may be its main attractant. The desire to help others, and to do so in ways that engender long-lasting psychological development and change, transcends the profession and is rooted in the religious, cultural, and philosophical foundations of the modern world. The clinical psychologist's currency is not measured in dollars but in something more ethereal, optimistic, and enduring — human change. To know that one has helped another person through a process of change and to watch people grow and transform the way they view themselves and the world provide a tremendous sense of personal satisfaction. The fact that an entire profession is devoted specifically to helping others address psychological problems and suffering is, in many ways, validation of the need for clinical psychologists. In a society where it is not always clear that there are safety nets to catch those who have fallen, the clinical psychologist is the professional with the most training and greatest number of tools at his or her disposal. It is a responsibility not to be taken lightly.

Although all clinical psychologists share the common goal of engendering change to help others, the exact way in which this is done varies tremendously from one professional to the next. As a result, this book reflects the tremendous diversity of the field. Although the chapters are broadly organized into three major sections (i.e., assessment, treatment, and contemporary issues), what exactly a clinician does as part of assessment and treatment depends substantially on his or her theoretical orientation. This is a theme that will be explored throughout the book. Suffice it to say at this point that we consider theoretical diversity to be a strength of the field, not a weakness. Indeed, given the complexities of the human experience, we think it is untenable for any one theory to provide both a comprehensive and adequate account of psychological problems. Instead, the learned clinician will value diverse perspectives (if not always agree with them) for the illumination they provide in understanding the full range of issues associated with any clinical problem.

This book is unusual in that it was conceptualized from the beginning to be thoroughly eclectic. As you will see throughout the chapters, the ideas and points of view are often diverse, and the authors have taken liberty to write about and support their ideas while recognizing and respecting the diversity within professional clinical psychology. Thus, our goal from the beginning was to bring together diverse views within the profession with regard to assessment, treatment, and other germane issues. In doing this, we frequently found ourselves working not to impose our own theoretical predispositions on the work of our contributors. This was no easy task given that one of us is psychodynamic (SH) and the other cognitive-behavioral (DCR). Indeed, we occasionally found ourselves in

theoretical and empirical debates using the commenting function in Microsoft Word as an impromptu forum for intellectual discourse, which our authors saw and were asked to grapple with. To our contributors, we offer a special thanks (and even congratulations) on surviving a feedback process that, at times, may have resembled the ramblings of dissociating editors rather than a theoretically coherent set of remarks.

Thus, the reader should look forward to a spirited text written in a mentoring style that is designed to expose the reader to the full range of contemporary thinking in our field. Each of the contributors took on his or her chapter knowing that the target audience was the first-year graduate student in clinical psychology or an advanced undergraduate. Thus, they focused their work in a way that is meant to be most useful to the clinician in training. We believe that this text serves as a solid foundation for your development as a clinician and that you will refer to it often in succeeding years. We hope it is a worthy introduction to your future profession, and we wish you nothing but the best in your journey.

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Contents

CHAPTER

1

Professional Psychology Education and Training: Models, Sequence, and Current Issues

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OUTLINE

In this chapter, we discuss education and training in clinical psychology. Because the doctoral degree has been considered the entry degree for **licensure** and practice for psychologists, we have focused on the doctoral level. First, we discuss the history of education and training in professional psychology. Included in this history are a sample of training conferences and a description of the models of education and training in clinical psychology that have developed over the years. The remainder of the chapter focuses on the sequence of education, training, and credentialing that leads to entry into the profession of psychology.

