Consensus Conference on Combined-Integrated Doctoral Training in Psychology

Date: May 2-4, 2003 James Madison University, Harrisonburg, Virginia

Issue:

Although the concept of combined and integrated doctoral training among clinical, counseling, and school psychology programs has existed for a number of years, and is often enthusiastically endorsed by training faculty and students alike (cf., Beutler & Fischer, 1994; Minke & Brown, 1996; Schwebel & Coster, 1998; Shealy, 2002; Stewart, Shealy, & Cobb, 2001; Tryon, 2000), programs that train from this perspective have yet to articulate—in one time and place—the many advantages of a combined and integrated model of training or its unique and timely relevance for the larger field. This lack of consensus has led to unnecessary confusion for prospective students and employers, the profession, accrediting processes, and the public at large, and has hindered the potential of combined and integrated approaches to doctoral training. At the same time, there is great interest in attempting to address and resolve these issues, as evidenced by the "integration movement" in general (e.g., Norcross, 2002), calls for greater unification in our field (cf., Sternberg & Grigorenko, 2001), a symposium on combined and integrated training at APA in August, 2002 (Shealy, 2002), and of particular note, the recent Competencies 2002 Conference held in Scottsdale, Arizona (see www.appic.org).

Background

The “Boulder conference” and its “scientist-practitioner” ethic (cf., Belar, 2000; Benjamin & Baker, 2000; Gaudiano & Statler, 2001) are rightly considered a cornerstone of doctoral training in general. However, a robust and relevant debate over specifics (e.g., how students should be trained, what knowledge, skills, and competencies should be mastered; how programs should articulate and actualize their training objectives) continues to this day (e.g., Belar, 1998; CoA Self-Study, 2002; Fox, 1994; Resnick, 1997; Peterson, Peterson, Abrams, & Stricker, 1997; Shapiro & Wiggins, 1994; Smith, 2001).

At the same time, a consensus appears to be emerging that applied and professional psychology is "at a critical juncture in the continuing evolution of the field" (Olvey, Hogg, & Counts, 2002, p. 327). Although the "causes" of our current situation are economic and historic and well as complex and multidetermined, the effects are not in doubt: the students we are producing are too often saddled with post-graduate debt that will not be covered by the incomes they can reasonably expect in an increasingly competitive milieu, and the time expected of them to obtain licensure seems difficult to justify in terms of costs and benefits. As Olvey, Hogg, and Counts (2002) starkly conclude,

“if earnings for psychologists continue to decline, the demographics of students seeking admission into graduate programs of psychology are likely to mirror admissions into lower wage helping professions such as social work or masters-level counseling programs….When compared to other professions, professional psychologists are clearly at the top-of-the-line in terms of requirements for licensure. It is also apparent that psychologists lie near the bottom-of-the-heap in terms of earnings…From a big picture perspective, psychology needs to develop a stronger base by broadening its paradigm to focus on a whole range of occupations for its professionals (pp. 327-328).”

Complicating matters, it is not at all clear that the training we provide to students reliably predicts either the perception of the professional competencies or their eventual employment outcomes. For example, data from the Association of Psychology Postdoctoral and Internship Centers (APPIC), suggests that internship training directors across a wide range of program types "prefer" or "accept" applicants in a

manner that is not predicted by the doctoral program area in which they were trained (e.g., clinical, counseling, or school) (APPIC, 2003). Likewise, data from the Committee on Accreditation of the American Psychological Association indicate that students trained in clinical, counseling, and school psychology are employed across a wide and often overlapping range of employment settings (APA, 2002). Not surprisingly in relation to such perceptions and outcomes, it has proved exceedingly difficult to clarify what are the real and substantive distinctions between the "specialty areas" of clinical, child clinical, counseling, or school psychology; in fact, all four of these areas rightly note that their practitioners work with most of the same clinical populations, presenting problems, and procedures (see Cobb, 2002; www.apa.org/crsppp). In addition to these challenges, the field has not yet resolved a number of other vexing problems having to do with fundamentals of training sequence and specialization and relevance to the current job market (Williams-Nickelson, 2001).

Fortunately, over the past several years, a range of conferences and initiatives within the larger field of professional psychology have addressed aspects of the larger problem in a comprehensive and systematic manner, and have essentially provided crucial “pieces” of a larger puzzle that might now be assembled into a more coherent and appealing whole. Such activities and policies include, but are not limited to, the inaugural Education Leadership Conference (Belar, 2002), the educational model of the National Council of Schools and Programs of Professional Psychology (Peterson et al., 1997), Competencies 2002: Future Directions in Education and Credentialing in Professional Psychology (Kaslow & Vasquez, 2002; see www.appic.org), the Commission on Education and Training Leading to Licensure in Psychology (see Williams-Nickelson, 2001), and the Comprehensive Principles for Health Services Specialization in Professional Psychology (see www.apa.org).