HISTORICAL OVERVIEW

"Psychology," in the general sense, has existed for all of recorded history. There have always been individuals who provided support and advice to others, and others who wondered about functions like memory, learning, and the meaning of dreams. When psychology first began to grow as a discipline in the nineteenth century, though, the formal discipline of psychology was founded. At that time, the only existing psychology programs focused on experimental psychology and on the observation and measurement of individual differences. In fact, a 1934 study by the American Psychological Association (**APA**) Committee on the PhD Degree in Psychology found that the only training commonality among the 22 institutions surveyed was that "training in experimental psychology is fundamental and required for all psychologists" (p. 71). Most programs required basic science courses for admission and agreed that "there must be close personal contacts with the candidate which will enable the department to evaluate his research ability and scientific imagination" (p. 71). The emphasis on science was clear, as was the lack of focus on practice. It may surprise students to know that venereal disease and war were largely responsible for increasing attention to education for practice and for moving psychology from an academic discipline to a profession.

Advanced, untreated syphilis can lead to the development of general paresis, a set of symptoms that resemble a severe psychological disorder. When antibiotics were discovered and found to be effective in the treatment of syphilis, the observation was made that this type of "insanity" could be cured. In addition, the "humane" or "moral" treatment of Pinel, Tuke, and Dix was observed to have a positive impact on those with mental illness. With the recognition that both medical and psychosocial interventions could help those with psychological problems, there was a change in prevailing views of mental health and illness. For the first time, mental illness was seen as treatable and even curable.

The two world wars brought with them an awareness that psychologists, with expertise in measurement and interest in the increasing number of approaches to the treatment of mental illness, might be helpful in evaluating military recruits and in treating traumatized soldiers, particularly after World War II. However, even after the war, there were no standards for how to teach psychologists to move from the laboratory into the clinic. Figure 1.1 summarizes the history of education and training in clinical psychology.

MODELS OF TRAINING

Boulder Scientist-Practitioner Model

With the growing participation of psychologists in applied activities following World War II, the need to examine the education and training of clinical psychologists became obvious. The Veterans Administration **(VA)** pledged support for the training of clinical psychologists but wanted the field of psychology to designate appropriate programs to receive funding. Thus began the concept of psychology program accreditation; however, clinical psychology did

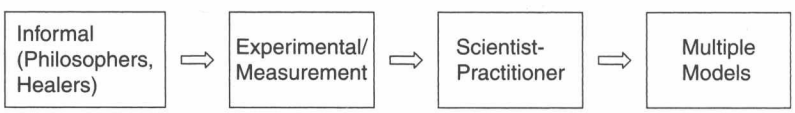

FIGURE 1.1 History of Education and Training in Clinical Psychology.

not have clear standards to apply in the program approval process. In an effort to define appropriate education and training in clinical psychology, the APA formed a Committee on Training in Clinical Psychology in 1947, chaired by David Shakow. The committee provided the first set of guidelines for training in clinical psychology (Committee on Training in Clinical Psychology of the American Psychological Association, 1947). The committee's recommendations discussed the "raw material" or characteristics of applicants likely to succeed in clinical psychology. In addition to intelligence and other traits, admissions criteria were to focus on finding applicants with "a reasonably well-adjusted and attractive personality" (p. 541). In addition, applicants were expected to have strong undergraduate science and humanities backgrounds. Program recommendations described by this committee became the basis for the **scientist-practitioner model** of training, developed at the Boulder conference in 1949 (Raimy, 1950). Specific recommendations were made for a four-year sequence including coursework, **practicum**, **internship**, and **dissertation**.

The pressured doctoral student of today will appreciate the committee's additional recommendation that "students must be given time to read and think" and develop strong critical thinking skills, asking questions and searching for scientific evidence to support their views. More recent restatements and clarifications of the model have been published (e.g., Belar, 2000; Belar & Perry, 1992). Approximately 52% of clinical psychology programs that indicated a training model in 2006 (the most recent year available) stated that they followed the scientist-practitioner model, and approximately 31% of clinical psychology degrees were awarded by these programs (APA, 2008). Many of these programs are members of the Council of University Directors of Clinical Psychology (**CUDCP**), a training council made up of member programs that meet to share ideas and improve and update scientist-practitioner training.

The Shakow report and Boulder model, supported by training grants from the (VA) and the United States Public Health Service (USPHS), focused clinical psychology on blending into the health-care system. The Boulder model's acceptance of the medical model and of training and practice in medical settings as primary has been criticized for ignoring education, business, and other settings where the need for psychological services was evident (Albee, 2000; Baker & Benjamin, 2000).

Vail Professional Model

The Boulder model of scientist-practitioner training was the only existing model for approximately 20 years. During the 1960s, legislation led to a plan for deinstitutionalization of the chronically mentally ill and to the development of community-based mental health centers (**CMHCs**) across the United States designed to offer a continuum of prevention and intervention services. The development of numerous CMHCs created jobs in administration, assessment, and intervention for psychologists. But many psychologists at that time who had been trained as scientist-practitioners had not received sufficient applied clinical training for these positions. Because the universities in which scientist-practitioner programs were housed generally rewarded faculty for research rather than clinical productivity, and because most early Boulder model program faculty had been trained as experimental psychologists, faculty and their programs focused more on training students for research than for practice. Thus, the balance proposed at the Boulder conference was not achieved. While many scientist-practitioner programs sought to train academic researchers, many graduates went into clinical practice, and the modal number of publications of those graduates was zero. Yet training for work in real-world clinical settings often was not sufficient in what had become research-focused programs. Some began to

wonder if it was possible to train students equally well in both research and practice. The "Chicago conference" of 1965 was held to review alternative models of training for clinical psychologists, but the ultimate outcome was an endorsement of scientist-practitioner training (Hoch, Ross, & Winder, 1966).

Growing concern about the adequacy of clinical training for practitioners led to another well-known training conference, the Vail conference (Korman, 1973a), which yielded a description of an alternative model of training, the professional model. In the proceedings of the Vail conference, Pottharst (1973) pointed out that the Boulder model was developed in response to the need for programs to train psychology practitioners. However, locating practitioner training in psychology departments rather than in separate schools of psychology, accreditation criteria of the time, offering the PhD research degree rather than an alternative practice degree as is common in other professions, maintaining faculty who were researchers rather than practitioners, and related structural characteristics made it difficult to infuse sufficient practitioner training into clinical programs. The advanced level of clinical skills expected of doctoral-level practitioners was not achieved until after graduation or even licensure and was often learned on the job (Pottharst, 1973). Many felt that it was extremely difficult to train each student to be both a practitioner and a scientist with equal success (Albee, 1971; Peterson, 1991).

The Vail conference sought to remedy this situation by recommending more practice-based education and training activities. Students were still to be trained in the broad psychological foundations of practice and in research methods, and science was still to be integrated with practice, but these were done with the purpose of educating practitioners. The PsyD degree was recommended for those intending to practice and the PhD for those intending careers in research and teaching. University schools of psychology, medical schools, education departments, and free-standing schools of psychology as well as university departments of psychology were all described as appropriate settings for clinical psychology programs.

Because research has shown that much of the work done at the doctoral level can be done equally well by those with a master's degree, the delegates to the Vail conference recommended that doctoral-level psychologists engage in program development and evaluation, the development of new clinical procedures and models, the integration of practice with theory, supervision and training, and the management and administration of facilities and programs (Korman, 1973b). Delegates thus proposed the idea of training for **multiple roles**, a suggestion that has been realized in current accreditation criteria. Unfortunately, the master's vs. doctoral issue, including issues surrounding the continuity of education and the differentiation of practice domains, still has not been adequately addressed. However, the positive result of the Vail conference was attention to direct education for practice careers and a greater choice in training models, emphases, goals, degrees, and training settings available to students.

In 2006, approximately 22% of programs indicated that they followed the Vail **practitioner-scholar model** (the term that will be used for the remainder of this chapter for programs based on the Vail model), and approximately 42% of the degrees awarded in clinical psychology that year came from these programs (APA, 2008). Vail model programs usually maintain membership in their own training council, the National Council of Schools and Programs of Professional Psychology (**NCSPP**), which has further developed this training model (e.g., Peterson, Peterson, Abrams, & Stricker, 1997). Most NCSPP programs offer the doctor of psychology (PsyD) degree.