At a crucial and complementary level, there is a growing perception—now codified into regulation at a federal level and in a number of licensure contexts—that professional psychology and applied psychologists (e.g., in clinical, counseling, and school psychology) are rightly considered “health care providers,” broadly defined. As the new Chief Executive Officer of the American Psychological Association notes, “Now that the scientific foundation for psychology as a health profession has been established, the challenge for us is to move to the center of health care delivery systems and be viewed as health care providers more generally” (Anderson, 2003, p. 9). This conceptual framework provides important opportunities for applied and professional psychology to redefine its identity and the nature and scope of its impact within the broader health care field. Such possibilities are revealed most dramatically, perhaps, in the new Graduate Psychology Education program, which was established in the Bureau of Health Professions in 2002, and provided $2,000,000 for the education and training of psychologists and

the doctoral and internship level. This program is the first ever designed explicitly and exclusively for doctoral-level psychology training. As significant, at a statutory level, GPE is explicitly "…targeted to health service psychologists, who provide evidence-based services in the prevention, diagnosis, treatment, and rehabilitation of a wide range of behavioral health problems" (Levitt, 2003, p. 2).

In consideration of all of these interrelated issues, which directly relate to the nature, scope, and future of education, training, and practice in professional psychology—and in the context of a growing chorus of voices which advocates for a more unified and integrated approach to psychology in general and professional practice in particular (e.g., Norcross, 2002; Shealy, 2002; Sternberg, 2001)—a three-day Consensus Conference on Combined and Integrated Doctoral Training in Psychology was held May 2-4, 2003, at James Madison University in Harrisonburg, Virginia. The participants, sponsors, goals, structure, and results of the Consensus Conference are described below.

Consensus Conference Steering Committee

- Susan Crowley, Ph.D.
- Paul Nelson, Ph.D.
- Gary Peterson, Ph.D.
- Craig Shealy, Ph.D., Chair

Consensus Conference Sponsors

- American Psychological Association of Graduate Students
- Association of Psychology Postdoctoral and Internship Centers
- Consortium of Combined-Integrated Doctoral Programs in Psychology
- Division 29, American Psychological Association
- Education Directorate, American Psychological Association
- James Madison University

Consensus Conference Participants: Combined Doctoral Program Training/Program Directors

- Susan Crowley, Ph.D.
  Utah State University
- Michael Furlong, Ph.D.
  University of California Santa Barbara
- Abraham Givner, Ph.D.
  Yeshiva University
- Nancy Link, Ph.D.
  University of Toronto
- Barbara Mowder, Ph.D.
  Pace University
- Barbara Okun, Ph.D.
  Northeastern University
- Jim Sampson, Ph.D.
  Florida State University
- Mitchell Schare, Ph.D.
  Hofstra University
- Craig Shealy, Ph.D.
  James Madison University
- Martin Volker, Ph.D.
  University of Buffalo

Invited Speakers and Consultants

- Mardi Allen, Ph.D.
  Association of State and Provincial Psychology Boards

- Virginia Andreoli-Mathie, Ph.D.
  Past President, Division 2
- Cynthia Belar, Ph.D.
  Executive Director, Education Directorate
- Larry Beutler, Ph.D.
  Past President, Division 12
- Jessica Blom-Hoffman, Ph.D.
  Combined Doctoral Program, Northeastern University
- Harrison Braxton
  Combined Doctoral Program Student, James Madison University
- Rodney Goodyear, Ph.D.
  Council of Counseling Psychology Training Programs
- Judy Hall, Ph.D.
  Director, National Register of Health Service Providers in Psychology
- Scotty Hargrove, Ph.D.
  Chair, Committee on Accreditation
- Gregg Henriques, Ph.D.
  Core Faculty Member (8/03), JMU Combined Doctoral Program
- Howard Kassinove, Ph.D.
  Department Chair, Hofstra University
- Chris Loftis, M.S.
  Chair, American Psychological Association of Graduate Students
- Ann Loper, Ph.D.
  Association of Directors of Psychology Training Clinics
- Paul Nelson, Ph.D.
  Deputy Executive Director and Director of Graduate Education and Training Programs, Education Directorate
- John Norcross, Ph.D.
  Past-President, Division 29
- Ron Reeve, Ph.D.
  Department Head, Curry School of Education, University of Virginia
- Emil Rodolfa, Ph.D.
  Chair, Association of Psychology Postdoctoral and Internship Centers