Some concerns have been expressed about the Vail model. Research training is often seen as one way to distinguish psychologists from other mental health practitioners, and some believe that practitioner programs do not emphasize science and research skills sufficiently. Others worry that locating programs outside of university psychology departments may mean insufficient resources for these programs, and that with larger class sizes than in most Boulder model programs the opportunity to learn through research mentorships might be lost. One strength of Vail model programs is the relevance of direct multiple roles training for the practice jobs most graduates are likely to hold.

Clinical Scientist Model

Since Vail, an additional model of training has entered the scene, the **clinical scientist model** of training (McFall, 1991, 2000; Hébert, 2002). This model (McFall, 1996) emphasizes first that "psychological services should not be administered to the public (except under strict experimental control) until they have satisfied" (p. 9) specific criteria for empirical validation. Second, "doctoral training programs in clinical psychology must ... produce the most competent clinical scientists possible" (p. 9). Programs using the clinical scientist model are typically members of the Academy of Psychological Clinical Science (**APCS**) and often maintain membership in CUDCP as well. In 2006, approximately 16.5% of programs indicated that they followed the clinical scientist model, and approximately 9.5% of clinical psychology doctorates were awarded by these programs (APA, 2008).

Critics of the clinical scientist model express two primary concerns (Peterson, 1996a, 1996b). First, McFall (1996) uses a very narrow definition of research support. Second, by limiting psychologists to "proven" methods, critics assert that we will be unable to discover new potentially effective methods or to address problems that do not yet have clearly demonstrated effective treatments. Even in medicine, when there is no cure for a particular type of cancer, medical professionals will focus on improving the comfort of the patient and treating secondary conditions resulting from the cancer. Many psychologists believe we should provide such assistance to people with psychological conditions for which there is no empirically supported treatment and do our best to see if there is some not-yet-proven technique that might be effective. In addition, some are concerned that the nonspecific factors effective in the treatment relationship are not given sufficient attention in these programs and that the "sanitary" environment of the laboratory rarely exists in the clinic. Nonetheless, the strength of this model is the attention it has focused on the need for testing new methods and demonstrating that what we do as professional psychologists works.

Education and Training Models: Putting It All Together

Despite the varied emphases of each model of treatment, there are many more similarities than differences among clinical psychology programs using different training models. Accreditation criteria have ensured that all programs provide broad and general training at the doctoral level; doctoral students are to be trained for general practice, and specialization is not expected until the postdoctoral level. All programs must provide grounding in the scientific foundations of psychology and the foundations of practice, provide adequate practicum experiences, and teach students to integrate science and practice. All must teach students about empirically supported interventions and evidence-based practice (APA, 2007b). Additional requirements for accreditation are presented in Highlight Box 1.1.

HIGHLIGHT BOX 1.1

DOMAINS FOR APA ACCREDITATION*

A. Eligibility
   a. Factors related to the institutional setting and structure
   b. Residency requirement
B. Program Philosophy, Objectives, and Curriculum Plan
   a. Stated philosophy, objectives, and curriculum plan
   b. Experiences to teach specific content areas
      i. Scientific foundation
      ii. Foundations of practice
      iii. Application
   c. Practicum
C. Program Resources
   a. Faculty
   b. Students
   c. Financial, clerical, technical, training materials, physical facilities, student support, practicum sites
D. Cultural and Individual Differences and Diversity
   a. Recruitment, support, and advancement of diverse students and faculty
   b. Education prepares students to work in a diverse world
E. Student-Faculty Relations
   a. Rights and ethics are respected, respect for diversity, written policies and procedures
   b. Faculty are accessible and serve as role models
   c. Complaints are handled appropriately
F. Program Self-Assessment and Quality Enhancement
   a. Program gathers short- and long-term data on student and program outcomes
   b. Changes are made to improve the program based on data collected
G. Public Disclosure
   a. All crucial information is readily available
H. Relationship with the Accrediting Body
   a. Abides by CoA guidelines and informs CoA of program changes
   b. Pays dues to CoA and makes required interim reports

*From American Psychological Association (2007b). Guidelines and principles for accreditation of programs in professional psychology. Washington, DC: Author.

The research-practice continuum is often used to distinguish different program models. One interesting observation is that *all* of the major training conferences and training councils in psychology have endorsed and even emphasized the need to integrate research and practice. All accredited programs must do this. Clinical science and scientist-practitioner programs are more likely to focus research training on traditional, experimental, generalizable studies and toward having graduates who produce and publish original research. Most practitioner-scholar programs focus on graduates conducting "disciplined inquiry" (Peterson, 1996b), functioning as "local clinical scientists" (Stricker & Trierweiler, 1995; Trierweiler & Stricker, 1998) or "scientific practitioners" (Peterson, 2000) who engage in science-based practice, critical thinking and logic, and local (i.e., not necessarily generalizable) quasi-experiments (including outcome and program evaluation) as they engage in

clinical practice. In addition, some programs devote more resources to support faculty research and expect more publications in research journals, while others provide fewer resources for original faculty research and do not require the same number or types of publications. Despite these differences of emphasis, students in all models of clinical psychology programs should expect much of what they learn to be based on an integration of research and practice.

A recent survey of program directors found that there were no significant differences in professional psychology student exposure to measurement theory, research methods, or statistical analyses based on the program model and that the only difference based on degree was in the direction of more coverage of qualitative methods in PsyD than in PhD programs (Rossen & Oakland, 2008). It is clear that despite the program model or degree, students receive training in all of these areas. However, the Rossen and Oakland study did not examine whether differences in the programs' training goals influence the level of depth and detail in which these topics are taught. In addition, students being trained in CUDCP member programs indicated that about 37% of their time was spent in research training, 29% in clinical work, and 17% in their integration (Merlo, Collins, & Bernstein, 2008). It would be interesting to have comparative data for NCSPP and APCS programs as an indication of how different or similar we actually are on this dimension.

The issue of models and degrees may be quite confusing to outsiders. It has caused a fair amount of conflict within the field as well. Psychologists often lose their scientific, evidence-based focus and stubbornly hold the view that "if it is like me, it must be OK" and "if it's not like me, it must be deficient in some way" (Meehl, 1973). There is much overlap among the different models of training within clinical psychology, and more research-focused Vail model programs are hard to distinguish from more practice-focused Boulder model programs. If we placed all clinical psychology programs along a continuum based on research-practice emphasis, we would certainly have overlapping distributions among the models of training (see Figure 1.2). Clearly, psychology needs excellent researchers *and* excellent practitioners. The advantage of what may at first appear to be a chaotic state of affairs is that all aspects of psychology education and training are covered. The past animosity among proponents of each model damages psychology's public image and slows the progress we can make together when we join as a science and a profession to solve today's important problems. By allowing applicants to choose the training models, degrees, and programs that best fit their interests and career goals, we ensure the continuation and enhancement of research, practice, and their integration in professional psychology.

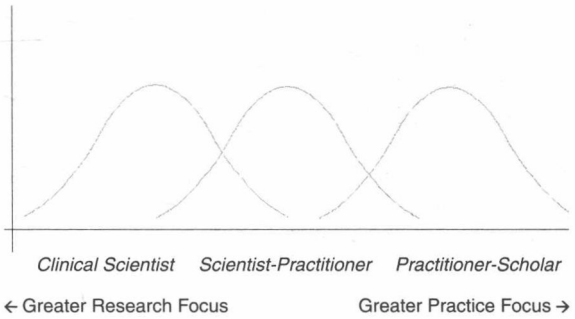

FIGURE 1.2 Theoretical Distribution of Research and Practice Emphasis of Programs Indicating Different Training Models.

MOVEMENT TOWARD COMPETENCIES

Identification of Competencies

The development of a standardized core curriculum in psychology has been controversial for many years and has never fully succeeded