- Juan Jose Sanchez Sosa, Ph.D.
  President, Division of Clinical and Community Psychology in the International Association of Applied Psychology
- Robert Sternberg, Ph.D.
  President, American Psychological Association
- Anne Stewart, Ph.D.
  Combined Doctoral Program, James Madison University
- William Strein, Ed.D.
  Chair-Elect, Council of Directors of School Psychology Programs
- LaPearl Logan Winfrey, Ph.D.
  President, National Council of Schools and Programs of Professional Psychology

CCIDPIP Conference Goals

The Consensus Conference had three overarching goals:

1. define what a truly integrated, combined model of training would look like and be called;
2. clarify the relationship between this model and the other practice/specialty areas in psychology;
3. consider the potential role and place of this model within the larger profession and health care field.

In the context of these overarching goals, there were six expected conference outcomes:

1. Review historical and current context/information about combined doctoral programs (e.g., key figures at the outset, when first recognized by APA, how many programs now, etc.), and consider

how a combined and integrated model may help address historic and current issues and trends within our field (e.g., the “unification” and “psychology-as-a-health-profession” movements).

2. Highlight the many benefits of combined and integrated doctoral training for students, faculty, administrators, clients, our field, and the public. These benefits include (but are not limited to): a) increased employment opportunities and greater professional flexibility (e.g., based upon CoA and other data); b) greater responsiveness to student perspectives and preferences; c) reduction of artificial barriers between the three practice areas; d) the financial, time, and resource savings that accrue from supporting one integrated and APA-accredited program (versus two or more); e) congruence with calls for greater “unification” in our field as well as data demonstrating that overall, no one single therapeutic approach is superior to any other; f) reduced confusion by the public and other health professions as to what practicing psychologists are, what they are qualified to do, and what they are called.
3. In the context of Competencies 2002 (e.g., see the “Competency Cube”), adopt a consensus model of combined and doctoral training that a) specifies (at least) the “minimal level of competence” expected of our students across these practice areas (e.g., what core or foundation knowledge, skills, and values our students must demonstrate); b) clarifies the nature and scope of didactic and experiential opportunities that are integral to such a model; and c) affirms that all practicing psychologists must demonstrate such competence regardless of eventual professional roles, activities, or identity.
4. Consider the high degree of overlap between the practice areas of clinical, counseling, and school psychology in the context of CRSSP guidelines, internship/CoA data, the CoA substantive/ emerging area discussion, and the CCOPP specialization document; consider these issues in the context of general and specialty practice, training sequence, accreditation, and licensure.
5. Review the future role of psychology in general and professional practice in particular within the larger health care field; in the context of a combined and integrated model, consider relevant and applicable developments within the field and at a funding/advocacy/regulatory/legislative level.
6. Discuss the suitability of the term “combined” (as in “combined programs”), decide whether an alternative term is preferable, and determine what “label” psychologists from such combined programs are to assume (e.g., Health Service Psychologists, Professional Psychologists, Combined Psychologists, General Practitioners, Integrative Psychologists, etc.); consider how this model can best be disseminated within the larger field.

Consensus Conference: Proceedings and Results

The Consensus Conference was covered in the American Psychological Association's Monitor on Psychology, and can be accessed electronically at http://www.apa.org/monitor/julaug03/combined.html. Finally, the conference and related topics will be covered in a Special Series of the Journal of Clinical Psychology, which is slated for release in 2004.

The "results" of the Consensus Conference emerged from the working groups described above. Ultimately, participants developed specific content and/or recommendations in the following five areas, which are described below.

A. **Program Name**
   - The group changed the name "combined doctoral program" to "combined-integrated or C-I doctoral program."

B. **Mission Statement**
   - Participants approved the following mission statement for combined-integrated doctoral training programs in psychology:

     "Combined-Integrated Doctoral Training Programs in Psychology produce general practice, primary care, and health service psychologists who are competent to function in a variety of professional and academic settings and roles; these programs achieve this goal by intentionally combining and/or integrating education and training across two or more of the recognized practice areas."

C. **Rationale for Combined-Integrated Doctoral Training**
   - In addition to "rationale" elements that were implicit and explicit throughout the Consensus Conference, participants also emphasized the following four points:

1. there is tremendous overlap in the basic competencies (i.e., knowledge, skills, and values) needed to function effectively in each of the single practice areas of psychology;
2. psychologists with training across the practice areas are employed in increasingly similar settings and thus are required to possess comparable competencies;
3. psychologists are perceived as alike by many outside the field, including relevant funding systems and regulatory boards; and
4. competence within and across the practice areas of psychology can and should be taught in a manner that is complementary and synergistic.

D. **Distinctiveness of Combined-Integrated Doctoral Training Programs**
   - In addition to "distinctiveness" elements that were implicit and explicit throughout the Consensus Conference, participants also emphasized that combined-integrated doctoral programs:
     1. fill a unique and necessary niche in the education and training of psychologists;
     2. respond proactively to current realities for and needs of students and the public;
     3. operationalize a vision of education and training that would help ensure the long-term viability and prosperity of the profession and field.

E. **Principles of Combined-Integrated Doctoral Training in Psychology**
   - Consensus Conference participants completed their work in both a large group and small group format. After a series of presentations, small working groups considered issues within two topic areas (see "schedule of events"). Following these discussions, the entire group met and developed the following eighteen principles of Combined-Integrated (C-I) Doctoral Training in Psychology:
     1. C-I programs provide a unique educational and training model that affords students a wide breadth of training, increases their flexibility and marketability, and optimally prepares them to function as psychologists in a wide variety of professional and academic roles and settings.
     2. C-I programs achieve their unique curriculum in large part by intentionally exposing students to the following:
        a. two or more psychological practice areas, which are woven throughout the curriculum;
        b. multiple theoretical orientations;
        c. the wide parameters of practice, including a variety of problems addressed, settings, and populations across the life span.
        d. population presentations that exist along the functional/adaptive continuum.
     3. C-I programs provide an educational environment that facilitates effective intra- and inter-professional communication, training, and scholarship in a manner that is respectful, collaborative, and informed.
     4. C-I programs are committed to developing clear and specific competencies for their programs and students. In that regard, the conclusions of the Competencies 2002 Conference (see www.appic.org) including, but not limited to, the Competencies Cube provide a useful framework for guiding program development and modification (e.g., in the context of the

Comprehensive Principles for Health Services Specialization in Professional Psychology; see www.apa.org).

5. C-I programs are structured to support prominent student representation, are sensitive to the implications of training requirements for students, and are aware of the interface between training and regulatory/licensing bodies that students will ultimately encounter in their professional development and careers.
6. C-I program faculty accept the responsibility for training students to at least an entry-level of competence for a particular area of practice and assume the authority to evaluate student competencies in the relevant practice areas.
7. C-I program faculty seek to protect the integrity and welfare of their programs, the profession, and the public and therefore accept responsibility, insofar as possible, for the timely identification and remediation of student problems as well as any subsequent program actions vis-à-vis the ultimate status of all students in their programs.
8. C-I program faculty accept the responsibility for the relative imbalance of power between faculty and trainees that is inherent in doctoral level training, and subsequently expect training faculty to behave in an appropriate, responsible, and ethical manner, and to exhibit a level of self-awareness that equals or exceeds that required of students.
9. C-I program administrators and faculty demonstrate that they are supportive of the combined-integrated model of education and training, and recognize that aspects of the single practice model (e.g., training processes and cultures) must be modified somewhat in order to create the unique learning environment provided by C-I programs.
10. C-I programs actively work to engender a climate of diversity, and endorse relevant professional and ethical guidelines (e.g., see the 2002 Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists, at www.apa.org).
11. C-I programs are committed to teaching an ethic of social responsibility as well as the capacity to respond effectively to evident social and psychological needs within the larger community.
12. C-I programs are sensitive to and aware of issues pertaining to the field of psychology at a global level and strive to establish productive relationships and alliances with international psychological training associations, models, and programs.
13. C-I programs endorse the basic knowledge areas identified by the Committee on Accreditation's Guidelines and Procedures including, but not limited to, exposing students to the scientific foundations necessary for informed and competent practice.
14. C-I programs support evidence-based practice that is ecologically valid and relevant for practitioners and scientists alike.
15. C-I programs support the highest standards of quality assurance, and design programs to be simultaneously efficient and rigorous.
16. C-I programs engage in the assessment of outcomes relevant to their programs, use such data to inform program development, and disseminate results as appropriate.

17. C-I programs are actively self-reflective vis-à-vis their model and approach to education and training.
18. C-I programs endorse a commitment from faculty and trainees to continue their professional development throughout their careers.